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1/9/2014

Enclosed please find my comments as the whistleblower in response to the Office of the Special Counsel (OSC) investigation case # DI-13-3661 regarding the massive privacy breaches at the Veterans Affairs Medical Center located in Northport New York. I received the OSC report re: OSC case # DI-13-3661 in the mail on 12/19/13 and was given an extension to 1/21/2014 to submit my response to this report. 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 "report." 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 - enclosed please find a copy of 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 it is 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 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. 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. It is highly disturbing that a VA cop is allowed to waltz through my medical record since your local cop or sheriff just can't waltz into your private doctor's office and peruse your medical records at a whim; 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 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 her 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.

The agency's OMI 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. 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) if applicable. 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 report jumps to erroneous conclusions based on superficial face value biased.

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 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.

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?

### **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, Omaid 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 separately. 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](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 Squicciarini) 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.

<b>If you:</b>	<b>You are eligible for:</b>	<b>Through:</b>
Have a service-connected compensable dental disability or condition.	Any needed dental care.	Class I
Are a former prisoner of war.	Any needed dental care.	Class IIC

<p>Have service-connected disabilities rated 100% disabling, or are unemployable and paid at the 100% rate due to service-connected conditions.</p>	<p>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></p>	
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**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 Awareness (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**

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**VA Directives**

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

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[http://vaww1.va.gov/vapubs/viewPublication.asp?Pub\\_ID=700&FType=2](http://vaww1.va.gov/vapubs/viewPublication.asp?Pub_ID=700&FType=2)

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[http://vaww1.va.gov/vapubs/viewPublication.asp?Pub\\_ID=404&FType=2](http://vaww1.va.gov/vapubs/viewPublication.asp?Pub_ID=404&FType=2)

#### **Other**

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Veteran Population, (January 12, 2010). *National Center for Veterans Analysis and Statistics*. Retrieved from: [http://www.va.gov/vetdata/Veteran\\_Population.asp](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 concern for the safety of patients the SLB

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

1100.19 misconduct process should

privileges be reduced or revoked for this reason

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

1100.19 result in imminent danger to health of any Individual privileges

1100.17

Flow charts and sample letters:

[http://vaww.va.gov/ohrm/EmployeeRelations/other\\_t38\\_issues.htm](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)** <sup>(1)</sup> 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) permissible. 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:

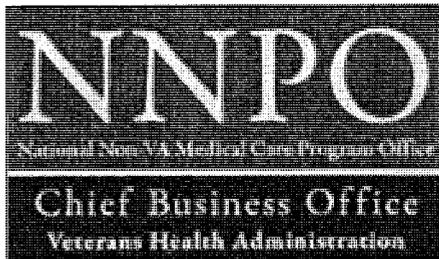
Building 200 -> 30/48 staff  
Building 10 -> 11/48 staff  
Building 12 -> 2/48 staff  
Building 9 -> 1/48 staff

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**

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State Homes

Dialysis

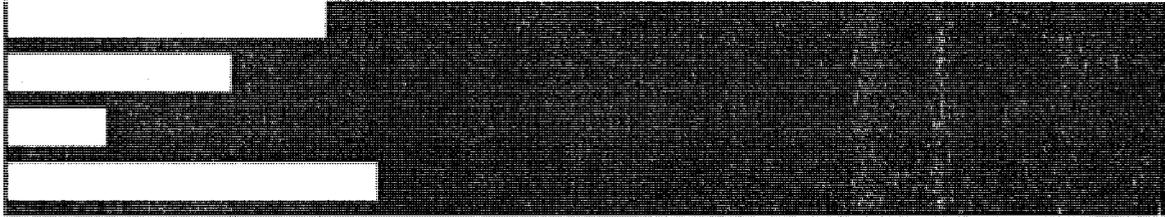
Program Integrity

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:

<b>Level of Access</b>	<b>Access</b>	<b>Explanation</b>
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://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

VA Software Document Library – IFCAP and Fee Basis

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 Informtion (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 of 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#.Uo9ZeDe85A.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 sub-specialty 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 HANDBOOK 1907.01 August 25, 2006 66**

*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, hearings 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**

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###### **§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.
- §17.98** Mental health services.

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.tpl](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=1854ae35b609bbdf3106c25185a900a3&c=ecfr&tpl=/ecfrbrowse/Title38/38tab_02.tpl)

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://vawww.northport.med.va.gov/Forms\\_Publications/Center%20Memorandums/Documents/Director\\_Office/CM%2000%20104%20workplace%20violence.doc](http://vawww.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](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](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](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. Moschitta. 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](mailto: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

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[www.archives.gov/ogis](http://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 shits 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, Pl 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 11<sup>th</sup>. 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 11<sup>th</sup>, I have responded to all of your requests. I now am working on the five requests you sent since the 11<sup>th</sup>. 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](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](mailto:IntegratedEthics@va.gov)

## **Service Connected (SC)/Special Authority (SA) conditions**

### **The Business Office, Administrative and Provider responsibilities for SC/SA care and Fee Basis requests**

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.

## **The Department of Veterans Affairs Administrations**

The Department of Veterans Affairs (VA) is divided into three administrations: National Cemetery Administration (NCA), Veterans Benefit Administration (VBA) and Veterans Health Administration (VHA). For the purpose of this document, only VHA and VBA will be discussed.

The VHA is responsible for administering health care to eligible Veterans. VA operates the nation's largest integrated health care system with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliary, readjustment counseling centers and various other facilities maintaining a vast System of Records (SOR) on over 22.3 million living veterans nationwide on many data platforms (electronic and hard copy).

The VBA is responsible for administering the Department's programs that provide financial and other forms of assistance to Veterans, their dependents and survivors. Major benefits include Veterans' compensation, Veterans' pension, survivors' benefits, rehabilitation, employment assistance, education assistance, home loan guaranties and life insurance coverage.

Compensation and Pension (C&P) Programs provide direct payments to Veterans, dependents and survivors as a result of the Veteran's SC disability or because of financial need. Disability compensation is a monetary benefit paid to Veterans with disabilities that are the result of a disease or injury incurred or aggravated during active military service. The benefit amount is graduated according to the degree of the Veteran's disability on a scale from 0 to 100 percent (in increments of 10 percent).

## **What is Service Connected and How is it Determined?**

A Veteran can apply for Service Connected (SC) consideration by filling out VA Form 21-526, Veterans Application for Compensation and/or Pension. The VBA will review the Veteran's claim including records submitted and findings from a compensation and pension exam (if required) and render a decision on the claim.

The definition of Service Connected (SC) has its origin in the VA mission and the fulfillment of President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans.

SC means, with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval, or air service. This can include a range of conditions from an actual combat injury, such as a gunshot wound, to a medical condition such as Chronic Obstructive Pulmonary Disease (COPD), allergic rhinitis, or arteriosclerotic heart disease (ASHD).

Additional points to consider:

- treatment of service connected conditions is exempt from VA first party copayments and third party insurance billing;
- a Veteran may have more than one adjudicated SC condition; and
- if the primary rated condition worsens over time, the Veteran should be encouraged to contact VBA for possible reassessment of rated disabilities.

### **What Does Compensable Mean?**

Compensable refers to a VBA rated SC disability for which monetary compensation is authorized for payment. A Veteran might even be entitled to compensation when disabilities are rated 0% disabling.

For additional information on the topic of compensation see Chapter 2 of the Federal Benefits for Veterans.

#### **Note**

For those who suffer the most severe injuries or disabilities, VA Disability Compensation is designed to ensure that our Veterans are able to live with dignity.

### **What is a Special Authority?**

#### **Important Note**

Providers are responsible for clinically determining if care/treatment is related to a Special Authority and indicating this by answering yes/no to designated prompts in CPRS. Clinical documentation must also support this determination. There will be no first party copayment or third party insurance billing for treatment/care related to Special Authorities.

Veterans who have Special Authority (SA) eligibility receive cost-free medical care at VHA for those conditions related to that specific SA eligibility per Title 38 legislation. In accordance with VHA regulation and policy, VHA has **not** published an all-inclusive list of conditions for these SA eligibilities. The VHA provider has wide latitude and makes the determination if the visit, care, or treatment is related to a specific SA eligibility after prudent consideration of applicable clinical research and clinical decision-making.

Current SA eligibility authorities include (list subject to change as new legislation occurs):

- Agent Orange (AO)
- Camp Lejeune Environmental Action Registry (CLEAR)
- Ionizing Radiation (IR)
- Project Shipboard Hazard and Defense (SHAD)
- Head and Neck Cancer
- Combat Veteran (CV)
- Military Sexual Trauma (MST)
- Southwest Asia Conditions (SWA)

### **What is Military Sexual Trauma?**

Sexual trauma experienced while on active duty in the military is considered Military Sexual Trauma (MST). Sexual trauma is defined as sexual harassment, sexual assault, rape and other acts of violence. Sexual harassment is further defined as repeated, unsolicited, verbal or physical contact of a sexual nature, which is

considered threatening. VHA may bill first party copayments and third party payers for non-MST related care or treatment.

Eligibility is established in the form of a clinical reminder screening. If that screening is positive, the MST question will then be open for each encounter thereafter. Veterans may also be eligible for free counseling and treatment for conditions related to MST even if they are not eligible for other VA care.

For more information on MST, visit this website: <http://vaww.mst.va.gov>

## **Public Law 104–262**

PL 104–262, the Veterans Health Care Eligibility Reform Act of 1996, paved the way for the creation of a Medical Benefits Package—a standardized, enhanced health benefits plan available to all enrolled Veterans. The law also simplified the process for Veterans to receive services.

The Benefits Package does not generally include hearing aids and eyeglasses, unless they are needed for an SC disability or for Prisoner of War or Purple Heart recipients. Sensorineural aids may also be provided to Veterans with severe visual or hearing impairment. Although some Veterans are still eligible for services that are not part of the Medical Benefits Package, they may need to apply for them on a case-by-case basis and special restrictions may apply.

Other laws that impact revenue but are not covered in this course:

1. Public Law 102–139: The Department of Veterans Affairs and HUD Appropriations Act of 1992
2. Public Law 103–66: The Veterans Reconciliation Act of 1993
3. Public Law 106–413: Veterans' Compensation Cost-of-Living Adjustment Act of 2000
4. Public Law 106–419: Veterans Benefits and Health Care Improvement Act of 2000
5. Public Law 112–154: Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012

## **Where to Find Veterans' Service Connected Conditions: Tools to Assist with Service Connection and Special Authority Determination**

Service connected conditions are listed in VHA records under several options. Providers access this information most often through the consolidated health record. Conditions are also listed in the eligibility screen of patient registration. Designated VHA staff has been granted access to VBA Virtual VA database where narrative and coded rating sheets reside. This provides VHA with the actual Veteran rating and is the most authoritative source of information.

The following are tools to assist with SC/SA determination:

- Virtual VA: VBA website where rating code sheets and narrative documents are stored containing the root source of the Veterans' rated conditions.
- The most definitive source of the Veterans' rated conditions is the rating decision maintained by VBA Regional Offices.
- CPRS Encounter Form: The Encounter Form will list SC conditions and highlight special authorities applicable to the Veteran prompting the provider to indicate if the care or treatment provided was SC/SA.
- Compensation and Pension Exams (if available in CPRS) may be very helpful but are not the definitive VBA rating.
- Patient Care Encounter (PCE): a VistA option that contains future and past appointment lists.

- Registration and eligibility staff: These individuals can provide eligibility-based information regarding SC/SA.
- Patient interview: The patient may be a source of information of rated condition, but the provider makes the final encounter determination—use all of your resources.

### What is the Role/Responsibility of the Department of Veterans Affairs Provider?

The provider makes the determination that the treatment/care provided during an encounter is for a service connected condition or special authority eligibility. The provider also identifies the primary diagnosis as supported by clinical documentation. If the primary diagnosis for the encounter is the Veteran's rated SC condition, the encounter is SC. If a secondary diagnosis is a rated SC condition, the provider must determine if active treatment was provided for that condition. Designation of SC/SA requires clinical judgment and prudent application of SC/SA guidelines. Neither the Veteran nor the Veteran's health care plan will be billed if care/treatment is validated as SC/SA. Clinical documentation must support a provider's designation of SC/SA.

Active treatment in this context includes a change in the patient's treatment regimen or active diagnostic testing for the SC condition. Mention of stable conditions and/or re-ordering of routine medications or labs does not constitute active treatment for revenue purposes. Treatment of secondary or adjunct conditions is non-service connected (NSC) and will be billed to the Veteran's third party insurance company unless the conditions are specifically rated. If the primary rated condition worsens over time, encourage the Veteran to have VBA complete a reassessment of their rated disabilities. The provider also evaluates treatment or care provided during an encounter for relationships to applicable special authority eligibilities.

### Valuable Links

- VA Mental Health Service's Military Sexual Trauma (MST) Resource: <http://vaww.mst.va.gov>
- VA learning site that currently has two SA eligibility courses available for CME credit:  
<https://www.tms.va.gov/learning/user/login.jsp>
  - VHI: Military Sexual Trauma Web Course—Course number: VA5957
  - VHI: Vietnam Veterans and Agent Orange Exposure Web Course—Course number: VA6269
- For general information about ratings, codes, and percentages:  
<http://vbaw.vba.va.gov/bl/21/publicat/regs/Part4/toc.htm>
- Special Authority list is located on the HIMS website for physician documentation. **(This is for guidance only, this is not an all inclusive list)**
- Flip Cards: <http://vaww.vhaco.va.gov/him/edutaining/FlipCards-2012.pdf>
- VHA HANDBOOK 1302.02, dated June 5, 2007 –Gulf War (Including Operation Iraqi Freedom) Registry (GWR) Program (Formerly Persian Gulf Registry (GWR) Program)  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=1574](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1574)
- Title 38 USC, Part II Chapter 17, Subchapter III § 1729. Recovery by the United States of the cost of certain care and services. <http://www.law.cornell.edu/uscode/text>
- VHA Directive 2008–054—**Combat Veteran Health Care Benefits and Copay Exemption Post-Discharge from Military Service**  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=1758](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1758)
- VHA Handbook 1601C.02 **Revenue Utilization Review (RUR)**.  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2542](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2542)

### References

1. United States Department of Veterans Affairs: Compensation  
<http://www.vba.va.gov/bln/21/compensation/index.htm>
2. Priority Group 8 Enhancements:  
[http://vaww.va.gov/ENROLLMENT/Priority\\_Group\\_8\\_Enhancements.asp](http://vaww.va.gov/ENROLLMENT/Priority_Group_8_Enhancements.asp)

3. United States Department of Veterans Affairs: Women Veterans Health Care  
<http://www.publichealth.va.gov/womenshealth/trauma.asp>
4. Public Law Guidance <http://vaww1.va.gov/cbo/apps/policyguides/index.asp?mode=contents&id=III>
5. M-1, Part I Chapter 15, section 15.02b (5).
6. Department of Medicine and Surgery Manual - Operations:  
[http://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=784](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=784)

## **The Revenue Process in the Context of Service Connection and Special Authority**

### Revenue Process Overview

#### **Intake and Registration**

##### **Patient Registration**

Patient Registration encompasses activities relating to the initial establishment of an individual's application for VA health services, determination of their eligibility for these benefits, and enrollment in the VA health care system. Data collected during the registration process allows VA to:

- identify the types of health services requested;
- uniquely establish the patient's record;
- assess the applicant's priority for enrollment in the VA health care system and assess the applicant's eligibility for cost-free health care, long-term care, outpatient prescriptions and mileage reimbursement;
- determine the applicant's marital status, next of kin and emergency contact for care management and consent purposes;
- determine the applicant's demographic information, such as address and telephone numbers; and
- **identify the applicant's employment information and third party health insurance coverage necessary to facilitate recovery of the cost of care furnished for treatment of non-SC/SA conditions.**

##### **Insurance Identification**

The process for determining the existence of a third party payer that is responsible for covering a portion of the cost of providing medical care for the Veteran. Identification of insurance may occur:

- at the time of enrollment;
- prior to a visit/admission thru pre-registration; and
- or at the point of service.

Once identified, policyholder information is loaded into Veterans Health Information Systems and Technology Architecture (VistA) for verification.

##### **Insurance Verification**

Confirmation that identified insurance is valid for purposes of billing non-SC/SA care to third party payers. Verification includes confirming the effective and expiration dates of the Veteran and his or her spouse's insurance policy with the payer along with determining applicable cost shares, deductibles, precertification or certification requirements, and other policy provisions that dictate if billing should occur for an episode of care.

##### **Treatment**

##### **SC/NSC Determination**

- VA cannot bill for SC treatment

- VA can bill for NSC treatment

## **Coding and Documentation**

Coding is an art and science requiring specialized training, education, and skills. There are specific guidelines and criteria that must be followed to ensure proper code assignment, sequencing, and reporting. While coding is performed for a variety of reasons, it is primarily done to permit the search and retrieval of information according to diagnosis or procedure associated with an assigned code number. All codes must be based on provider documentation contained in the body of the health record.

### **Health Information Management Services (HIMS)**

## **Health Care Records**

The health record's main purpose is to aid providers in the continuity of care for patients by serving as a means of communication among healthcare providers. In addition, documentation in the health record is also used to evaluate the adequacy and appropriateness of quality care, provide clinical data for research and education, support reimbursement, medical necessity, quality of care measures, and public reporting for services rendered by a medical facility.

## **Coding Assignment**

Code assignments by HIMS professionals, using ICD and CPT classification systems, are based on documentation derived from the health record. Data integrity is extremely important and many times HIMS is faced with challenges when assigning codes. These challenges are often due to conflicting, incomplete, or ambiguous information documented by healthcare providers. Therefore, HIMS may query providers to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record.

### **Revenue Utilization Review**

## **Precertification**

The process of obtaining prior authorization for outpatient or inpatient services from a third party payer. This process may involve a clinical review against appropriateness screening criteria as required on selected procedures/services that are stipulated by the insurance carrier's pre-established policies. Review of outpatient non-emergent services and procedures often requires 48 hours or more prior notification. To avoid penalties and loss of revenue, timely identification and precertification of services or procedures is required through a systematic process. Failure to obtain precertification may result in a financial penalty. Identifying services and procedures that require prior authorization is a continuous process due to insurance policies being subject to change.

## **Admission Certification**

A form of medical care review in which an assessment is made of the medical necessity of a patient's admission to a hospital or other inpatient institution. Admission certification seeks to assure that patients require a hospital level of care. Certification can be done before (preadmission) or shortly after (concurrent admission) depending on insurance policy stipulations.

## **Continued Stay Reviews**

A review during a patient's hospitalization to determine the medical necessity and appropriateness of continuation of the patient's inpatient stay. Concurrent reviews typically involve reviewing the patient's case while the patient is still in-house to obtain pertinent clinical information in support of medical necessity. Revenue Utilization Review nurses provide clinical continued stay reviews to third party payers for the purpose of continued authorization.

## **Billing**

### **Bill Creation**

Billing is the process of submitting claims to third party insurance companies in order to receive payment for services rendered by a health care provider. Bill creation includes the process of applying charges to services or care provided to a Veteran including but not limited to:

- facility charges (inpatient/outpatient);
- skilled nursing facility/sub-acute inpatient Institutional per diem charges;
- prescriptions;
- prostheses and durable medical equipment (DME);
- Non-VA medical care; and/or
- professional charges.

Billing may occur for:

- non-SC/SA illness or injury for which the Veteran is entitled to care (or the payment of expenses of care) under a health-plan contract;
- illness or injury incurred incident to the Veteran's employment and covered under non-federal workers' compensation; or
- illness or injury incurred as a result of a motor vehicle accident in a state that requires automobile accident reparations insurance, or fees from tortiously liable third parties for care rendered by VA, also called "tortfeasor."

Bill creation includes input of data in all required form locator fields for standard billing documents including the UB-04 and the Centers for Medicare and Medicaid Services form CMS-1500. This process also includes using automated tools including Electronic Data Interchange (EDI) and the electronic Medicare Remittance Advice (e-MRA) process.

### **Claims Correspondence and Inquiries**

Involves follow-up on correspondence or telephone inquiries from third party payers in response to receipt of a claim for services provided to a Veteran. Correspondence may indicate the need for more information to process the claim such as health records or may indicate a reason for denial of the claim. Medical Care Collections Fund (MCCF) staff research correspondence to determine whether to close out an account or to re-submit the claim.

### **Accounts Receivable/Collections**

#### **Establishment of Receivables**

The process of transferring a claim from the integrated billing package to the accounts receivable package within VistA. Upon completion of a bill to a third party payer, the claim must be audited to be established as a receivable. Once audited, a claim will be submitted to a third party payer and payments can be posted to the Veteran's account.

## **Payment Processing**

Posting remittance from either a third party payer or first party debtor to a specific account number. Payment processing includes evaluating the payment to ensure it was appropriate in terms of coverage for the patient. Upon posting payment, an account becomes either paid in full or paid in part. Payment processing for a third party payer also includes a determination of whether any portion of the payment must be used to offset a corresponding first party copayment debt if the Veteran is required to pay copayments for medical services and/or medications as part of their eligibility. The payment process concludes with the reconciliation of receipts and deposit.

## **Collection Correspondence and Inquiries**

Once claims are received by payers, correspondence indicating payment (partial or full) is submitted back to the facility that generated the claim. Typically, this correspondence is in the form of an Explanation of Benefits (EOB) or an Electronic Remittance Advice (ERA). Follow-up must occur on all partial payments, potential overpayments, and/or payments not made timely in order to determine if additional reimbursement or a refund is due based on policy provisions and care provided. Follow-up typically occurs by telephone, accessing the payer's internet website, or written correspondence. Claims correspondence also includes processing documentation from Veterans concerning their accounts including: requests for hardships consideration and/or waiver of copayment charges, requests for refunds, or establishment of repayment plans.

## **Referral of Indebtedness**

Referral of indebtedness involves enforced collection actions. In the case of a first party claim, enforced collection involves forwarding the claim to the Debt Management Center for potential offset of VA pension and benefit payments and the Treasury Offset Program (TOP) for offset of other federal payments including income tax returns, social security, child care rebate, etc. As for referral of third party claims, when an insurance company refuses to pay VA for legitimate claims and all follow-up procedures have been exhausted, the claims should be referred to Regional Counsel.

## **Appeals**

The formal process of disputing a decision on a claim by a third party payer in order to obtain payment for all or part of the denied services or days of care. Individual third party payers and States have established guidelines for filing an appeal of a claims decision. Appeals are an integral part of the revenue program for securing justified reimbursement for third party payment denials. An important aspect of the revenue utilization review process is to evaluate clinical denials and determine appropriate follow-up action. Regardless of efficiency of the RUR program, occasionally payers deny payment for medically necessary treatment provided to a covered patient, which may require submission of an appeal. Disputing such denials requires the clinical expertise of the RUR Nurse.

### **The Importance of Accuracy**

Why is it important to have accurate recognition, determination, and validation of SC/SA encounters, and episodes of care at each touch point of the revenue process?

- SC and SA determination is monitored by: Congress, Office of Management and Budget (OMB), Office of Inspector General (OIG), VHA Leadership, Third Party Payers, and Veterans.
- VHA requires the data for: Utilization studies, research, budgeting, and business office operations.
- Title 38 legislation 38CFR 17.101 Section 1729 requires VHA to bill for care provided for a non-SC/SA condition, including conditions that are adjunct or secondary if they are not specifically rated.
- Veterans are eligible for cost-free medical care for conditions that have been adjudicated as an SC condition or for SAs related to exposures or experiences.

## **Where to Find Veterans' SC Conditions: Tools to Assist with SC/SA Determination**

Service connected conditions are listed in VHA records under several options. Providers access this information most often through the consolidated health record. Conditions are also listed in the eligibility screen of patient registration. Designated VHA staff has been granted access to VBA Virtual VA database where narrative and coded rating sheets reside. This provides VHA with the actual Veteran rating and is the most authoritative source of information.

The following are tools to assist with SC/SA determination:

- Virtual VA: VBA website where rating code sheets and narrative documents are stored containing the root source of the Veterans' rated conditions.
- The most definitive source of the Veterans' rated conditions is the rating decision maintained by VBA Regional Offices.
- CPRS Encounter Form: The Encounter Form will list SC conditions and highlight special authorities applicable to the Veteran prompting the provider to indicate if the care or treatment provided was SC/SA.
- Compensation and Pension Exams (if available in CPRS) may be very helpful but are not the definitive VBA rating.
- Patient Care Encounter (PCE): a VistA option that contains future and past appointment lists.
- Registration and eligibility staff: These individuals can provide eligibility-based information regarding SC/SA.
- Patient interview: The patient may be a source of information of rated condition, but the provider makes the final encounter determination—use all of your resources.

### **What is the Role/Responsibility of the Department of Veterans Affairs provider?**

The provider makes the determination that the treatment/care provided during an encounter is for a service connected condition or special authority eligibility. The provider also identifies the primary diagnosis as supported by clinical documentation. If the primary diagnosis for the encounter is the Veteran's rated SC condition, the encounter is SC. If a secondary diagnosis is a rated SC condition, the provider must determine if active treatment was provided for that condition. Designation of SC/SA requires clinical judgment and prudent application of SC/SA guidelines. Neither the Veteran nor the Veteran's health care plan will be billed if care/treatment is validated as SC/SA. Clinical documentation must support a provider's designation of SC/SA.

Active treatment in this context includes a change in the patient's treatment regimen or active diagnostic testing for the SC condition. Mention of stable conditions and/or re-ordering of routine medications or labs does not constitute active treatment for revenue purposes. Treatment of secondary or adjunct conditions is non-service connected (NSC) and will be billed to the Veteran's third party insurance company unless the conditions are specifically rated. If the primary rated condition worsens over time, encourage the Veteran to have VBA complete a reassessment of their rated disabilities. The provider also evaluates treatment or care provided during an encounter for relationships to applicable special authority eligibilities.

### **Team Communication**

The following departments and associated staff must work together to ensure proper assignment and validation of SC/SA care or treatment:

- providers;
- RUR nurses;
- Facility Revenue Technician (FRT);

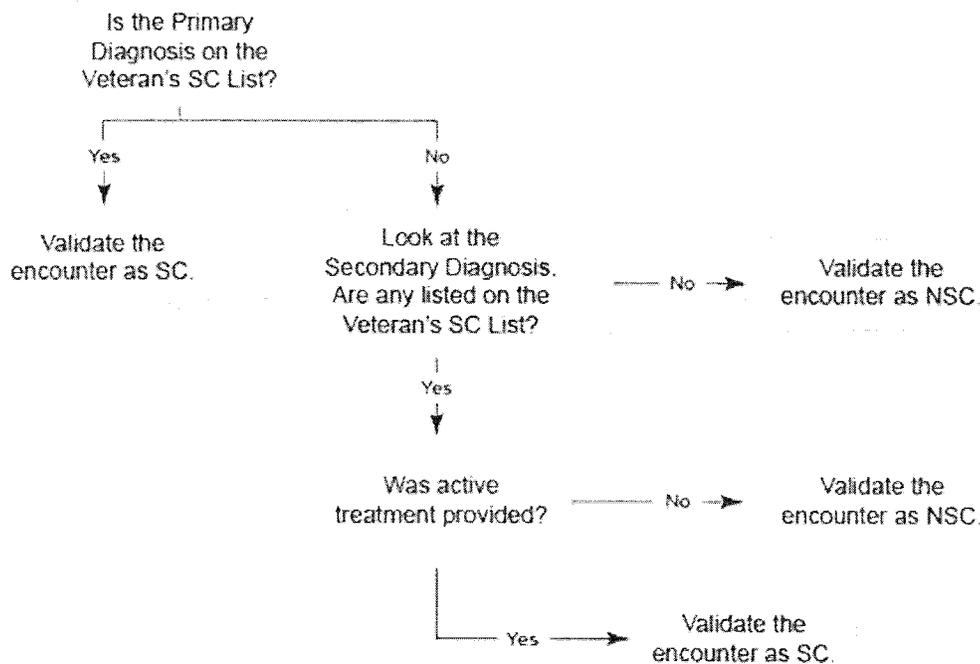
- Health Information Management Services (HIMS) coders; and
- billers.

### What Is Revenue Utilization Review?

Revenue Utilization Review (RUR) is an integral part of the VHA revenue process. RUR is a clinical process that requires the skills of a Title 38 Registered Nurse (RN). The duties performed by RUR nurses have a foundation in the Nursing Process, as other clinical activities performed by nurses.

The VA RUR nurse is a patient advocate, program liaison, clinical reviewer with advanced clinical knowledge, and consultant who conducts focused reviews requiring clinical input, including SC/SA validation. The RUR nurse will validate the appropriateness of SC or SA designation based on the provider's documentation of treatment provided in the consolidated health record. The RUR nurse has several available resources to assist in the accuracy of validation with the most definitive being Virtual VA, a VBA repository where rating code sheets and narratives reside. RUR nurses review and validate SC/SA based on recurring assignments, internal or external referrals, and/or customer service requests. One of RUR's most important tasks related to SC/SA validation is providing feedback and education for providers to ensure communication of current policies, guidelines, and processes.

### Validating Outpatient Encounters/Visits



The RUR nurse will validate revenue outpatient encounters marked SC/SA and may also review Veteran prescriptions based on provider documentation. Each progress note is required to stand alone in validation that the Veteran was actively treated for his or her SC condition to support the designation. If there are discrepancies with the progress note or lack of documentation, the RUR nurse will communicate with the provider as applicable. Outpatient validation includes but is not limited to: clinic encounters; mental health encounters; ambulatory procedures; medical specialty procedures; imaging; and applicable Non-VA medical care. Previously in the course, this diagram was used to depict the course of action the provider must take when making a SC validation. This is also true for the RUR nurse. Let's look at the diagram again.

### **Validating Prescriptions**

RUR nurses receive referrals for first or third party prescription review. The nurse reviews the consolidated health record to determine if the prescription is ordered for SC/SA condition. Medications ordered for treatment of secondary or adjunct conditions are NSC. This includes drugs that may prevent comorbid disease progression or drugs prescribed to treat side effects of SC medications.

### **Validating Prosthetics**

RUR nurses receive referrals for SC/SA validation of applicable revenue prosthetics. The nurse reviews the consolidated health record to determine if the prosthetic/Durable Medical Equipment (DME) is ordered for SC/SA condition. Prosthetic devices ordered for treatment of secondary or adjunct conditions are NSC.

### **Role of Facility Revenue Technician**

Facility Revenue Technician's (FRT) role in SC/SA process is to prepare and refer applicable cases/encounters to RUR nurses for validation. FRTs work closely with RUR to ensure SC/SA validation for many processes including but not limited to customer service requests, first party Veteran copay responsibility, applicable Non-VA medical care, ambulance claims, legal cases, and VistA mailman automated notices.

### **Role of Health Information Management Services Coders**

Health Information Management Services (HIMS) is a key and vital partner in the success of the CPAC. HIMS coders oversee and assure that the clinical coding process is completed in accordance with all current VHA guidance. HIMS professionals ensure that all billable services are identified, validated or coded as outlined in VHA coding guidance to meet timely and accurate submissions. To ensure success, communication among the local VA medical facilities, VISNs and their associated CPACs, and HIMS is essential. Some duties are listed below:

- code inpatient admissions to determine principal diagnosis and Diagnosis Related Group (DRG);
- identify and code all professional services provided during the course of an inpatient admission that are not SC/SA;
- ensure treatment documented in the progress note supports the diagnosis code;
- ensure any and all modifiers are correct;
- ensure Current Procedural Terminology (CPT) codes are correct;
- HIMS will review and assign codes to billable encounters and billable ancillary services, such as Laboratory and Radiology; and
- if a coder questions the SC/SA determination, the encounter will be referred for RUR validation review.

### **Role of Billers**

Billers process non-SC/SA claims as part of the VA revenue process. Billers refer encounters to RUR nurse for review and validation if there is a question of SC/SA care or treatment.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Medical Center (632)**  
**79 Middleville Road**  
**Northport, NY 11768-2290**

December 9, 2013

Joseph Fasano  
115 Stonehurst Lane  
Dix Hills, NY 11746

Dear Mr. Fasano,

I am writing to you as the Director of the Northport VA Medical Center. This letter is regarding the improper access of your VA medical record and personal information by multiple Northport VA employees on multiple occasions between Sept. 1, 2005 and Aug. 31, 2013. You brought the matter to our attention first on June 28, 2013 and again on July 2, 2013, and Sept. 16, 2013, each time notifying us of additional individuals to investigate as you became aware of them through your Sensitive Patient Access Report (SPAR). Your name, home address, medical information, and other identifying information were exposed.

The investigation of this issue was handled by the VHA Office of the Medical Inspector in cooperation with the Northport Privacy Office. As part of the investigation each named individual's access of your record was scrutinized for appropriateness through interviews, supervisor comments, individual job description and proof of official purpose. The investigation summary indicates 28 instances of improper access:

- 10 were mistaken access,
- 10 were without apparent reason,
- 6 were possibly job-related, and
- 2 were unauthorized.

We regret that you have had this experience. Appropriate corrective action is being taken to ensure that such incidents do not occur again. Our Human Resources Office and the supervisors of those employees are taking appropriate action, sensitive record access is being monitored on a weekly basis, and departments are receiving personal privacy in-services regarding appropriate record access.

We are notifying you so that you may choose to take appropriate steps to protect yourself against identity theft. If you receive phone calls, e-mails, or other communications asking for your personally identifiable information (PII), such as your date of birth or mailing address, you should verify the identity of the requester and the

purpose and validity of the request before deciding whether to provide any information. If you decide to provide information in response to such a request, you should provide only as much information as you consider appropriate and necessary.

Under the Fair Credit Reporting Act, you have the right to access your credit report for free every 12 months from one or more of the three (3) national credit reporting companies. You may request the report online at [www.annualcreditreport.com](http://www.annualcreditreport.com), by calling 1-877-322-8228, or by mailing your request to: Annual Credit Report Request Service, P.O. Box 105281, Atlanta, GA 30348-5281. More information about the free annual credit report is available from the Federal Trade Commission (FTC) at: <http://www.ftc.gov/bcp/edu/microsites/freereports/index.shtml>

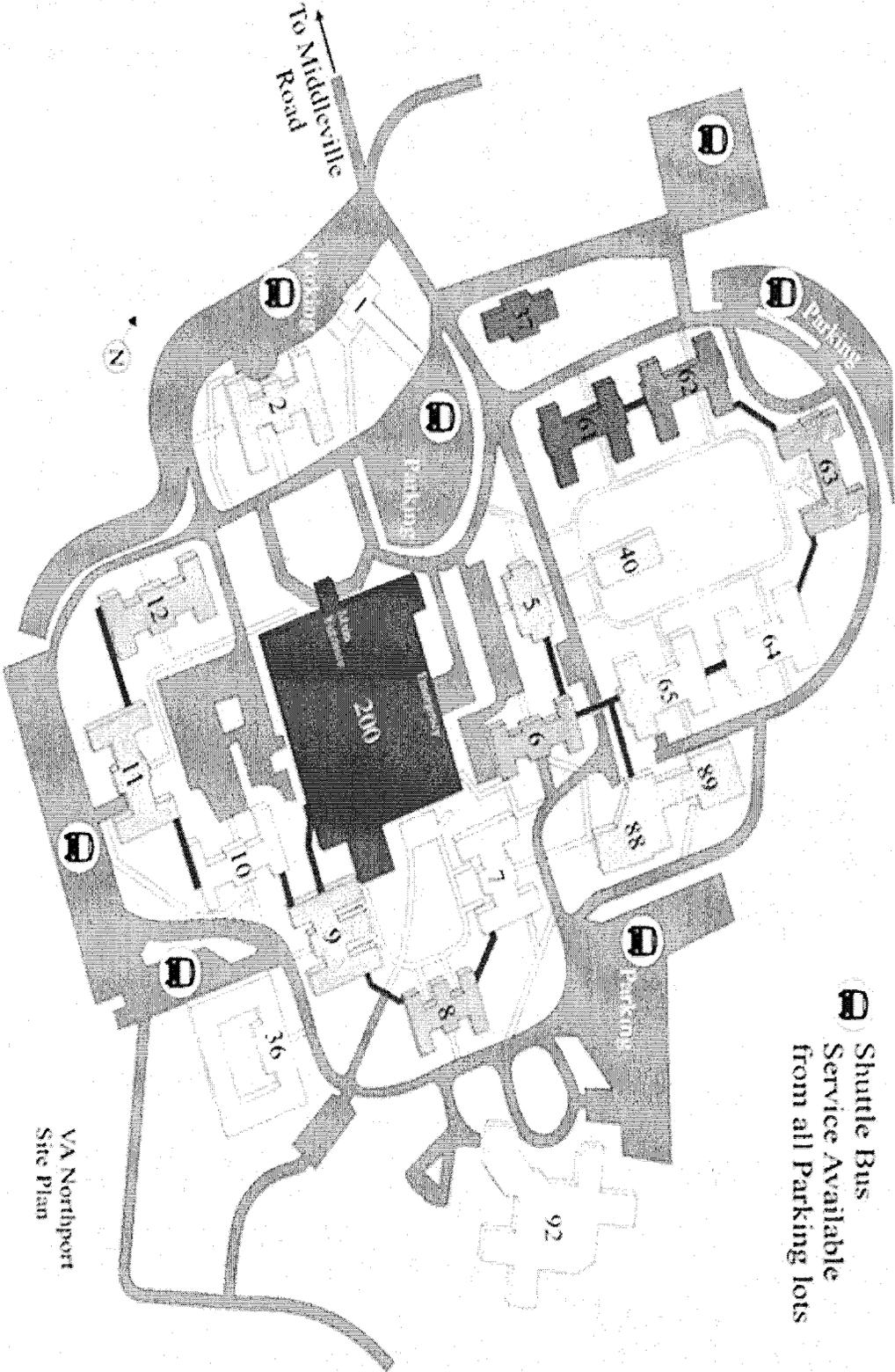
Additional information about the various precautions you can take is available by calling the FTC at its toll free number, 1-877-438-4338, or by visiting its website, <http://www.consumer.ftc.gov/features/feature-0014-identity-theft>. Information about your privacy rights is also available in the Veterans Health Administration (VHA) Notice of Privacy Practices. You may obtain a paper copy of this notice from your local VHA health care facility or download an electronic copy at <http://www1.va.gov/vhapublications/ViewPublication.asp?pubID=1089>.

If you have specific questions concerning this letter, please contact Steven Wintch, the Privacy Officer of Northport VA Medical Center, at (631) 261-4400 x4544 or at mailing address 79 Middleville Road, Northport, NY, 11768. If you are concerned that your privacy rights have been violated, you may file a complaint with VHA by contacting Mr. Wintch or by writing to the VHA Privacy Officer, VHA Privacy Office, (10P2C1) Office of Informatics and Analytics, Health Information Governance, 810 Vermont Avenue, NW, Washington DC 20420. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights, at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>. You will not be penalized or retaliated against for filing a complaint, because it is your right under the law.

VA takes our obligation to honor and serve America's Veterans very seriously. We believe it is important for you to be fully informed of any potential risk to you and apologize for any inconvenience or concern this situation may cause.

Sincerely,

  
Philip Moschitta  
Director



**D** Shuttle Bus  
 Service Available  
 from all Parking lots

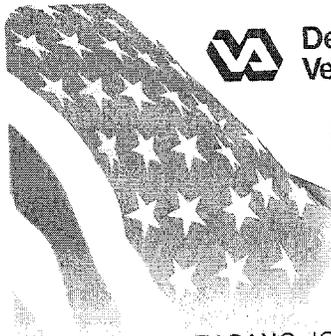
VA Northport  
 Site Plan

<b>Name</b>	<b>Title</b>
Patricia Helgesen	Compliance Officer
William Marengo	Patient Advocate
Luesender Carter	File Clerk
Omaida Wilson	Lead Financial Accounts Tech
Steven Wintch	Privacy Officer
April Miles	Medical Support Assistant
Staci Beauchamp	Medical Support Assistant
Devon Westerlind	Medical Support Assistant
Fran Maida	Patient Advocate
Kristin Sievers	Supervisory Program Specialist
Mary Ellen Conroy	IT Specialist
Thomas Sledge	Medical Admin Specialist
Linda McGinty	Information Security Officer
Christine Daurizio	Release of Information Clerk
Maria George	Medical Reception Admin Specialist
Christopher Japour	Chief of Podiatry
Gino Nardelli	Police Officer
April Esposito	Supervisory Program Specialist
Marie Irwin	Supervisory Program Specialist
Martha Kearns	?
Maribel Haddock	Medical Support Assistant
Nyny Romero	Medical Support Assistant
Ruth Zingerman	Medical Record Technician
Lidia Desmond	Medical Admin Specialist
Marilyn Muller	Medical Support Assistant
Kiyomi Hasegawa	File Clerk
Barbara Inskip	Utilization Management Nurse
Regina Divico	Health Technician
Angeles Gallimore	Registered Nurse
Eleanor Hobbs	Occupational Health Nurse Practitioner
Stacy Anne Harris	Licensed Practical Nurse
Kathy Washburn	Patient Representative
Frank Mirabelli	Release of Information Clerk
Florence Ford	Registered Nurse
Lauren Maguire	Medical Record Technician
Maureen Insignares	Medical Admin Specialist
Scott Diaz	Patient Relations Assistant
Craig Pesko	Pharmacist
Annette Cuti	Medical Support Assistant
Annamarie Hyne	Registered Nurse
Douglas Young	Accounts Receivable Technician
Adetutu Okeowo	Medical Support Assistant
Harold Clough	Registered Nurse
Jessica Amador	Medical Support Assistant
Daniel Carroll	Medical Support Assistant
Angel Thomas	Program Support Assistant

Sharran Chambers-Murphy	Program Support Assistant
Niharika Walia	Medical Record Technician

Office/Dept	Location
Directors Office	Building 10
Social Work Dept	Building 200
Business Office	Building 200
Business Office	Building 10
Business Office	Building 10
Business Office	Building 200
Business Office	Building 10
Business Office	Building 10
Social Work Dept	Building 200
Business Office	Building 200
OI & T Office	Building 12
Business Office	Building 200
OI & T Office	Building 12
Business Office	Building 200
Business Office	Building 10
Orthopaedics Dept	Building 200
Police Service	Building 6
Business Office	Building 10
Business Office	Building 10
?	?
Business Office	Building 200
Nursing Service	Building 200
Business Office	Building 200
Performance Improvement	Building 10
Business Office	Building 200
Nursing Service	Building 200
Chief of Staff Office	Building 200
Nursing Service	Building 200
Chief of Staff Office	Building 9
Business Office	Building 200
Nursing Service	Building 200
Business Office	Building 200
Business Office	Building 200
Community Relations	Building 200
Pharmacy Service	Building 200
Radiology Service	Building 200
Chief of Staff Office	Building 200
Business Office	Building 10
Nursing Service	Building 200
Nursing Service	Building 200
PM & R Service	Building 200
Business Office	Building 11
Social Work Dept	Building 6

Business Office	Building 10
Business Office	Building 200



Department of  
Veterans Affairs



SERVICE CONNECTED

FASANO, JOSEPH ANTHONY

## 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.
- 2. SUMMARY OF CHANGES.** Public Law 108-170, the "Veterans Health Care, Capital Asset, and Business Improvement Act of 2003," was enacted authorizing VA to provide hospital care, nursing home care, and outpatient medical services to certain Filipino Veterans in the same manner and subject to the same terms and conditions as apply to United States Veterans. This Handbook incorporates the provision of VHA policy Directive 2004-010, "Expansion of Health Care Benefits for Certain Filipino Veterans in the United States," and revised VHA Manual, M-1, "Operations," Part I, "Medical Administration Activities," Chapter 4, "Admissions-- Hospital and Domiciliary Care."
- 3. RELATED ISSUES.** VHA Handbooks 1601A.01, 1601A.03, 1601B.05, 1601C.01, 1601C.02, 1601D.02, and 1601E.01.
- 4. RESPONSIBLE OFFICE.** The Chief Business Office (16) is the responsible for the contents of this VHA Handbook. Questions may be addressed to (202) 461-1589.
- 5. RECISIONS.** VHA Manual M-1, Part I, Chapter 4, and VHA Directive 2004-010, are rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of November 2014.

Gerald M. Cross, MD, FAAFP  
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publication Distribution List 11/13/09

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## ELIGIBILITY DETERMINATIONS

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides information on determining eligibility for Department of Veterans Affairs (VA) health care benefits.

### 2. AUTHORITY

In determining eligibility for hospital care, Community Living Center care, domiciliary care, and medical services, Title 38 United States Code (U.S.C.) Part 17 authorizes the Secretary of Veterans Affairs to furnish needed care to any eligible Veteran. This Handbook establishes VHA procedures for determining the eligibility for such Veterans.

### 3. DEFINITIONS

a. **Applicant.** An applicant is a person who has submitted a written request for VA health care benefits or for enrollment in the VA Health Care System.

b. **Atomic Veteran.** An atomic Veteran is a former member of the United States (U.S.) Armed Forces who was exposed to ionizing radiation from atomic and nuclear weapons testing during the period beginning with the Trinity Blast of July 16, 1945, at Alamogordo, NM; continuing through the U.S. clean-up of Nagasaki and Hiroshima; and during the 235 atmospheric atomic and nuclear weapons tests in the Pacific and Nevada test sites until the Nuclear Test Ban Treaty of 1963. **NOTE:** *For further information on this subject see 38 U.S.C. §1112(c)(3)(B)(i, ii, and iii). For information on the Ionizing Radiation Registry Program see VHA Handbook 1301.01.*

c. **Catastrophic Disability.** A catastrophic disability is a permanent severely-disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living (ADL) to such a degree that the individual requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others. **NOTE:** *The complete definition is at Title 38 Code of Federal Regulations US CODE: Title 38.101. Definitions.*

d. **Collateral.** Collateral is a spouse, family member, or significant other who receives services relative to the patient's care.

e. **Combat Veteran.** Under 38 U.S.C. §1710(e)(1)(D), a combat Veteran is defined as a Veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after November 11, 1998.

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.

g. **Copayment.** Copayment is a specific monetary charge for either medical services or medications provided by VA to Veterans.

h. **Counseling and Treatment for Sexual Trauma.** Counseling services for sexual trauma is counseling and appropriate care authorized in 38 U.S.C. 1720D, which is needed to overcome psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment, which VA determines occurred while the Veteran (male or female) was serving on active duty or Active Duty for Training (ADUTRA) as defined under 38 U.S. CODE: Title 38,101. Definitions.

i. **Earned Income.** Earned income is the gross wages a Veteran receives from working.

j. **Enrollment.** Enrollment is the acceptance of an eligible Veteran into the VA Health Care System and assignment to an enrollment priority group.

k. **Financial Assessment.** Financial assessment is the process used by VA to discern a Veteran's household attributable gross income, or income and assets. The financial assessment determines a Veteran's copayment responsibilities, helps to determine enrollment priority, and assists in determining eligibility for beneficiary travel.

l. **Former Prisoner of War (POW).** A former POW is a person who, while serving on active military duty, was forcibly detained or interned by an enemy government or a hostile force, during a period of war, or in a situation comparable to war.

m. **Fugitive Felon.** A fugitive felon is a VA beneficiary who is subject to an outstanding felony warrant. ***NOTE: VA may not provide benefits to a Fugitive Felon under VHA Handbook 1000.2.***

n. **Health Eligibility Center (HEC).** HEC is the authoritative source for the verification of a Veteran's eligibility for VA health care benefits, including enrollment determination, priority group assignment, and income verification (IV).

o. **Hostilities.** Hostilities refers to an armed conflict in which the members of the Armed Forces are subjected to danger comparable to the danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary of Veterans Affairs in consultation with the Secretary of Defense.

p. **Income Verification (IV).** IV is a process that independently verifies the self-reported financial information used to determine a Veteran's eligibility for VA health care benefits, enrollment priority group assignment, and copayment responsibility.

q. **Minimum Active Duty Requirement.** The minimum period of active duty service that most Veterans who served after September 7, 1980, must have served in order to receive most

VA benefits (see US CODE: Title 38,101. Definitions). *NOTE: For further information see subparagraph 6d.*

r. **Nonservice-Connected (NSC) Veteran.** A NSC Veteran is one who does not have a VA-adjudicated illness or injury incurred in, or aggravated by, military service.

s. **Project 112/Shipboard Hazard and Defense Testing (SHAD).** SHAD refers to tests conducted by the Department of Defense (DOD) Desert Test Center as a part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as "Project SHAD" and related land-based test).

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).

u. **Unearned Income.** Unearned income includes, but is not limited to income from interest, dividends received, money from retirement funds, Social Security payments, annuities, or earnings from other assets.

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;
- c. Special treatment eligibility due to certain environmental exposures;
- d. Eligibility for specific categories;
- e. Eligibility for individuals and groups whose particular form of service is deemed to constitute active military, naval, and air service;
- f. Eligibility for VA care available to certain non-Veteran beneficiaries; and
- g. VHA's income verification match (IVM) program administered by HEC.

## 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.*

(2) Veterans who were discharged or released from active duty under "Other Than Honorable" (OTH) conditions, or who were discharged with a Bad Conduct Discharge (BCD) and, Veterans who were issued a DD-215, Correction to DD Form 214 Certificate of Release or Discharge from Active Duty, or a similar document from a military service department that upgraded or revised a discharge that was not an honorable or under honorable conditions discharge require a Veteran's status adjudication by a regional office (RO) before routine care may be provided. Veterans who receive a Dishonorable Discharge are barred from receiving health care benefits based on the period of service terminated by the Dishonorable Discharge. Such an individual may, however, be able to establish eligibility for VA health care benefits based upon a prior period of military service (see VA Opinion of the General Counsel – a precedent opinion (VAOPGCPREC) 61-91).

(3) Exception: A Veteran who has received a discharge that VA has determined to be disqualifying under application of 38 CFR §3.12 or 38 U.S.C. § 101(2) still retains eligibility for

VA health care benefits for service-incurred or service-aggravated disabilities unless he or she is subject to one of the statutory bars to benefits set forth in 38 U.S.C. §5303(a), or when the disabilities in question were incurred during a period of service from which the individual was discharged by reason of a bad conduct discharge (see Public Law (Pub. L.) 95-126, §2 (Oct. 8, 1977)).

**NOTE:** *If the DD-214 indicates OTH or BCD as the character of discharge, VHA must submit VA Form 10-7131, Exchange of Beneficiary Information and Request for Adjudicative Action, to the Regional Office (RO) for appropriate action to obtain an adjudicative decision. Eligibility status will be pending verification until a decision is rendered.*

d. **Minimum Active Duty Requirements.** Persons who enlisted after September 7, 1980, and any other person (officer as well as enlisted) who entered on active duty after October 16, 1981, the shorter of the following periods apply:

- (1) The minimum active duty requirements for those who entered the active duty after September 7, 1980 are described in 38 U.S.C. §5303A.
- (2) The minimum active-duty service requirement for VA health care benefits is the shorter of:
  - (a) 24 months of continuous active duty, or
  - (b) Completion of the full period for which the Veteran was called or ordered to active duty.

**NOTE:** *Non-duty periods (lost time noted on the DD-214 or the Hospital Inquiry (HINQ) that are excludable in determining the VA benefit are not considered as a break in service for continuity purposes, but are to be subtracted from total time served.)*

- (3) The following Veterans must meet the minimum active duty service requirement:
  - (a) Veterans who enlisted in the Armed Forces for their first term of active duty after September 7, 1980;
  - (b) Veterans who originally signed up under a delayed entry program on, or before, September 7, 1980, and who subsequently entered active duty after that date (see 38 CFR 3.12a(c));
  - (c) Former commissioned officers and warrant officers whose first term of active duty began after October 16, 1981; and
  - (d) Any other person who entered active duty after October 16, 1981, and who had:
    1. Not previously completed at least 24 months of continuous active duty service, or
    2. Been discharged or released from active duty under 10 U.S.C. §1171.

(4) Reservists and National Guards activated under title 10 U.S. C. may be eligible for care or enrollment if such discharge from active duty is not a bar to VA benefits and they meet the time requirements outlined in subparagraphs 6d and 6e.

e. **Exceptions to Minimum Active Duty Requirements.** Minimum active-duty service requirements do not apply to:

- (1) Veterans who were discharged or released for reason of early out under 10 U.S.C. §1171 ;
- (2) Veterans who were discharged or released for reason of hardships under 10 U.S.C. §1173 ;
- (3) Veterans who were discharged or released for reason of disability(ies) incurred in, or aggravated by, a line of duty;
- (4) Veterans with VA-rated compensable SC conditions; or
- (5) Veterans who have the provision of a benefit for, or in connection with, a SC disability, condition, or death (see 38 U.S.C. 5303 or 38 CFR 3.12 ).

f. **Acceptable Documentation of Minimum Active Duty Service Requirements**

- (1) Acceptable documentation of minimum active-duty service requirements include:
  - (a) Proof of discharge under 10 U.S.C. §1171 where a member of the armed force may be discharged within 3 months before the expiration of the term of enlistment or extended enlistment, or
  - (b) The narrative reason on the DD-214 specifies “Overseas Returnee.”
- (2) RO confirmation of separation under 10 U.S.C. §1171 is needed if the DD-214 narrative shows:
  - (a) Convenience of the government,
  - (b) Unit inactivation,
  - (c) Secretarial authority,
  - (d) Physical disqualification for duty in Military Occupational Specialty (MOS), or
  - (e) Hardship due to disability.

## **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.

(1) **Class I.** Those Veterans having SC compensable dental disability or condition are eligible for any needed dental care as implemented by 38 CFR 17.161.

(2) **Class II.** Those Veterans having a SC non-compensable dental condition(s) or disability shown to have been in existence at the time of discharge or release from active duty (after September 30, 1981) may be authorized any treatment, as reasonably necessary, for a one-time correction of the SC non-compensable condition, but only if:

(a) The Veteran served on active duty during the Persian Gulf War and was discharged or released, under conditions other than dishonorable, from a period of active military, naval, or air service of not less than 90 days, or they were discharged or released under conditions other than dishonorable, from any other period of active military service of not less than 180 days. **NOTE:** *This is an exception to minimum active duty requirement for medical or dental care.*

(b) Application for treatment is made within 180 days after such discharge or release.

(c) The DD-214 does not bear certification that the Veteran was provided, within the 90-day period immediately before such discharge or release, a complete dental examination, dental X-rays, and all appropriate dental treatment indicated by the examination to be needed.

1. Veterans discharged from their final period of service after August 12, 1981, who had reentered active military service within 90 days after discharge or release from a prior period of active military service may apply for treatment of SC non-compensable dental conditions within 180 days from the date of their final discharge or release.

2. If a disqualifying discharge or release (ones other than general to honorable) has been corrected, application may be made within 180 days after the date of upgrading. Since general discharges are not disqualifying for VA benefits, the 180-day time limitation on applications for class II dental care begins on the date of release from active duty.

(3) **Class II(a).** Those Veterans having a SC non-compensable dental condition, or a disability adjudicated as resulting from combat wounds or service trauma, are eligible for repeat care for the SC condition(s).

**NOTE:** *Class II(b) has been deleted (see PL 108-170. SEC). 101, Improved Benefits for Former Prisoners of War. (a) Outpatient Dental Care For All Former Prisoners of War, Section*

1712(a)(1)(F) is amended by striking "and who was detained or interned for a period of not less than 90 days."

(4) **Class II(c).** Veterans who were POWs are eligible for any needed dental care, including repeat care. Eligibility for former POWs may be verified through a HINQ request, submission or transmission of VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative Action, or transmittal of the Automated Medical Information Exchange (AMIE) screen information to a Regional Office. This action does not apply to the provision of emergency treatment prior to an eligibility determination.

(5) **Class III.** Those Veterans, having a dental condition professionally determined by VA to be currently aggravating a SC medical condition, are eligible for dental care to satisfactorily resolve the problem. Each episode of dental care must be based upon a clinical, judgmental decision.

(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.

(7) **Class V.** A Veteran who is considered to be participating in a rehabilitation program under 38 U.S.C. 31, and who is medically determined to be in need of dental care may be provided dental care to:

- (a) Make it possible to enter the course of training.
- (b) Achieve the goals of the program.
- (c) Prevent interruption of the training.
- (d) Hasten the return to the program of a Veteran placed in discontinued status because of a dental condition.
- (e) Hasten the return to a rehabilitation program of a Veteran in interrupted or leave status.
- (f) Secure and adjust to employment during the period of employment assistance.
- (g) Enable the Veteran to achieve maximum independence in daily living.

(8) **Class VI.** Any Veteran scheduled for admission or receiving outpatient care under 38 U.S.C. Chapter 17 may receive dental care, if the dental condition is clinically determined to be complicating a medical condition currently under treatment. Each episode of dental care must be predicated on referral and consultation, followed by a clinical judgmental decision.

**NOTE:** For more information on Dental refer to VHA Handbook 1130.1.

b. **Dental Services Provided for Certain Homeless and Other Enrolled Veterans**

(1) In accordance with Title 38 U.S.C. § 2062, VHA health care facilities must provide outpatient dental services and treatment considered medically necessary to certain homeless and other enrolled Veterans if they are:

(a) Necessary for the Veteran to successfully gain or regain employment; or

(b) Necessary to alleviate pain or treat moderate, severe, or severe and complicated gingival and periodontal pathology.

(2) A Veteran is eligible for such medically necessary outpatient dental services and treatment if the Veteran is:

(a) Enrolled in the VA Health Care System; and

(b) Receiving care (directly or by contract) for a period of 60 consecutive days in any of the following settings:

1. VA Domiciliary Residential Rehabilitation Program;

2. A Compensated Work Therapy-Transitional Residence;

3. A Community Residential Care Program home, if VA coordinated the placement;

4. A Community-based resident treatment program serving homeless Veterans under the Health Care for Homeless Veterans (HCHV) Program; or

5. Setting operated by a provider to whom VA provides grant and per diem funds under the VA Homeless Provider Grant and Per Diem Program.

c. **Limitations on the Provision of Outpatient Dental.** Dental benefits provided under 38 U.S.C. §2062 are furnished on a one-time course of dental care that is provided in the same manner as the dental benefits provided to a Veteran newly discharged from military service.

**8. SPECIAL TREATMENT ELIGIBILITY DUE TO IONIZING RADIATION EXPOSURE, COMBAT SERVICE, OR PARTICIPATION IN CERTAIN DOD CHEMICAL AND BIOLOGICAL TESTING**

a. **Authority for Treatment of Exposure to Radiation, or Other Conditions Defined by Law.** Veterans claiming exposure to Ionizing Radiation, service in a combat-theater, or Project SHAD testing are provided services in accordance with 38 U.S.C. §1710. **NOTE:** For information on Project SHAD see subparagraph 3s.

b. **Ionizing Radiation Exposure.** VA has the authority to provide medical care and other medical services to Veterans who were exposed to radiation for any disease described in

38 U.S.C. §1710(e)(1)(B). For purposes of this treatment authority, a “radiation-exposed Veteran” means a Veteran who participated in a “radiation-risk activity” as defined in 38 U.S. C. §1112(c)(3). It is these Veterans who are unofficially referred to as “Atomic Veterans.”

**NOTE:** For information on presumptive and non-presumptive diseases, see 38 U.S.C. §1112(c).

## 9. ELIGIBILITY FOR SPECIFIC CATEGORIES

### a. Catastrophically Disabled

(1) The definition of catastrophically disabled is met if the Chief of Staff, or designee, at the VA health care facility where a review of the Veteran’s health record has been conducted or the Veteran was examined, finds that the Veteran meets the criteria for:

(a) One of the permanent diagnoses found under View CD Diagnoses at the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Reports Page Web site at: Under Secretary U.S. Department of veterans Affairs Reports . **NOTE:** *This is an internal Web site and is not available to the public.*

(b) A condition that results in the assignment of two of the:

1. International Classification of Diseases, 9<sup>th</sup> Edition, Clinical Modification (ICD-9-CM) procedure codes or associated V-codes, when applicable; or

2. Current Procedural Terminology (CPT) ® codes, provided that two amputation procedures were not on the same limb; or

**NOTE:** For more information on the ICD-9-CM and CPT ® codes, see View CD Diagnoses at the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning Reports Page Web site at Under Secretary U.S. Department of Veterans Affairs Reports. **NOTE:** *This is an internal Web site and is not available to the public.*

(c) One of the following permanent conditions:

1. Dependency in three or more ADLs (such as: eating, dressing, bathing, toileting, transferring, and incontinence of bowel or bladder), with at least three of the dependencies being permanent with a score of 1 using the Katz scale. **NOTE:** *For more information on the Katz scale and its score requirements, see VHA Procedure Guide(PG) 1601A.02.4.B.7.a (for internal VHA use only).*

2. A score of 10 or lower using the Folstein Mini-Mental State Examination (MMSE). **NOTE:** *For more information on the MMSE and its score requirements, see VHA PG 1601A.02.4.B.7.a (for internal VHA use only).*

3. A score of 2 or lower on at least four of the 13 motor items using the Functional Independence Measure (FIM). **NOTE:** *For more information on the FIM and its score requirements, see VHA PG 1601A.02.4.B.7.a (for internal VHA use only).*

4. A score of 30 or lower using the Global Assessment of Functioning (GAF). **NOTE:** For more information on the GAF and its score requirements, see VHA.PG.1601A.02.4.B.7.a (for internal VHA use only).

(2) A Veteran may meet the definition of catastrophically disabled by either a:

(a) Clinical evaluation of the patient's medical records that documents that the patient previously met, and continues to meet, the criteria set forth in subparagraph 8b(1) (permanently), or would continue to meet such criteria (permanently) without the continuation of on-going treatment; or

(b) Current medical examination that documents that the patient meets, and will continue to meet, the criteria set forth in subparagraph 8b(1), or would continue to meet such criteria (permanently) without the continuation of on-going treatment.

**NOTE:** For further information on *Catastrophically Disabled* see 38 CFR §17.36(e).

b. **Combat Veteran.** Under 38 U.S.C. §1710(e)(1)(D), a combat Veteran is defined as a Veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after November 11, 1998.

(1) Combat Veterans are eligible for cost-free care for any illness that cannot be disassociated from their combat service for a 5-year period following separation or release from military service, if they served:

(a) On active duty in a theater of combat operations during a period of war after the Gulf War, or

(b) In armed combat against a hostile force during a period of hostilities (as defined in accordance with 38 U.S.C. §1712A) after November 11, 1998.

(2) The statutory 5-year period also:

(a) Allows for the collection of basic health information to aid in the evaluation of specific-health questions, such as those related to difficult to diagnose illnesses; and

(b) Provides such combat Veterans with time to seek disability ratings for their conditions.

(3) Combat Veterans, who were discharged from active duty before January 28, 2003, but did not enroll in VA's health care system, have 3 years under this authority to enroll in VA's health care system. This 3-year period of enhanced eligibility began on January 28, 2008, and expires after January 27, 2011, during which time the combat Veteran is placed in priority group 6 (unless eligible for higher priority group placement).

c. **Fugitive Felons.** In accordance with 38 U.S.C. §5313B, Veterans who are fugitive felons, and dependents of Veterans who are fugitive felons, are not eligible for VA health care benefits.

d. **Head and Neck Cancer Associated with Nasopharyngeal (NP) Radium Treatments.** Under 38 U.S.C. § 1720E, a Veteran is eligible for a medical exam, and hospital care, medical services, and nursing home care needed for treatment of any cancer of the head or neck, which the Secretary of Veterans Affairs finds may be associated with receipt of nasopharyngeal (NP) radium treatments in active military, naval, or air service. Evidence of NP exposure must be documented in the Veteran's service records. This documentation requirement does not apply to Veterans who served as aviators in the active military, naval, or air service before the end of the Korean conflict or who underwent submarine training in active naval service before January 1, 1965. **NOTE:** *For more information on NP radium treatment, see Office of Public Health & Environmental Hazards Home.*

e. **Incarcerated Veterans.** Veterans who are incarcerated are generally not eligible for VA health care benefits except under sharing or contractual agreements. **NOTE:** *This excludes incarcerated Veterans referred to VHA for compensation and pension examinations. For more information on incarcerated Veterans, see 38 CFR §17.38(c)(5). (Exclusion from medical benefits package applies where another agency, including institutions of other government agencies, state mental health hospitals, etc., has the responsibility to provide the needed care. In some cases, the responsible agency may not be required to provide the needed care and then VA would check for eligibility for VA health care benefits.)* For Veterans who are on house arrest or living in group homes, seek guidance from the local Regional Counsel.

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.

g. **Project 112/SHAD.** Veterans who participated in a test conducted by DOD Desert Test Center as part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as "Project Shipboard Hazard and Defense (SHAD)" and related land-based tests) are eligible for hospital care, medical services, and nursing home care under 38 U.S.C. 1710(a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such illness is attributable to such testing. However, this authority does not apply to illnesses found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than such participation in testing. **NOTE:** *For more information on Project SHAD, see 38 U.S.C. §1710(e)(1)(E), or subparagraph 3s.*

h. **Purple Heart.** Veterans who were awarded the Purple Heart medal are enrolled in enrollment priority group 3, unless otherwise eligible for placement in a higher priority group, and are exempt from any copayment requirement associated with the provision of hospital care and outpatient medical services; however, they are not exempt from pharmacy copayments. Documentation of the award is annotated on the DD-214, DD-215, official service records, or military orders of award. A copy of this documentation is to be included in the Veteran's Consolidated Health Record (CHR). The health care facilities must fax a copy of the documentation to HEC at (404) 828-5060.

i. **Treatment at the Manila Outpatient Clinic.** Service-connected U.S. Veterans who receive services through the Manila VA Clinic may be treated for NSC disabilities, as provided for by 38 U.S.C. 1724(e), within the limits of available resources. The Veterans Integrated Service Network (VISN) Director of VISN 21 and the Director of the Manila VA Clinic are responsible for ensuring that services are provided in accordance with 38 U.S.C. 1724 (e).

## 10. INDIVIDUALS AND GROUPS CONSIDERED TO HAVE PERFORMED ACTIVE MILITARY, NAVAL, AND AIR SERVICE

A number of special groups who have provided military-related services to the U.S. are considered to have performed active military, naval, or air service. These groups are defined in 38 CFR §3.7. Some of those groups are outlined in the following paragraphs.

a. **Aerial Transportation of Mail.** This includes persons who were injured or died while serving under conditions set forth in Pub. L. 73-140.

b. **Active Military Service Certified as Such Under Section 401 of Pub. L. 95-202.** These persons are considered to have active military service under Pub. L. 95-202 if the Secretary of Defense certifies the service and that they received a discharge under honorable conditions. *NOTE: An award cannot be made effective earlier than November 23, 1977. For more information on effective dates for these types of awards, see Pub. L. 95-202.*

(1) The following civilian contractual personnel are eligible for VA health care benefits, but must be certified on their DD-214 as having served on active duty under honorable conditions:

(a) Quartermaster Corps female clerical employees serving with the American Expeditionary Forces in World War I (WWI).

(b) Civilian employees of Pacific Naval Air Bases who actively participated in the defense of Wake Island during World War II (WWII).

(c) Civilian Navy Identification Friend or Foe (IFF) radar technicians who served in combat areas of the Pacific during WWII from December 7, 1941, to August 15, 1945.

(d) Civilian personnel assigned to the Secret Intelligence Element of the Office of Strategic Services (OSS).

(e) Reconstruction Aides and Dietitians, World War I.

- (f) Wake Island Defenders from Guam.
  - (g) Guam Combat Patrol.
  - (h) Signal Corps Female Telephone Operators Unit of WWI.
  - (i) Engineer Field Clerks, WWI.
  - (j) Male Civilian Ferry Pilots.
  - (k) Quartermaster Corps Keswick Crew on Corregidor (WWII).
  - (l) U.S. civilian volunteers who actively participated in the defense of Bataan.
  - (m) U.S. civilian employees of the U.S. Army Nurse Corps who served in the defense of Bataan and Corregidor from January 2, 1942, to February 3, 1945.
  - (n) Woman's Reserve or Navy, Marine Corps, and Coast Guard.
  - (o) Woman's Army Auxiliary Corps (WAAC)
- (2) U.S. civilians of the American Field Service (AFS) may be eligible for VA health care benefits after they have received a DD-214 and served overseas; they include those who:
- (a) Were under U.S. Armies and U.S. Army groups in WWII from December 7, 1941, to May 8, 1945, or
  - (b) Served operationally in WWI during the period August 31, 1917, to January 1, 1918.
  - (c) The Operational Analysis Group of the Office of Scientific Research and Development, Office of Emergency Management, which served overseas with the U.S. Army Air Corps from December 7, 1941, through August 15, 1944.
  - (d) Alaska Territorial Guard: Members of the Alaska Territorial Guard during World War II who were honorably discharged from such service as determined by the Secretary of Defense.
- (3) Honorably-discharged members of the American Volunteer Group and Flying Tigers are eligible for VA health care benefits, if they served during the period December 7, 1941, to July 4, 1942.
- (4) Honorably-discharged members of the American Volunteer Guard, Eritrea Service Command are eligible for VA health care benefits, if they served during the period June 21, 1942, to March 31, 1943.
- (5) Merchant Marine policies are as follows:

(a) Merchant Marines who served in the Oceangoing Service between December 7, 1941, and August 15, 1945 are eligible for VA medical care benefits.

(b) U.S. merchant seamen who served on blockships in support of Operation Mulberry during the invasion of Normandy are eligible for VA health care benefits. *NOTE: The term Merchant Marine and Merchant Seaman are interchangeable and can mean the same. Normally a Merchant Marine is a graduate from a Merchant Marine Academy while the term "merchant seamen" is commonly used to identify crew members of merchant ships.*

(6) U.S. civilian flight crews and aviation ground support employees of the following companies, who served overseas during the period December 14, 1941, to August 14, 1945 under the airline's contract with the Air Transport Command, are eligible for VA health care benefits:

(a) American Airlines;

(b) Braniff Airways;

(c) Consolidated Vultree Aircraft Corporation (Consairway Division);

(d) Northeast Airlines, Atlantic Division;

(e) Northwest Airlines;

(f) Pan American World Airways;

(g) Transcontinental and Western Air, Inc. (TWA); and

(h) United Airlines.

(7) For information on Coast and Geodetic Survey, see subparagraph 10g.

(8) For information on Women's Air Force Service Pilots (WASPs), see subparagraph 10j(3)(a).

c. **Aliens.** As noted in 38 CFR §3.7(b), effective July 28, 1959, the following are considered to have performed active military, naval, or air service:

(1) A Veteran discharged for alienage during a period of hostilities unless evidence affirmatively shows the Veteran was discharged at the Veteran's own request (a discharge that was changed prior to January 7, 1957, to honorable by a board established under 10 U.S.C. §§ 1552 or 1553 is evidence that the discharge was not at the alien's request); or

(2) A Veteran who was discharged for alienage after a period of hostilities and whose service was honest and faithful if not barred from benefits, if otherwise entitled.

d. Auxiliary Military Service

(1) Active service personnel in the Coast Guard on or after January 29, 1915, while under the jurisdiction of the Treasury Department, Navy Department, or the Department of Transportation are considered to have performed active military service. *NOTE: For more information on duty periods, see 38 CFR §3.6(c)-(d).*

(2) Lighthouse service personnel transferred to service and jurisdiction of War or Navy departments by Executive Order, under the Act of August 29, 1916, are considered to have performed active military service. *NOTE: This service was consolidated with the Coast Guard effective July 1, 1939.*

(3) The approximately 50 Chamorro and Carolinian former native policemen who received military training in the Donnal area of central Saipan and were placed under the command of Lt. Casino of the 6<sup>th</sup> Provisional Military Police Battalion United States Marines on active, combat-patrol activity from August 19, 1945, to September 2, 1945.

(4) Persons ordered to service are:

(a) Any person ordered to service is considered to have been on active military, naval, or air service if the person has:

1. Applied for enlistment or enrollment in the active military, naval, or air service and who has been provisionally accepted and directed, or ordered, to report to a place for final acceptance into the service; or

2. Been selected or drafted for such service, and has reported according to a call from the person's local draft board and before final rejection; or

3. Been called into Federal service as a member of the National Guard, but has not been enrolled for Federal service, and

4. Suffered injury or disease in the line of duty while going to, coming from, or at such place for final acceptance or entry upon active duty. *NOTE: The injury or disease must be due to some factor relating to compliance with proper orders.*

(b) Draftees and selectees when reporting for pre-induction examination or for final induction on active duty are not included for injury or disease suffered during the period of inactive duty or the period of waiting, after a final physical examination, or prior to beginning the trip to report for induction.

(c) Members of the National Guard are included when reporting to a designated assignment.

(5) Philippine Scouts, to include Commonwealth Army Veterans and those who were recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces who reside in, or are citizens of, the U.S., or lawfully admitted for permanent residence, are eligible for care on the same basis as U.S. Veterans.

**NOTE:** For additional information on Philippine and Insular Forces, see 38 CFR §3.40.

(6) Revenue Cutter Service members serving under the direction of the Secretary of the Navy in cooperation with the Navy are considered to have performed active military service.

(7) Service at any time as a cadet at the U.S. Military, Air Force, or Coast Guard Academy, or as a midshipman at the U.S. Naval Academy are considered to have performed active military service.

(8) Russian Railway Service Corps that provided service during WWI, as certified by the Secretary of the Army, are considered to have performed active military service.

e. **Camps**

(1) Students of aviation camps who were enlisted men during WWI are considered to have performed active military service.

(2) Members of training camps authorized under Pub. L. 85, 64<sup>th</sup> Congress Section 54, National Defense Act of June 3, 1916, who were enrolled in such camps on or after April 6, 1917, and before November 12, 1918, to obtain a commission upon satisfactory conclusion of such training are eligible for VA health care benefits. **NOTE:** *Persons who attended these camps to qualify as instructors in various colleges are not eligible.*

(3) Members of the following Student Army Training Corps Camps during the period July 18, 1918, to September 16, 1918, are not considered to have performed active military service:

- (a) The Presidio of San Francisco, CA;
- (b) Plattsburg, NY;
- (c) Fort Sheridan, IL;
- (d) Howard University, Washington, DC;
- (e) Camp Perry, OH; and
- (f) Camp Hancock, GA.

f. **Clerks**

(1) Army and Quartermaster Corps field clerks are included as enlisted men and are therefore considered to have performed active military service.

(2) Persons who served as Paymaster's Clerks of the U.S. Army in the Philippine Insurrection or Boxer Rebellion are considered to have performed active military service.

g. Coast and Geodetic Survey

(1) Members of Civilian Crewmen of U.S. Coast and Geodetic Survey vessels, who served as crewmen in areas of immediate military hazard, while conducting cooperative operations with and for the U.S. Armed Forces between December 7, 1941, and August 15, 1945, aboard the following vessels, may be eligible for VA health care benefits:

- (a) The Derickson;
- (b) The Explorer;
- (c) The Gilbert;
- (d) The Hilgard;
- (e) The E. Lester Jones;
- (f) The Lydonia;
- (g) The Patton;
- (h) The Surveyor;
- (i) The Wainwright; and
- (j) The Westdahl.

(2) Full-time duty as a commissioned officer of the Coast and Geodetic Survey, and its successor agencies, the Environmental Science Services Administration and the National Oceanic and Atmospheric Administration are considered to have performed active military, naval, or air service. **NOTE:** *For more information on duty periods for Coast and Geodetic Survey, see 38 CFR §3.6(b)(3).*

h. Medical Services Personnel

(1) Female Army and Navy Nurse Corps on active service under order of the service department are considered to have performed active military or naval service.

(2) Female dietetic and physical therapy personnel appointed with relative rank (*civilian rank/experience level they may have attained based on their skills before they were commissioned*) on, or after, December 22, 1942, or commissioned on, or after, June 22, 1944, are considered to have performed active military service. **NOTE:** *Students and apprentices are not included in this group.*

(3) Contract surgeons who sustain a disability or death as the result of disease or injury contracted in the line of duty during a war period while performing the duties of assistant surgeon or acting assistant surgeon with any military force in the field, in transit, or in hospital

are considered to have performed active military service. *NOTE: This applies for the purposes of compensation, dependency, and indemnity compensation.*

(4) Male nurses who were enlisted men of the Medical Corp are considered to have performed active military service.

(5) Contract nurses who served as U.S. Army nurses under contract are considered to have performed active military service.

i. **National Guard and Reserves**

(1) National Guard and Reservists may be eligible for VA health care benefits on the basis they may meet the Title 38 definition of "Veteran." This includes health care provided under 38 U.S.C. §1710(e)(1)(D). To be eligible for VA health care benefits, members of the National Guard and Reservists must meet the following criteria:

(a) They performed active military, naval, or air service as defined in 38 CFR § 3.6;

(b) They meet the character of discharge requirements of subparagraph 6c; and

(c) They meet the minimum period of services requirements of subparagraph 6d, if applicable, based on their dates of service.

*NOTE: Mobilization as a result of an order of the Chief Executive of a State is not considered active military service and service in this circumstance does not establish eligibility.*

j. **Public Health Services.** Full-time duty for other than training purposes performed as commissioned officers of the Regular or Reserve Corps of the Public Health Service is considered active military service, if they performed such full-time duty:

(1) On or after July 29, 1945, or

(2) Before July 29, 1945, under circumstances affording entitlement to full military benefits.

*NOTE: For additional information on duty periods for National Guard and Reservists, see 38 CFR §3.6(a)-(d).*

k. **Women's Organizations**

(1) Members of the Woman's Auxiliary Army Corps (WAAC) who served between May 13, 1942, and September 30, 1943, prior to establishment of the Women's Army Corps (WAC), are considered to have completed active military service.

(2) Members of the WAC who served on or after July 1, 1943, are considered to have completed active military service.

(3) Individuals who have been certified on DD-214 by the DOD as having served on active duty are considered to have completed active military service, including:

(a) Members of the WASP, a group of Federal civilian employees attached to the U.S. Army Air Force during WWII, or

(b) Any person in any other similarly-situated group.

*NOTE: The members of these groups rendered service to the Armed Forces of the U.S. in a capacity considered civilian employment or contractual service at the time such service was rendered.*

## 11. NON-VETERAN BENEFICIARIES

For information on eligibility determinations for:

a. Beneficiaries of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), see 38 U.S.C. § 1781; 38 CFR §§17.270, 17.271, 17.272, 17.273, 17.274, 17.275, 17.276, 17.277, and 17.278.

b. Allied beneficiaries, see VHA Handbook 1601D.02.

c. Czechoslovakia and Polish Veterans are eligible for care as any other U.S. Veterans providing they provide proof of:

(1) U.S. citizenship for at least 10 years; and

(2) Honorable service in the armed forces of Czechoslovakia or Poland during WWI or WWII; and

(3) Honorable service in, or with, British or French armed forces.

d. For information on children of Vietnam Veterans with Spina Bifida or covered birth defects, see Children of Women Vietnam Veterans Health Care Benefits Program at: <http://www.va.gov/hac/forbeneficiaries/spina/handbook/cwvhandbook.pdf>

e. For individuals who receive care on a humanitarian basis, see 38 U.S.C. §1784; 38 CFR §17.102(b).

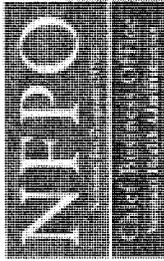
## 12. HEALTH ELIGIBILITY CENTER (HEC) INCOME VERIFICATION MATCH (IVM) PROGRAM

a. **Authority.** Pub. L. 101-508 permits VA to verify Veteran self-reported income with the Internal Revenue Service (IRS) and Social Security Administration (SSA). Veterans subject to income verification are those in a copayment exempt status.

b. **Disclosure of Information.** HEC is required by the Internal Revenue Code (IRC) 7213, 6103, and 7431 not to disclose data received from the IRS and SSA with anyone other than the person associated with the data.

## Policy & Procedure References (NNPO) 2012

The DSS FBCS User Manual v2.1 (Patch 12)	<a href="http://www.dssinc.com/Documentation/Class_1/?dir=./FBCS/FBCS%20%20Manuals/Patch%2012">http://www.dssinc.com/Documentation/Class_1/?dir=./FBCS/FBCS%20%20Manuals/Patch%2012</a>
<ul style="list-style-type: none"> <li>• FBCS Update Manuals</li> <li>• Fact Sheets</li> <li>• Guidelines</li> </ul>	<a href="http://vhahacnonva.vha.med.va.gov/fbcs/">http://vhahacnonva.vha.med.va.gov/fbcs/</a>
FBCS Report email	<a href="mailto:fbcs_report@portal.va.gov">fbcs_report@portal.va.gov</a>
FBCS Report SharePoint page	<a href="https://vaww.portal.va.gov/sites/CBO_PCI/Purchased%20Care%20Field%20Site/Weekly%20FBCS%20Claims%20Status/Forms/AllItems.aspx">https://vaww.portal.va.gov/sites/CBO_PCI/Purchased%20Care%20Field%20Site/Weekly%20FBCS%20Claims%20Status/Forms/AllItems.aspx</a>
DSS Fee Basis Claims System User Manual	<a href="#">DSS Fee Basis Claims System User Manual Version 2.1 November 2011</a>
Emergency Care Considered Under 38 U.S.C. 1703	<a href="http://vhahacnonva.vha.med.va.gov/docs/1703FlowChart.pdf">http://vhahacnonva.vha.med.va.gov/docs/1703FlowChart.pdf</a>
Emergency Care Considered Under 38 U.S.C. 1725 & 1728	<a href="http://vhahacnonva.vha.med.va.gov/docs/1725or1728FlowChart.pdf">http://vhahacnonva.vha.med.va.gov/docs/1725or1728FlowChart.pdf</a>
38 USC 1703 Eligibility Criteria	<a href="#">38 USC 1703 Eligibility Criteria</a>
Administrative Requirements-Preauthorization	<a href="#">Administrative Requirements-Preauthorization Flow Chart</a>

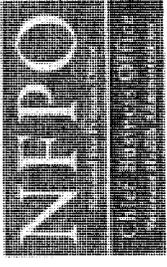


# Service Connected Classification

**A Non-VA Care Education and Training Program  
Non VA Purchased Care Programs Office  
Chief Business Office**



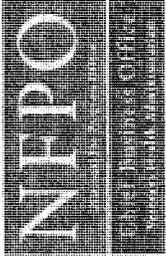
# Objectives



- The student will be able to locate Service Connected (SC) conditions
- The student will identify various software applications used in researching SC conditions
- The student will be able to identify a secondary condition



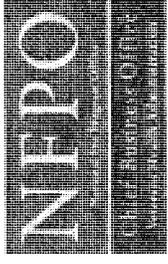
# Overview



- SC Rating Verification
- Why the SC rating is important
- Definitions
- Rating Representation
- VBA Rating Codes and Descriptions
- Examples of Rating Sources
- Adjunct & Secondary Conditions
- Finding SC Information
- Special Authorities
- VBA Rating Codes
- HINQ
- VIS
- FAQ's



# Why SC/NSC is so Important

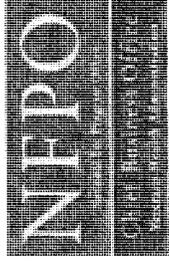


- Monitored By:
  - Congress
  - Office of Management and Budget (OMB)
  - Top VHA Officials
  - Third Party Payers
  - Veterans (patients)





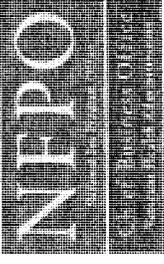
## Why SC/NSC is so Important



- It differentiates Veteran Health Administration from all other health delivery systems/insurance
- VHA requires this Data for:
  - Business Operations
  - Budgeting
  - Utilization Studies
  - Research



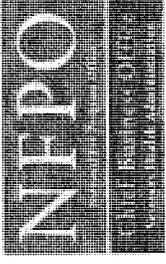
# Definitions



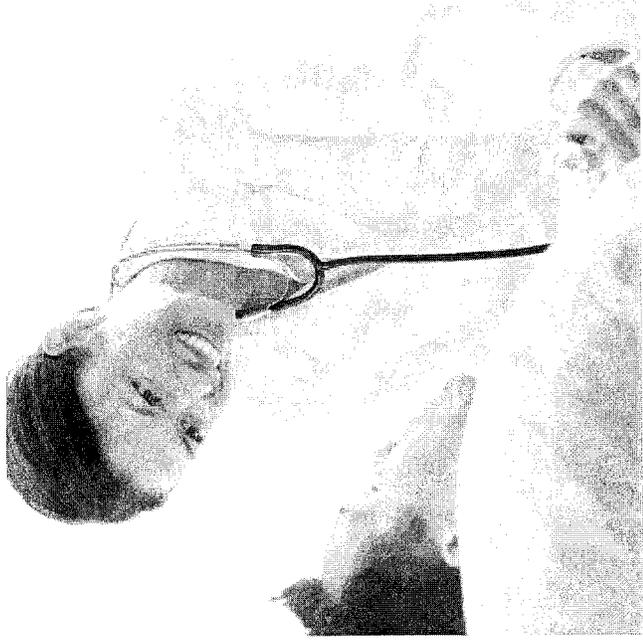
- “Service Connected” refers to a VBA decision that a Veteran’s illness or injury was incurred in or aggravated by military service
- VBA establishes the degree of disability for each service connected condition
- A Veteran may have more than one adjudicated service connected condition



# SC Rating Verification

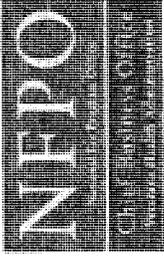


A condition is **ONLY** service connected if it has been rated as an adjudicated service connected disability through the Veterans Benefits Administration (VBA)





# Rating Representation



- What does the service connected % rating represent?
  - The percentage ratings represent as far as can practically be determined;
    - The average impairment in earning capacity resulting from such diseases
    - Injuries and/or their residual conditions in civil occupations



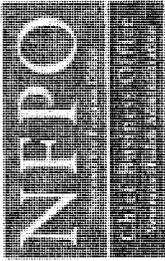
# VBA Rating Codes



- Each condition is rated from 0% to 100% as described in Rating Schedule found in 38 CFR, Part 4
- General Information about ratings, codes, and percentages can be found at VBA intranet websites:
  - <http://vbaw.vba.va.gov>
  - <http://vbaw.vba.gov/bl/21/Publicat/Regs/Index.htm>
  - <http://www.warms.vba.va.gov.TOCindex.htm#k>



# VBA Intranet



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Address: http://vbaw.vba.va.gov/

U.S. DEPARTMENT OF VETERANS AFFAIRS  
**VETERANS BENEFITS ADMINISTRATION**  
**INTRANET**

VA Intranet Home About VA Organizations Locations Employee Resources

## Veterans Benefits Administration Intranet Home

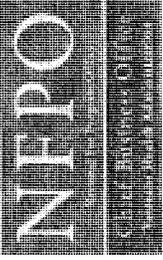
<p><b>VBA Intranet Home</b></p> <ul style="list-style-type: none"> <li>Central Office</li> <li>Compensation &amp; Pension</li> <li>Education</li> <li>Loan Guaranty</li> <li>Vocational Rehabilitation &amp; Employment</li> <li>Insurance</li> <li>Regional Offices</li> <li>Economic Recovery</li> </ul>	<p><b>Employee Information</b></p> <ul style="list-style-type: none"> <li>Benefits</li> <li>Job Announcements</li> <li>Online Training Login (VA LMS)</li> <li>more...</li> </ul>	<p><b>Reference Tools</b></p> <ul style="list-style-type: none"> <li>Veterans Benefits Reference System (VRS)</li> <li>Planning Job Aids</li> <li>Web Site Manager Tools</li> <li>Rating Job Aids</li> <li>more...</li> </ul>	<p><b>What's New</b></p> <p>6/5/2009  Mentors are being solicited for the Leadership Enhancement and Development program.  <a href="#">More...</a></p>
<p><b>Firms and Publications</b></p> <ul style="list-style-type: none"> <li>VA Forms</li> <li>VBA Letters</li> <li>C&amp;P Publications</li> <li>Education Publications</li> <li>M28 online</li> <li>more...</li> </ul>	<p><b>Reports</b></p> <ul style="list-style-type: none"> <li>Monday Morning Workload</li> <li>VEISQL Reports</li> <li>IMS Reports</li> <li>Telephone Reports</li> <li>Web Site Reports</li> <li>more...</li> </ul>	<p><b>Internet Links</b></p> <ul style="list-style-type: none"> <li>VA Home</li> <li>VBA Home</li> <li>Compensation &amp; Pension</li> <li>Education</li> <li>Loan Guaranty</li> <li>Vocational Rehabilitation &amp; Employment</li> <li>Insurance</li> </ul>	
<p><b>Web Applications</b></p> <ul style="list-style-type: none"> <li>VBA Applications Web Login</li> <li>Outlook Web Access</li> <li>more...</li> </ul>	<p><b>Information Availability</b></p> <ul style="list-style-type: none"> <li>Hines IIC</li> <li>Philadelphia IIC</li> <li>Austin SDC</li> </ul>		

U.S. DEPARTMENT OF VETERANS AFFAIRS  
<http://vbaw.vba.va.gov/b21/rating/index.htm>  
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# 38 Code Federal Regulations



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Part	Fast Find	By Section	By Subject	User's Guide	Word Copy
3	<a href="#">Cite Search</a>	<a href="#">Index</a>	N/A	<a href="#">Guide</a>	See WARMS, 38 Code of Federal Regulations, for word copies.
4	<a href="#">Cite Search</a>	<a href="#">Index</a>	N/A	<a href="#">Guide</a>	
13	N/A	<a href="#">Index</a>	<a href="#">Index</a>	<a href="#">Guide</a>	

**Additional Reference Materials**

Topic	Remarks	Updated
Appendix A [Part 4]	Amendments and Effective Dates Since	1987
Appendix B [Part 4]	National Index of Disabilities	1988
Appendix C [Part 4]	Alphabetical Index of Disabilities	1988
Disabilities/Disease [Part 3]	Index of Reference to Disabilities/Disease in 38 CFR 3.300 thru 3.385.	2006

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# Narrative of the Index of Diseases



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Calendar Program Operations FAQ Public Contact Publications VA Website  
Rating Job Aids Search Site Map Staff STAR Training HOME VBA Website

**38 CFR, Part 4**  
Rating Schedule

- # Appendix A to Part 4 -- Amendments/Effective Dates. See also P.G. 21-2
- # Appendix B to Part 4 -- Numerical Index of Disabilities # All Regulations
- # Appendix C to Part 4 -- Alphabetical Index of Disabilities
- # Index of References to Disabilities/Disease in 38 CFR 3.30
- # Fast Find # Table of Contents ? User's Guide

**Fast Find**

*See eCFR for the most up-to-date regulation text. Word copies of regulations may also be found at the WARMs webpage, however, regulations may have not been updated in WARMs yet.*

Type in any citation or diagnostic code, for example: citations) 4.1, 4.16(a) To search for text information, use the Search hyperlink in the top header. Once there, open All Regulations; 38 CFR, Part 4.

**How to Enter Data.** Citations (1) may be separated by a "7" or (2) must have parenthesis around each paragraph and subparagraph.  
Examples (1): 4 16(a)5  
Examples (2): 4 16(a)(5).  
Exceptions: 4.71a where the "a" designates the Section number.

For more information about 38 CFR, Part 3 & 4 On-line, see the User's Guide.

Questions about Regulations may be sent to the Q&A Committee at [YAVBVAWASICOf21Q&A](mailto:YAVBVAWASICOf21Q&A).  
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Web problems? E-mail [YAVBVAWASICOf21Web](mailto:YAVBVAWASICOf21Web).

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# Numerical Index of Disabilities



Appendix B to 38 CFR, Part 4 :: Numerical Index of Disabilities - Microsoft Internet Explorer

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Calendar Program Operations FAB Public Contact Publications VA Website  
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## 38 CFR, Part 4 Rating Schedule

- Appendix A to Part 4 -- Amendments, Effective Dates. See also PG 21-2
- Appendix B to Part 4 -- Numerical Index of Disabilities
- Appendix C to Part 4 -- Alphabetical Index of Disabilities
- Index of References to Disabilities Disease in 38 CFR 3.300 thru 3.385
- FastFind
- Table of Contents
- User's Guide

### Appendices to 38 CFR, Part 4

#### Appendix B - Numerical Index of Disabilities

##### Musculoskeletal System

Acute, Subacute, or Chronic Diseases

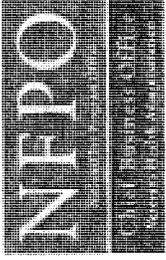
##### Diagnostic Code No.

- 5000 Osteomyelitis, acute, subacute, or chronic.
- 5001 Bones and Joints, tuberculosis.
- 5002 Arthritis, rheumatoid (atrophic).
- 5003 Arthritis, degenerative (hypertrophic, or osteoarthritis).
- 5004 Arthritis, gonorrheal.
- 5005 Arthritis, pneumococcal.
- 5006 Arthritis, typhoid.

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# Explanation of a Rating Code



38 CFR §4.119 Schedule of ratings-endocrine system - Microsoft Internet Explorer

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Address: [http://www.va.gov/bj21/Publicat/Regs/Pat4/4\\_119.htm#7909](http://www.va.gov/bj21/Publicat/Regs/Pat4/4_119.htm#7909)

gracuated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under §4.89. Assign the higher rating.

**7912 Pluriglandular syndrome**  
Evaluate according to major manifestations.

**7913 Diabetes mellitus**  
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated. **Rating**  
100

Requiring insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated. **Rating**  
60

Requiring insulin, restricted diet, and regulation of activities. **Rating**  
40

Requiring insulin and restricted diet, or oral hypoglycemic agent and restricted diet. **Rating**  
20

Manageable by restricted diet only. **Rating**  
10

**Note (1):** Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100 percent evaluation. Noncompensable complications are considered part of the diabetic process under diagnostic code 7913.

**Note (2):** When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.

**7914 Neoplasia, malignant, any specified part of the endocrine system**  
**Rating**  
100

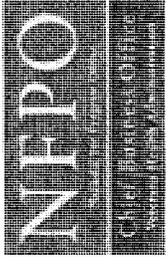
**Note:** A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

**7915 Neoplasia, benign, any specified part of the endocrine system**

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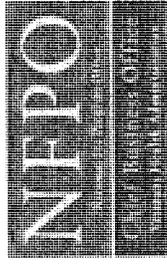
# Adjunct Condition



- **An adjunct condition, non-service connected condition which may aggravate a service-connected condition**
  - Ability to chew food because of bad teeth is aggravating the gastric ulcer which is SC
- **Be aware**
- **VA will bill the insurance carrier and Veterans responsible for co-payments for treatment provided solely for the adjunct condition and/or other non-service connected conditions**



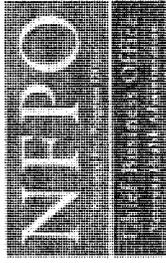
## Secondary Condition



- A secondary condition is a condition that has been caused by or is the result of a service connected condition
  - Diabetic foot ulcer caused by the diabetic disease progression
- This condition is also non-service connected and treatment provided is also billable



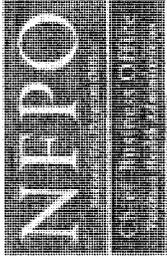
# Research the Patient Record



- The Fee clinical reviewer is responsible for determining when an episode of care is related to a SC eligibility or special authority



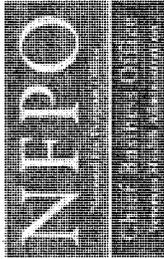
## **Where to find SC Information**



- Computerized Patient Record System (CPRS)
- Electronic Encounter Form
- Consolidated Health Record
- Patient Interview
- Appointment List
- Patient Inquiry
- Appointment Management
- Rating Decision
- Registration and Eligibility staff



# CPRS Patient Inquiry



ZZTESTPATIENT, SEVEN    Visit Not Selected    Primary Care Team Unassigned    Postings WAD  
 000-00-5407    Jan 01, 1950 (93)    Current Provider Not Selected

File Edit View Action Options Tools Help

Last 100 Signed Notes

- Jan 22,09 MRI ORDER TEMPLA
- Jan 20,09 MRI ORDER TEMPLA
- Jan 14,09 EDUCATION RADIOLO
- Jan 05,09 MRI SCREENING QUE
- Jan 05,09 EDUCATION IMED DC
- Jan 05,09 INFORMED CONSENT
- Jan 05,09 EDUCATION IMED DC
- Jan 05,09 EDUCATION IMED DC
- Dec 30,08 MENTAL HEALTH DR
- Dec 29,08 INFORMED CONSEN
- Dec 19,08 NURSING ICU REASS
- Dec 11,08 CARE COORDINATIO
- Dec 09,08 NURSING INFATIENT
- Dec 03,08 RADIOLOGY NUCLE
- Dec 03,08 EDUCATION IMED DC
- Dec 03,08 INFORMED CONSEN
- Dec 03,08 NURSING INFATIENT
- Dec 02,08 INFECTIOUS DISEAS
- Dec 02,08 INFECTIOUS DISEAS
- Dec 02,08 EDUCATION HIV NUIF
- Dec 02,08 NURSING CASE MAN
- Dec 02,08 NURSING CASE MAN
- Dec 02,08 EDUCATION HIV NUIF
- Dec 02,08 EDUCATION HIV NUIF
- Dec 02,08 MEDICATION REFILL
- Nov 24,08 NURSING INPATIENT

From/To: NO CONFIDENTIAL ADDRESS  
 From/To: NOT APPLICABLE

POS: VIETNAM ERA    Claim #: 000005407  
 Relig: ISLAM    Sex: MALE  
 Race: ASIAN, BLACK OR AFRICAN    Ethnicity: NOT HISPANIC OR LATINO  
 AMERICAN

Combat Vet Status: NOT ELIGIBLE  
 Primary Eligibility: SERVICE CONNECTED 50% TO 100% (NOT VERIFIED)  
 Other Eligibilities:  
 Unemployable: NO

STATUS : PATIENT HAS NO INPATIENT OR LODGER ACTIVITY IN THE COMPUTER

Future Appointments: NONE

Remarks:

Date of Death Information  
 Date of Death:  
 Source of Notification:  
 Updated Date/Time:  
 Last Edited By:

Health Insurance Information:  
 Insurance COB Subscriber ID    Group    Holder    Effective    Expires  
 =====  
 No Insurance Information

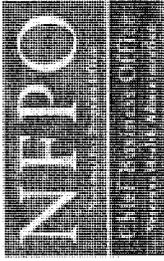
Service Connection/Pated Disabilities:  
 SC Percent: 50%  
 Rated Disabilities: HYPERTENSIVE HEART DISEASE (10\*-SC)  
 ARTERIOSCLEROTIC HEART DISEASE (30\*-SC)  
 TINNITUS (0\*-SC)  
 POST-TRAUMATIC STRESS DISORDER (10\*-SC)  
 DYSTHYMIC DISORDER (10\*-SC)

Print    Close

CPRS - Patient Inquiry    CPRS - Patient Chart    CPRS - Patient Chart    12:12 PM



# Vista



```

=====
ZZTESTPATIENT,SEVEN; 000-00-5407
=====
<1> Eligibility Status: NOT VERIFIED
    Status Entered By: NOT APPLICABLE
    Interim Response: UNANSWERED (NOT REQUIRED)
    Verif. Method: NOT APPLICABLE
    Verif. Source: VISTA
    Money Verified: NOT VERIFIED
    Service Verified: NOT VERIFIED
<2>
<3>
<4> Rated Disabilities: SC%: 50  EFF. DATE OF COMBINED SC%:
                                     Orig Eff Dt
                                     Extr  -  -  -  -  -
Rated Disability
7005-ARTERIOSCLEROTIC HEART DISEASE(30% SC)
7007-HYPERTENSIVE HEART DISEASE(10% SC)
9411-POST-TRAUMATIC STRESS DISORDER(10% SC)
9433-DYSTHYMIC DISORDER(10% SC)
6260-TINNITUS(0% SC)

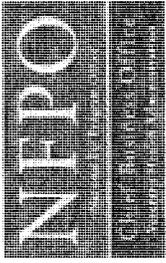
                                     Curr Eff Dt
                                     -  -  -  -  -
=====
Status Date: NOT APPLICABLE
=====
SC VETERAN
=====

```

<RET> to CONTINUE, ^N for screen N or '^' to QUIT: █



# Veterans Information Solution



Veterans Information Solution (Problem ID#) - Microsoft Internet Explorer (provided by VA North Texas PCs)

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address <https://va.www.visprod.aac.va.gov/vis/>

Permissions

Go Links >>



## Veterans Information Solution

**WELCOME TO THE VETERANS INFORMATION SOLUTION**  
 The VIS is an intranet-based application designed to provide a consolidated view of information about veterans and active service members.

**User Security Notification**

Use of this or any other Department of Veterans Affairs computer system constitutes your consent to monitoring by authorized personnel for computer security and system management purposes. This computer system and all related equipment are to be used for the communications, transmission, processing, manipulation, and storage of official U.S. Government or other authorized information only. Unauthorized use of this computer may subject you to criminal prosecution and penalties.

User ID:

Password:

Station:

Users experiencing problems logging on to VIS should contact the VBA Regional Office ISO where the original request for access was submitted. For all other problems email VA VIS Application Support at [VAVISApplicationSupport@va.gov](mailto:VAVISApplicationSupport@va.gov)

[Users Guide](#) [Privacy and Security Statement](#) (production ver 1.0)



# Electronic Eligibility



Address: https://www.sloped.scrva.gov/efsmenu/frame.asp

**Veterans Information Solution**

**VETERAN PROFILE**  
 Name: [Redacted]  
 Military Status: [Redacted]  
 Veterans POA: [Redacted]  
 Claim Received Date: [Redacted]

**Diagnostic Info:**  
 Seizure disorder - general

**SC Diagnostic Code(s) and Percentage(s)**

Diagnostic Code	Extremity Designation	Current Percent Disability	Paragraph Designation	Dec Type CO	Beginning Date	Current Date	Future Exm Date
7819		0		SVCCONNCTED			
9904		0		SVCCONNCTED			
6847		50		SVCCONNCTED			
9199		0		SVCCONNCTED			
8999		30		SVCCONNCTED			

**Other Rating Info:**  
 SC Combined Legal Effective Date: [Redacted]  
 SC Combined Record Effective Date: [Redacted]  
 SC Combined Percentage: 70  
 PI NSC: [Redacted]  
 Individual Through Indicator: [Redacted]

**Special Issue:**  
 Name: [Redacted]  
 Basis: [Redacted]

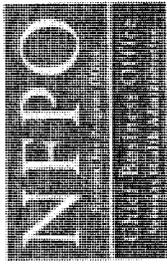
[VET INFO](#)  
[MIL HIST](#)  
[EDU](#)  
[Reports](#)  
[Help](#)  
[How Search](#)  
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[Home](#) | [About Us](#) | [Privacy Policy](#) | [Feedback](#) | [Contact Us](#) | [Site Map](#) | [Help](#) | [Log Out](#)

10:50 AM  
 Tuesday  
 4/22/2010



# Special Authority



- Agent Orange
- Environmental Contaminants
- Ionizing Radiation
- Military Sexual Trauma (MST)

**Information for Veterans, families and others about VA health care programs related to environmental issues can be found at:**

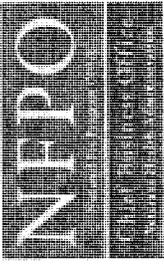
<http://www1.va.gov/environagents>

**VHA publications/directives can be found at:**

<http://vaww1.va.gov/vhapublications>



# Special Authority



Environmental Agents Service Home - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Search Favorites Links Go

Address: http://www1.va.gov/enviroagents/

Search All VA Web Pages Search

Open Advanced Search

Locations Contact VA

Apply Online Organizations Locations Contact VA

UNITED STATES  
DEPARTMENT OF VETERANS AFFAIRS

VA Home About VA Organizations Locations Contact VA

ENVIRONMENTAL AGENTS SERVICE

Environmental Agents Service Home

About Us

Newsletter Podcasts

Operations DIF/DEF

Environmental Health Clinicians

Environmental Health Coordinators

War-Related Illness Injury Study Centers (WRITISCs)

VHA Decontamination Planning and Implementation

Newsletter Notification

DoD Web Site: Chemical-Biological Warfare Exposures

Text Only

Information for veterans, their families and others about VA health care programs related to environmental issues.

PROGRAMS

- [OPERATIONS OIF/OEF](#)
- [GULF WAR](#)
- [VETERANS AND AGENT ORANGE](#)
- [IONIZING RADIATION](#)
- [Project 112 \(Including Project SHAD\)](#)
- [War-Related Illness and Injury Study Centers \(WRITISCs\)](#)
- [Depleted Uranium Follow-Up Program](#)

Holidays!

VA Health Care Eligibility & Enrollment Topics

Microsoft PowerPoint 2003

Local intranet 2:33 PM



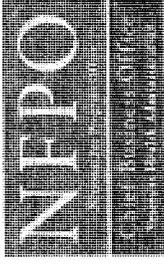
# Agent Orange



- Diabetes Type 2
- Chloracne
- Porphyria Cutanea Tarda
- Acute and Subacute Peripheral Neuropathy
- Prostate Cancer
- Amyotrophic Lateral Sclerosis
- Ischemic heart disease
- Hodgkin's disease
- Multiple Myeloma
- Non-Hodgkin's Lymphoma
- Respiratory Cancers
- Soft Tissue Sarcoma
- Chronic Lymphocytic Leukemia (CLL)
- B- Cell Leukemia



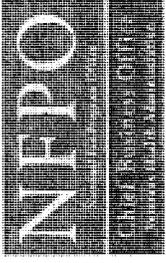
## Southwest Asia Contaminants



- Persistent Fatigue
- Skin Rash
- Headache
- Arthralgias/Myalgias
- Sleep Disturbance
- Forgetfulness
- Joint Pain
- Shortness of Breath/Chest Pain
- Feverishness
- Amyotrophic Lateral Sclerosis



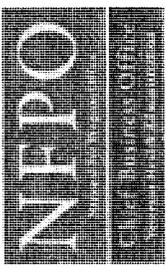
# **Ionizing Radiation**



- Leukemia, Lymphoid
- Leukemia, Myeloid
- Leukemia, Monocytic
- Leukemia, Hairy Cell
- Leukemia, Other
- Leukemia, Unspecified
- Thyroid Cancer
- Breast Cancer
- Lung Cancer
- Bone Cancer
- Primary Liver Cancer
- Skin Cancer
- Esophageal Cancer
- Stomach Cancer
- Pancreatic Cancer
- Kidney Cancer
- Urinary Bladder Cancer
- Salivary Gland Cancer
- Other Malignancies
- Multiple Myeloma
- Posterior Subcapsular Cataracts
- Non-Malignant Thyroid Nodular Disease
- Ovarian Cancer
- Parathyroid Adenoma
- Malignant tumors of the brain and Central Nervous System
- Lymphomas other than Hodgkin's
- Cancer of the Rectum
- Cancer of the Small Intestine
- Cancer of the Pharynx
- Cancer of the Bile Duct
- Cancer of the Gall Bladder
- Cancer of the Renal Pelvis, Ureters and Urethra
- Cancer of the Prostate
- Broncho-Alveolar Carcinoma ( Rare lung Disease)
- Benign Neoplasm of the brain and Central Nervous System



# VBA Rating Codes



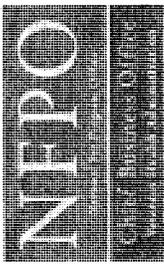
- Vague Codes
  - What do they mean?
  - Where do I find more information?
- Best Source
  - To clarify the patient's rated condition- the source information is from the Regional Office

General Information about ratings, codes and percentages visit the VBA Website

<http://vbaw.vba.gov/bl/21/publicat/regs/Part4/toc.htm>



# Health Inquiry HINQ



NAME: **WILLIE**      EMPLOYER: **NOI HISPANIC UN TRAIN**

COMBO VET STATUS: **NOT ELIGIBLE**  
 PRIMARY ELIGIBILITY: **SERVICE CONNECTED 50% CO 100% (VERIFIED)**  
 OTHER ELIGIBILITY:

LIC COVERAGE STATUS: **YES**      Last Test: **OCT 13, 2004**  
 STATUS: **INACTIVE INPATIENT**      Discharge Type: **OPT-NSC**

Admitted: **SEP 20, 2004 06:54:01**      Discharged: **MAR 16, 2005 01:03:06**  
 Ward: **VR08**      Room: **219-1-K5484**  
 Attending: **SHAPIRO, HONAIHAD P**      Specialty: **ZENHUO**  
 Attending: **SHAPIRO, HONAIHAD P**

Admission LOS: **174**      Absence days: **0**      Pass Days: **0**      ASIN days: **0**

FUTURE APPOINTMENTS: **NONE**  
 OTHER ACA RECORDS: **NONE**

Remarks: **PATIENT DIED ON 12/16/06**  
 Date of Death Information:  
 Date of Death: **DEC 16, 2006**  
 Source of Notification:  
 Entered Date/Time:  
 Last Edited By: **POSTMASTER**

Referral Contact Information:  
 Referral: **TRINER, MRS KENNETH**  
 Relationship: **SISTER**  
 Address: **174 TERRACE COURT  
 LANCASTER, OHIO 43029**  
 Work Phone: **(740) 681-2792**  
 Home Phone: **UNSPECIFIED**

Health Insurance Information:  
 Insurance: **COB**      Member ID:  
 App Health: **SA17025281A**  
 Medicare: **P**      SSN: **25165581A**  
 Medicare: **P**      SSN: **25165581A**

Service Connection/Reed Disabilities:  
 SC Percent: **50%**  
 Reed Disabilities: **LIMITED MOTION IN LUMBAR SPINE (40%-SC)  
 L5/S1 DISC CONDITION (40%-SC)  
 CLAVICLE OF SCAPULA, IMPAIRMENT OF (20%-SC)  
 IMPAIRMENT OF TOES (10%-SC)  
 IMPAIRMENT OF TOES (10%-SC)  
 NEOPLASM, BENIGN, GYNTOURINARY (0%-SC)**

Name of Referral Information:  
 Name: **TRINER, MRS KENNETH (SISTER)**  
 Address: **174 TERRACE COURT  
 LANCASTER, OHIO 43029**

Select New Patient      Print      Close



# Virtual VA



Virtual VA - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites

Address: http://virtualva.vba.va.gov/

**Virtual VA Training**

- [SEE WHAT'S NEW! Guide\(pdf\)](#)
- [Learn about Virtual VA Barcode Capture Guide\(pdf\)](#)
- [Learn about DOD Inquiry Guide\(pdf\)](#)
- [Learn about Work Items User Guide\(pdf\)](#)
- [Learn about CIMS \(Marine Corps records\) CBT Guide\(pdf\)](#)

**Online Applications**

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- [Education](#)
- [Health](#)
- [Vocation Rehab & Employment Services](#)
- [U.S. Marine Corps Combat Action Ribbon](#)
- [General APO-FPO Locations Current](#)
- [General 1990 APO-FPO Directory](#)

**Special Programs**

- [Accessibility](#)
- [Homeless Veterans](#)
- [Military Services](#)
- [Women Veterans](#)

**Today's VA**

- [About VA](#)



**VIRTUAL VA**

DEPARTMENT OF VETERANS AFFAIRS  
COMPENSATION & PENSION SERVICE

Station Number:

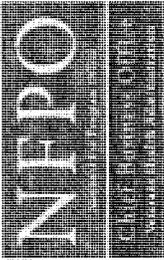
Username:

Password:

Local Intranet



# Virtual VA



Virtual VA - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address http://virtua.va.va.gov/

Find eFolder

Search

Claim Number

Name:  Date of Birth:

Last Social Security:  (mm/dd/yyyy) Service Number:

Jurisdictional RO:  Local  All

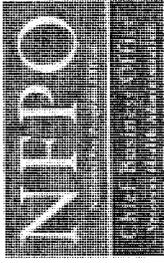
0 matches found.

#	Claim #	Name	DOB	SSN	Service #	Jurisdictional RO	Current RO	Created on
1								

Local intranet



# Rating Sheet



DEPARTMENT OF VETERANS AFFAIRS  
REGIONAL OFFICE  
8810 RIO SAN DIEGO DRIVE  
SAN DIEGO, CA 92108

Mr. Veteran  
VA File Number  
XXX XX XXXX  
Rating Decision  
December 3, 2008

## INTRODUCTION

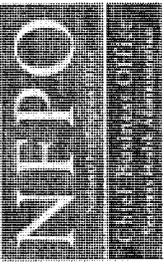
The records reflect that you are a veteran of the Vietnam Era. You served in the U.S. Marine Corps from \_\_\_\_\_, to \_\_\_\_\_. You filed an original disability claim that was received on \_\_\_\_\_. Based on a review of the evidence listed below, we have made the following decisions on your claim.

## DECISION

1. Service connection for diabetes mellitus, type II, associated with herbicide exposure (Agent Orange) is granted with a 20 percent evaluation effective April 2, 2008.
2. Service connection for peripheral neuropathy, left lower extremity, is granted with an evaluation of 10 percent effective April 2, 2008.
3. Service connection for peripheral neuropathy, right upper extremity, is granted with an evaluation of 10 percent effective April 2, 2008.



# Rating Sheet



4. Service connection for peripheral neuropathy, left upper extremity, is granted with an evaluation of 10 percent effective April 2, 2008.
5. Service connection for peripheral neuropathy, right lower extremity, is granted with an evaluation of 10 percent effective April 2, 2008.
6. Service connection for cataracts is granted with an evaluation of 0 percent effective April 2, 2008.
7. Service connection for post-traumatic stress disorder is denied.

## EVIDENCE

### Personnel Records

Private Treatment Records dated \_\_\_\_\_, to \_\_\_\_\_

Your Letter dated \_\_\_\_\_

VA (Contract) Examination Reports dated \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_

VA \_\_\_\_\_ Treatment Records dated \_\_\_\_\_, to \_\_\_\_\_

DD Form 214 dated \_\_\_\_\_

Service Treatment Records dated \_\_\_\_\_, to \_\_\_\_\_



# Rating Sheet



## REASONS FOR DECISION

1. Service connection for diabetes mellitus, type II, associated with herbicide exposure (Agent Orange).

**Although not shown in service, service connection for diabetes mellitus, type II, has been granted on the basis of presumptive exposure to Agent Orange because the response we received from the National Personnel Records Center shows that you served in-country in the Republic of Vietnam from \_\_\_\_\_, to \_\_\_\_\_, and your VA and private treatment records show diagnoses of this condition.**

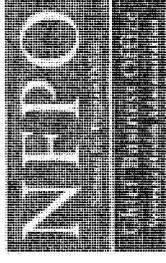
**A 20 percent evaluation is assigned effective April 2, 2008, the date of your claim, because your VA examination report shows that you are using oral hypoglycemic medication to control your diabetes.**

**Your private treatment records and VA treatment records show no evidence which would allow us to assign a higher evaluation for this condition.**

**A higher evaluation of 40 percent is not warranted unless insulin, restricted diet, and regulation of activities are required.**



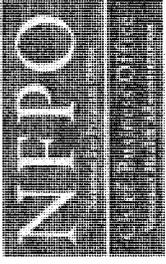
# Diabetes Mellitus Ratings



- 10% Manageable by restricted diet
- 20% Requiring insulin and restricted diet; or, hypoglycemic agent and restricted diet
- 40% Requiring insulin, restricted diet, and regulation of activities
- 60% All of the above plus episodes of ketoacidosis or hypoglycemic reactions



# Diabetes Mellitus Ratings



100%

Including all previous symptoms but more than one daily injection and hospitalization at least three times a year or weekly visits to diabetic care provider.

Progressive loss of weight, strength, or complications that would be compensable if separately evaluated



## Frequently Asked Questions



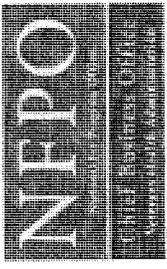
**Q. If a patient is 100% service connected for a specific condition, are all their encounters service connected?**

**A. No. The percentage (%) of service connection pertains only to the rated condition. If the encounter was for a non service connected condition, it would not be considered a service connected encounter.**

**If a patient is 0% or 100%, they are still rated for that specific condition.**



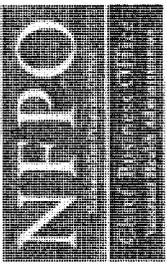
## Frequently Asked Questions



- Q.** Do veterans receive free care at the VA Medical Center?
- A.** Not all veterans.
- Most veterans have a Medication co-pay
  - Certain priority patients by law through income-based determinations (Means Test) must make co-payments



## Frequently Asked Questions



Q. Must the veteran's private insurance company be billed for conditions that are adjunct or secondary to the service-connected condition?

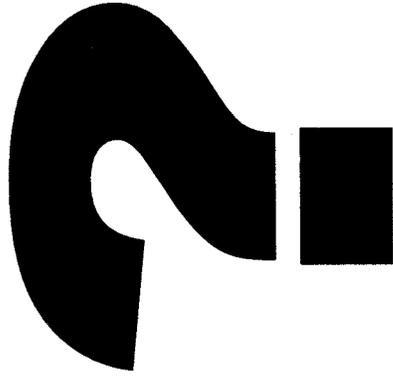
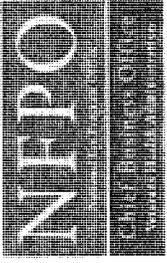
A. Yes. Current interpretation of the law:

- Adjunct condition associated with or aggravating a disease or condition which is service connected
- Secondary condition has been caused or is the result of a service connected condition

Adjunct and secondary conditions are not service-connected per interpretation of the law and should be billed to the insurance carrier

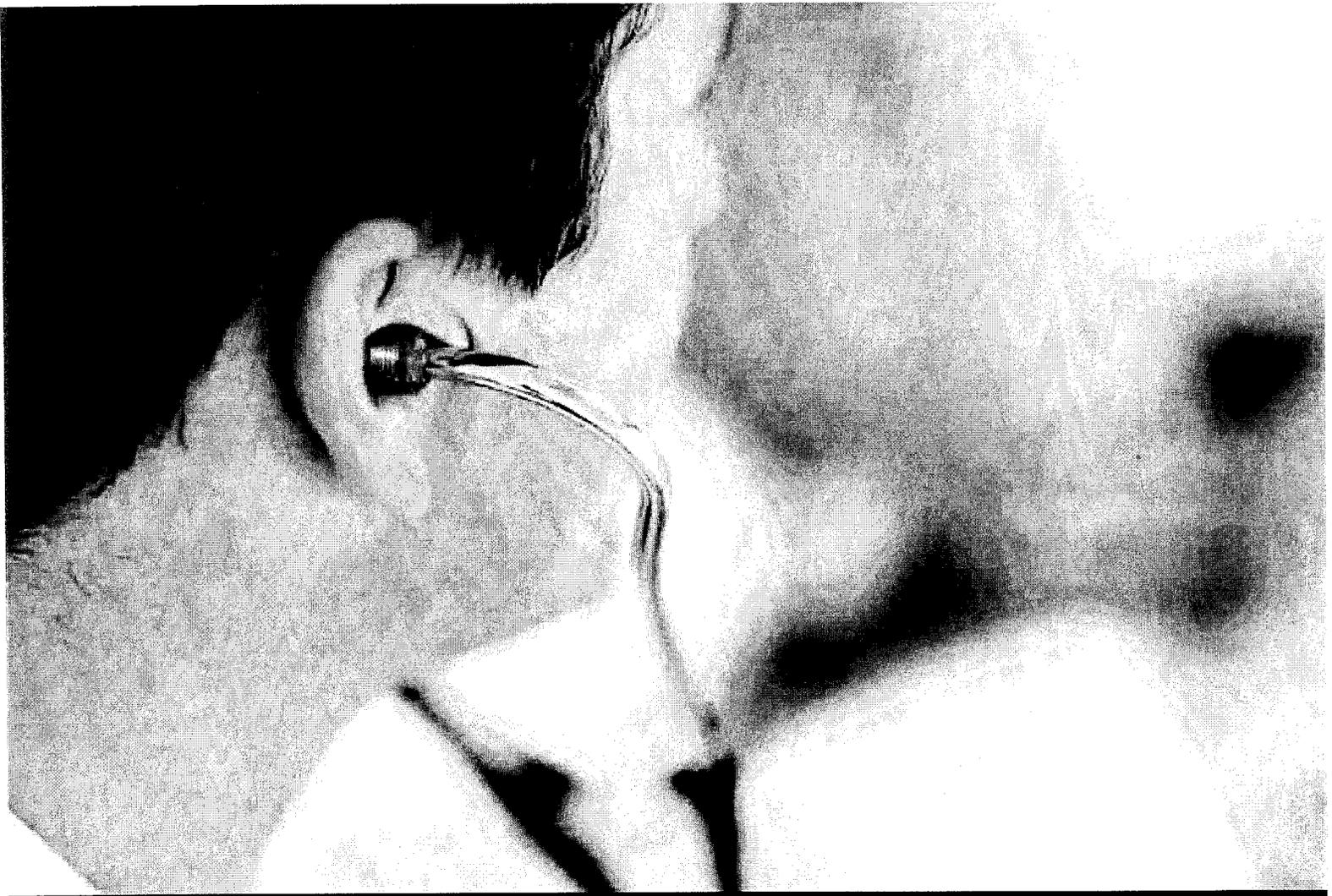


# Discussion



## Eligibility Criteria for Authorization of Preauthorized and Emergency Treatment Under 38 U.S.C. 1703

Criteria	IPT	OPT	Authority
The Veteran's VA rated SC disability, or for NSC condition that is associated with and aggravating the Veteran's SC condition	Yes	Yes	38 CFR § 17.52 (a)(1)(i)
A disability for which the Veteran was released from active duty	Yes	Yes	38 CFR § 17.52 (a)(1)(ii)
Any condition of a Veteran who is rated by VA as permanently and totally disabled from a SC disability	Yes	Yes	38 CFR § 17.52 (a)(1)(iii)
Care for an adjunct condition	Yes	Yes	38 CFR § 17.52 (a)(1)(iv)
Any condition of a Veteran who is participating in a VA Vocational Rehab program for whom it has been medically determined that treatment is required to make entrance into a course of training possible, or prevent any interruption of training.	Yes	Yes	38 CFR § 17.52 (a)(1)(v)
Any condition for a Veteran who has a VA SC disability rating of 50% or greater	No	Yes	38 CFR § 17.52 (a)(2)(i)
A condition for which the Veteran has been furnished VA hospital care, nursing home, domiciliary care, or medical services and requires medical services to complete treatment.	No	Yes	38 CFR § 17.52 (a)(2)(ii)
A condition requiring emergency care that developed while the Veteran was receiving medical services in a VA HCF or contract nursing home	Yes	Yes	38 CFR § 17.52 (a)(3)&(10)
A condition requiring emergency care that developed during VA authorized travel	Yes	Yes	38 CFR § 17.52 (a)(8)
Any care that will obviate the need for hospital admission for a Veteran in the state of Alaska or Hawaii and US Territories, excluding Puerto Rico	Yes	Yes	38 CFR § 17.52 (a)(6)
Any condition for women Veterans.	Yes	No	38 CFR § 17.52 (a)(4)
Any dental services and treatment, and related dental appliances, for Veterans who are former prisoners of war	No	Yes	38 CFR § 17.52 (a)(7)
Diagnostic services to determine the appropriate course of treatment at a VA outpatient clinic	No	Yes	38 CFR § 17.52 (a)(9)
Diagnostic services to complete C&P exams for a VA Regional Office	Yes	Yes	38 CFR § 17.52 (a)(11)



# Health Care Benefits Overview

## 2012

Building on over 50 years of providing quality health care services to our nation's Veterans



**VA**  
HEALTH  
CARE

Defining  
**EXCELLENCE**  
in the 21st Century

*"...to care for him who shall  
have borne the battle and for  
his widow, and his orphan..."*

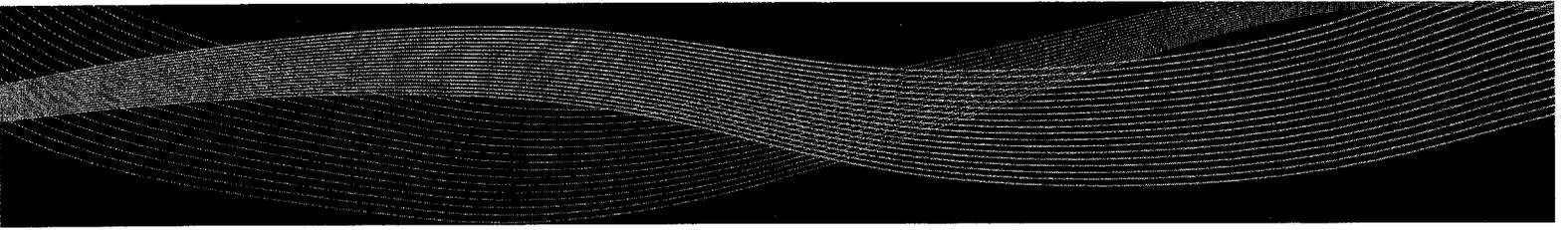
*- Abraham Lincoln*



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Benefits on the Go .....	2
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# Introduction

This guide is designed to provide Veterans and their families with the information they need to understand VA's health care system—eligibility requirements, the health benefits and services available to help Veterans and copays that certain Veterans may be charged.

Additionally, inside you will find helpful information about My HealtheVet, Creditable Coverage for Medicare Part D, Income Verification and medically related travel benefits.

This brochure is not intended to provide information on all of the health services offered by VA. If we have not addressed your specific questions, additional assistance is available at the following resources:

Your local VA health care facility's Enrollment Office

[www.va.gov/healthbenefits](http://www.va.gov/healthbenefits)

[www.myhealth.va.gov](http://www.myhealth.va.gov)

VA toll-free 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday

***VA enrollment also allows health care benefits to become completely portable throughout the entire VA system.***

## Overview

Today's Veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans (see Enrollment Priority Groups on page 19).

Complementing the expansion of benefits and improved access is our ongoing commitment to providing the very best in quality service. Our goal is to ensure our patients receive the finest quality health care regardless of the treatment program, regardless of the location. In addition to our ongoing quality assurance activities, we've made it easier for Veterans to get the health care they need. New locations continue to be added to the VA health care system—bringing the total number of treatment sites to over 1,400 nationwide.

All Veterans—including those who have special eligibility—are encouraged to apply for enrollment. Enrollment helps us determine the number of potential Veterans who may seek VA health care services and is a very important part of our planning efforts.

Enrollment in the VA health care system provides Veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period. In addition to the assurance that services will be available, enrolled Veterans welcome not having to repeat the application process—regardless of where they seek their care or how often.

## Veterans Choose the VA Facility

As part of the enrollment process, Veterans will be given the opportunity to select the VA health care facility or Community Based Outpatient Clinic (CBOC) to serve as his/her preferred facility.

## Benefits on the Go

VA enrollment also allows health care benefits to become completely portable throughout the entire VA health care system. Enrolled Veterans who are traveling or who spend time away from their preferred facility may obtain care at any VA health care facility across the country without the worry of having to reapply. Once you are enrolled, you will always be enrolled, however, you may be asked to update/verify your demographic and/or financial information when seeking care at a new VA facility. Veterans with a service-connected condition may receive treatment for that condition even in a foreign country (see Foreign Medical Program on page 26).

## Notice of Privacy Practices

Veterans who are enrolled for VA health care benefits have various privacy rights under federal law and regulations, including the right to a Notice of Privacy Practices. The VA Notice of Privacy Practices provides enrolled Veterans with information regarding how VHA may use and disclose personal health information, of their rights to know when and to whom their health information may have been disclosed, how to request access to or receive a copy of their health information on file with VHA, and how to request an amendment to correct inaccurate information on file and file a privacy complaint. The VA Notice of Privacy Practices may be obtained through the Internet at [www.va.gov/vhapublications/viewpublication.asp?pub\\_id=1089](http://www.va.gov/vhapublications/viewpublication.asp?pub_id=1089) or through the mail by writing the VHA Privacy Office (19F2), 810 Vermont Avenue NW, Washington, DC 20420.

## Your Personal VA Health Information Online

VA offers Veterans, Servicemembers, their dependents and caregivers their own Personal Health Record through My HealthVet, found at [www.myhealth.va.gov](http://www.myhealth.va.gov).

My HealthVet's free, online Personal Health Record is available 24/7, wherever there is Internet access. If you are a VA patient and have an upgraded account (obtained by completing the one-time In-Person Authentication\* process), you can:

- Participate in Secure Messaging with your participating VA health care team members
- View key portions of your DoD Military Service Information
- Get your VA Wellness Reminders
- View your VA Appointments
- View your VA Lab Results
- View your VA Allergies and Adverse Reactions
  - o PLUS, participate in future features as

they become available

With My HealthVet, you can access trusted health information to better manage your health care and learn about other VA benefits and services.

My HealthVet helps Veterans partner with your VA health care teams by providing tools to make shared, informed decisions. Simply follow the directions on the website to register. If you are a VA patient registered on My HealthVet, you can begin to refill your VA medications online. You can also use the VA Blue Button to view, print, or download the health data currently in your My HealthVet account. You can share this information with your family, caregivers or others such as your non-VA health care providers. It puts you in control of your information stored in My HealthVet.



My Health, My Care: 24/7 <sup>Online</sup> Access to VA

Accessible through My HealthVet VA Blue Button also provides Veterans who were discharged from military service after 1979 access to your DoD Military Service Information. This information may include Military Occupational Specialty (MOS) codes, pay details, service dates, deployment, and retirement periods.

\*To access the advanced My HealthVet features, Veterans will need to get an upgraded account by completing a one-time process at their VA facility called In-Person Authentication . Visit My HealthVet at [www.myhealth.va.gov](http://www.myhealth.va.gov), register and learn more about In-Person Authentication PLUS the many features and tools available to you 24/7 anywhere you have Internet access.

If you have any questions about My HealthVet, contact the My HealthVet Coordinator at your local VA facility.

## Frequently Asked Questions

### ***Were there changes to allow more high income Veterans to enroll for VA health care?***

Yes. On June 15, 2009, VA amended its regulations to expand enrollment of certain Veterans with higher income. Under this provision, VA is enrolling Priority Group 8 Veterans whose income does not exceed the new VA National Income Thresholds by more than 10%. While this provision does not remove consideration of income, it does increase income thresholds.

### ***Where can I find the new income thresholds?***

Because of the changes to the income thresholds each year, they are not published in this brochure. However, the income threshold tables can be viewed on-line at

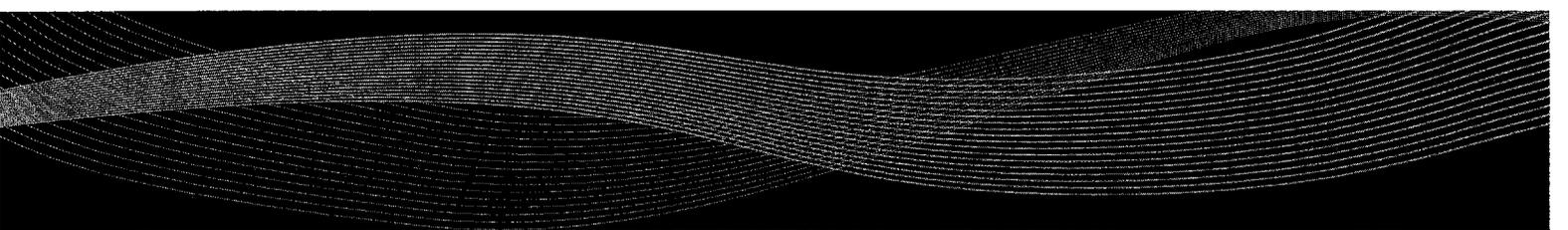
[http://www.va.gov/healthbenefits/cost/income\\_thresholds.asp](http://www.va.gov/healthbenefits/cost/income_thresholds.asp)

### ***How can I verify my enrollment?***

Once you enroll, you will receive either a letter or a newly introduced Veterans Health Benefits Handbook from us notifying you of the status of your enrollment. You may also call us to verify your enrollment at 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday.

[www.va.gov/healthbenefits/](http://www.va.gov/healthbenefits/)





# Eligibility and Medical Program Benefits

## Basic Eligibility

If you served in the active military, naval or air service and are separated under any condition other than dishonorable, you may qualify for VA health care benefits. Current and former members of the Reserves or National Guard who were called to active duty (other than for training only) by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA health care as well.

## Minimum Duty Requirements

Most Veterans who enlisted after September 7, 1980, or entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be eligible. This minimum duty requirement may not apply to Veterans who were discharged for a disability incurred or aggravated in the line of duty, discharged for a hardship, or received an "early out." Since there are a number of other exceptions to the minimum duty requirements, VA encourages all Veterans to apply in order to determine their enrollment eligibility.

## Women Veterans Eligibility

Current estimates of the projected growth of women Veterans predict there will be 1.9 million by 2020, up from 1.1 million in 1980. Thus, women will continue to make up a larger share of the Veteran population, add to its diversity, and require Veteran services geared to their specific needs.

VA is committed to meeting women Veterans' unique needs by delivering the highest quality health care in a setting that ensures privacy, dignity, and sensitivity. Your local VA facility offers a variety of services, including:

- Women's gender-specific health care (menopause evaluation and symptom management, osteoporosis, incontinence, birth control, breast and gynecological care, maternity and limited infertility services).
- Screening and disease prevention programs (for example, mammograms, bone density screening, and cervical cancer screening).
- Childbirth services to the newborn child of a woman Veteran



*Current estimates of the projected growth of women Veterans predict there will be 1.9 million by 2020, up from 1.1 million in 1980.*

Routine gynecologic services available through your local VA facility include:

- Human Papilloma Virus (HPV) vaccinations
- Pelvic exams, ultrasounds
- Birth control counseling and management (medical and surgical)
- Pre-pregnancy care
- Treatment and prevention of sexually transmitted infections

Your provider can assist with routine exams, diagnosis, and management of:

- Pelvic/abdominal pain
- Abnormal vaginal bleeding
- Vaginal symptoms (dryness/infections)
- Breast and other women's cancers
- Abnormal cervical screening results
- Infertility evaluation, including intrauterine insemination (IUI). VA is not authorized to provide or cover the cost of in vitro fertilization (IVF).
- Sexual dysfunction

Female Veterans are potentially eligible for Fee Basis care. However, the decision to utilize such care is left to the facility providing your care. By law, Fee Basis care can only be provided when your treating facility cannot provide you the care you require or because of geographical inaccessibility

Contact your local Women Veterans Program Manager for more information on available services.

## Medically Related Travel Benefits

Veterans may qualify for mileage reimbursement if they fall into one of the following categories:

- Have a service-connected disability rating of 30 percent or more
- Are traveling for treatment of a service-connected condition
- Receive a VA pension
- Are traveling for a scheduled compensation or pension examination
- Does not have income that exceeds the maximum annual VA pension rate
- Veterans meeting the above conditions may also be provided special mode travel (e.g., wheelchair van, ambulance) based on a clinical determination of need (authorization is not required for emergencies if a delay would endanger their life or health). More information on mileage rates and deductibles can be found on the internet at [www.va.gov/healthbenefits](http://www.va.gov/healthbenefits)

Travel benefits are subject to a deductible. Exceptions to the deductible requirement include: 1) travel for a compensation and pension examination; and 2) travel by an ambulance or a specially equipped van. Because travel benefits are subject to annual mileage rate and deductible changes, we publish a separate document detailing these amounts each year. You can obtain a copy at any VA health care facility.

*VA provides readjustment counseling  
and outreach services to all Veterans  
who served in any combat zone...*



## Readjustment Counseling Services

VA provides readjustment counseling and outreach services to all Veterans who served in any combat zone, through community based counseling centers called Vet Centers. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the Veteran or family. The Vet Centers are staffed by small multidisciplinary teams of dedicated personnel, many of whom are combat Veterans themselves. Vet Center staffs are available toll-free during normal business hours at 1-800-905-4675 (Eastern) and 1-866-496-8838 (Pacific). For information online, visit [www.vetcenter.va.gov](http://www.vetcenter.va.gov).

## Veterans Crisis Line

The Veterans Crisis Line is a toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring VA responders.

Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online at [www.VeteransCrisisLine.net](http://www.VeteransCrisisLine.net) or send a text message to 838255 to receive free, confidential support 24 hours a day, 7 days a week, 365 days a year, even if they are not registered with VA or enrolled in VA health care.

The professionals at the Veterans Crisis Line are specially trained and experienced in helping Veterans of all ages and circumstances—from Veterans coping with mental health issues that were never addressed to recent Veterans struggling with relationships or the transition back to civilian life.

U.S. Department of Veterans Affairs

**IT'S YOUR CALL**

Confidential help for Veterans and their families

**1-800-273-8255 PRESS 1**

Veterans Crisis Line

Confidential chat at [VeteransCrisisLine.net](http://VeteransCrisisLine.net) or text to 838255

## National Call Center for Homeless Veterans

VA has founded a National Call Center for Homeless Veterans to ensure that homeless Veterans or Veterans at-risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families, VA Medical Facilities, federal, state and local partners, community agencies, service providers and others in the community. To be connected with a trained VA staff member call **1-877-4AID VET (877-424-3838)**.

- Call for yourself or someone else
- Free and confidential
- Trained VA counselors to assist
- Available 24 hours a day, 7 days a week
- We have information about VA homeless programs and mental health services in your area that can help you.

More information can be found at [www.va.gov/HOMELESS/NationalCallCenter.asp](http://www.va.gov/HOMELESS/NationalCallCenter.asp).

## Family Caregivers Program

On May 5, 2010, Public Law 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law. The purpose of the caregivers benefit program is to provide certain medical, travel, training, and financial benefits to caregivers of certain veterans and Servicemembers who were seriously injured during service on or after September 11, 2001. VA began accepting 10-10CG (Caregiver) applications on May 9, 2011. VA's Family Caregivers Program provides support and assistance to caregivers of post 9/11 Veterans and Service Members being medically discharged. Eligible primary Family Caregivers can receive a stipend, training, mental health services, travel and lodging reimbursement, and access to health insurance if they are not already under a health care plan. For more information, contact your local VA medical facility and speak with a Caregiver Support Coordinator, visit [www.caregiver.va.gov](http://www.caregiver.va.gov) or dial toll-free 1-855-260-3274.

# VA Health Care Enrollment

## Applying for Enrollment is Now Easier and Faster than ever...

No more signing the application or mailing it in...applying is now easier and faster than ever! We've even shortened the form to make it easier to apply. When applying online at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>, Veterans simply fill out the application online and electronically submit it to VA for processing. No need for additional documents to verify military service - if the Veteran was recently discharged, we will get that information. Applying online significantly reduces the processing time for enrollment for Veterans to be able to access their medical benefits. Apply online now at <https://www.1010ez.med.va.gov/sec/vha/1010ez>. If you need help filling out the form while online, call 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday, or click on the "chat online with representative" button located on the website and a representative will assist you.

The application form can be downloaded from the website above, or if you prefer, to complete the application over the phone, or have a paper copy mailed to you, you may do so by calling 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday. You may also apply in person at any VA Healthcare Facility. Once you have submitted your application, you will be notified via letter of the status of your enrollment and priority group assignment.

Once you enroll in the VA health care system, you will receive either an enrollment letter or a Veterans Health Benefits Handbook. Each customized handbook includes VA health care benefit information, based on the Veteran's specific eligibility factors, in an organized, easy-to-read format. The handbook provides a current description of VA health care benefits available to each enrolled Veteran. It also includes information on the Veteran's preferred facility, copay responsibilities, how to schedule appointments, ways to communicate treatment needs, patient rights, how to obtain copies of medical records and more. For more information, visit [www.va.gov/healthbenefits/vhbh](http://www.va.gov/healthbenefits/vhbh).

*Regulations have enabled VA to relax income restrictions on enrollment for health benefits.*

## Priority Group 8 Enrollment Relaxation

Regulations went into effect on June 15, 2009 which enabled the Department of Veterans Affairs (VA) to relax income restrictions on enrollment for health benefits. While this provision does not remove consideration of income, it does increase income thresholds. You may be eligible for enrollment under this provision. The VA National Income Thresholds can be found online at [www.va.gov/healthbenefits/assets/documents/publications/AnnualThresholds.asp](http://www.va.gov/healthbenefits/assets/documents/publications/AnnualThresholds.asp).

Although the income relaxation regulation described above allows certain higher-income Veterans to be enrolled in the VA health care system, the previous Enrollment Restriction, effective January 17, 2003, by which VA suspended NEW enrollment of Veterans assigned to Priority Groups 8e and 8g is still in effect (VA's lowest priority group consisting of higher income Veterans). However, VA encourages Veterans in these priority groups to reapply for enrollment. They may now qualify if their current household income does not exceed the adjusted income thresholds under current regulations. The VA National Income Thresholds can be found on line at [www.va.gov/healthbenefits/assets/documents/publications/AnnualThresholds.asp](http://www.va.gov/healthbenefits/assets/documents/publications/AnnualThresholds.asp).

New Veteran applicants are assigned to Priority Groups 8e and 8g based on the following:

- The Veteran does not have any special qualifying eligibility, such as a compensable service-connected disability
- The Veteran's household income exceeds the current year adjusted VA income threshold and the adjusted geographic income threshold for the Veteran's residence
- Veterans who decline to provide their financial information

Veterans enrolled in Priority Groups 8a and 8c on or before January 16, 2003, remain enrolled and continue to be eligible for the full-range of VA health care benefits

Changes in VA's available resources may affect the number of priority groups VA can enroll in a given year. If that occurs, VA will publicize the enrollment changes and notify affected enrollees.

**IMPORTANT:** Veterans who may otherwise be ineligible for enrollment based on income may still be eligible based on a VA Catastrophically Disabled determination or due to loss of income or other economic factor by applying for a Hardship determination. For further information please contact VA at 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday.

## Obtaining an Appointment

You may request a doctor's appointment at the time you apply in person, or by checking 'yes' to the question asking if you want an appointment on the application for enrollment. An appointment will be made with a VA doctor or provider and you will be notified via mail of the appointment. If you need health care before your scheduled appointment, you may contact the Enrollment Coordinator, your clinic contact, Urgent Care Clinic or the Emergency Room at your local VA medical facility.

## Updating Your Information Using the Automated Health Benefits Renewal Form

Already enrolled and need to update your information? Enrolled Veterans may now automatically submit updates to their address, phone number, health insurance and financial information using the automated online VA Form 1010EZR, Health Benefits Renewal Form available at [www.1010ez.med.va.gov/sec/vha/1010ez/Form/1010ezr.pdf](http://www.1010ez.med.va.gov/sec/vha/1010ez/Form/1010ezr.pdf). If you need help filling out the form while online, you may call 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday, or click on the "chat online with representative" button located on the website and a representative will assist you.

Veterans may update their information at any time - whenever their financial or personal information changes, by completing VA Form 10-10EZR. Submitting the information online is the fastest way to update information and no signature is required. Other ways to update information are by phone at 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday, by mail or in person. If mailing the form, be sure to sign and date the form.

*Every VA medical center has a team ready to welcome OEF/OIF/OND Servicemembers and to help coordinate their care.*

## Special Eligibility and Coordination of Care for Combat Veterans Serving in Combat Theater After 11/11/1998– Returning Servicemembers (OEF/OIF/OND)

VA is ready to provide health care and other medical services to our nation's returning OEF/OIF/OND Servicemembers. Every VA medical center has a team ready to welcome OEF/OIF/OND Servicemembers and to help coordinate their care. For more information about the various programs available for recent returning service members, log on to the Returning Servicemembers web site at [http://www.oefoif.va.gov/VA\\_Help.asp](http://www.oefoif.va.gov/VA_Help.asp).

Veterans who served in a theater of combat operations also have special eligibility for VA health care. Under the "Combat Veteran" authority VA provides cost-free health care services and nursing home care for conditions possibly related to military service and enrollment in Priority Group 6 or higher for 5 years from the date of discharge or release from active duty, unless eligible for enrollment in a higher priority group to:

Combat Veterans who enroll with VA under this enhanced Combat Veteran authority will continue to be enrolled even after their enhanced eligibility period ends, although they may be shifted to Priority Group 7 or 8, depending on their income level, and required to make applicable copays. Additionally, for care not related to combat service, copays may be required depending on their financial assessment and other special eligibility factors.

**NOTE: The 5-year enrollment period applicable to these Veterans begins on the discharge or separation date** of the service member from active duty military service, or in the case of multiple call-ups, the most recent discharge date.

## Financial Assessment (Means Testing) and Income Thresholds

While many Veterans qualify for enrollment and cost-free health care services based on a compensable service-connected condition or other qualifying factors, certain Veterans will be asked to complete a financial assessment, or means test as part of their initial enrollment application process to determine their eligibility for cost-free medications and travel benefits. Otherwise known as the Means Test, this financial information may be used to determine the applicant's enrollment priority group (see Enrollment Priority Groups section on page 19) and whether he/she is eligible for cost-free VA health care. Higher-income Veterans may be required to share in the expense of their care by paying copays (Refer to the Copay section of this booklet on page 21).

Veterans who are already enrolled may submit their subsequent annual means test or at anytime their income or demographic information changes using the automated Online 10-10EZR, Health Benefits Renewal Form, (see information on page 10).

Income threshold information can be found online at: [http://www.va.gov/healthbenefits/cost/income\\_thresholds.asp](http://www.va.gov/healthbenefits/cost/income_thresholds.asp) or you may contact the Enrollment Coordinator at your local medical facility.

Due to VA's restricting enrollment of Priority Groups 8e and 8g, Veterans applying for enrollment who do not have any other special eligibility qualifying factors and decline to provide financial information, may not be accepted for enrollment.

## Geographically-Based Copays

Recognizing the cost of living can vary significantly from one geographic area to another, Congress added income thresholds based on geographic locations to the existing VA national income thresholds ([www.va.gov/healthbenefits/cost/income\\_thresholds.asp](http://www.va.gov/healthbenefits/cost/income_thresholds.asp)) for financial assessment purposes. This assists lower-income Veterans who live in high-cost areas by providing an enhanced enrollment priority and reducing the amount of their required inpatient copay.

Geographically-based copay reductions apply ONLY to INPATIENT SERVICES. Outpatient services, long-term care, as well as medication copays are NOT affected by this provision.

***Congress added income thresholds based on geographic locations to the existing VA national income thresholds for financial assessment purposes.***

## Catastrophically Disabled

To be considered catastrophically disabled, Veterans must have a severely disabling injury, disorder or disease that permanently compromises their ability to carry out the activities of daily living. The disability must be of such a degree that Veterans require personal or mechanical assistance to leave home or bed, or require constant supervision to avoid physical harm to themselves or others. Veterans may request a catastrophic disability evaluation by contacting the Enrollment Coordinator at their local VA health care facility. VA will make every effort to schedule an evaluation within 30 days of the request and there is no charge for the Catastrophic Disability evaluation. Veterans determined by a VA provider to be catastrophically disabled will be upgraded to Priority Group 4 if not otherwise eligible for a higher priority group. In addition, Veterans who are determined by VA to be Catastrophically Disabled receive cost-free care for their outpatient/inpatient treatment and for their medications. However, Veterans in this category may be subject to copays for extended care (long-term care).

NOTE: A Veteran who may not be eligible for enrollment due to VA's current enrollment restriction will be enrolled in Priority Group 4 if found to be Catastrophically Disabled.

## Income Verification

Veterans Health Administration's Income Verification (IV) program verifies earned and unearned total gross household income (spouse and dependents, if any) provided by non service-connected Veterans and Veterans rated non-compensable 0% service-connected.

The financial assessment is based on the Veteran's previous year gross household income (spouse and dependents, if any) and is used to determine their eligibility for VA health care benefits and in many cases, their priority group assignment. Income information provided by the Veteran is verified by matching records from the Internal Revenue Service and the Social Security Administration.

If the IV process confirms the Veteran's household income exceeds the established VA national income (means test) thresholds, the Veteran may be determined responsible for copays for health care provided since the date of completion of the initial financial assessment. In addition, if the Veteran enrolled on or after January 17, 2003, the Veteran's enrollment could become denied. As a result, the Veteran would no longer be eligible for VA health care for treatment of their non service-connected conditions. (For more information, refer to the Enrollment Restriction section on page 9 of this booklet or log on to [www.va.gov/healthbenefits/cost/financial\\_assessment.asp](http://www.va.gov/healthbenefits/cost/financial_assessment.asp)).

## Financial Hardships

If you are a Veteran who is suffering from financial distress, struggling to pay your VA copays, lost your job or currently face a significant decrease in your household income, VA has programs that can assist you. Additionally, VA's Medical Care Hardship program could help Veterans qualify for VA enrollment for health care services if they had a recent change in their income, even if they were previously denied enrollment based on their household income. Veterans who have not applied for VA enrollment because they thought their income was too high may want to reconsider applying if their projected current year's income is lower. Hardship determinations may be approved if the Veteran's current year income is substantially reduced from the prior year. Personal circumstances, such as loss of employment, sudden decrease in income or increases in out-of-pocket Veteran or family health care expenses, factor into VA's hardship determination.

If you are a Veteran and unable to pay your copay charges, you should discuss the matter with the Revenue Office at the VA health care facility where you received your care.

You must contact the facility where you received the care to request one of these options or call VA at 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday.

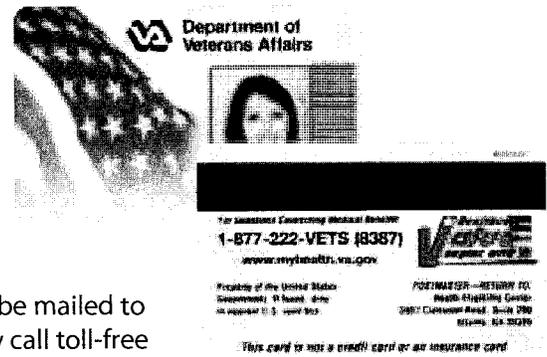
### Four possible options for Veterans unable to pay assessed copay charges

<b>Hardship Determination</b>	If a Veteran's current year income is substantially reduced from the prior year, the Veteran may be eligible for exemption from medical and hospital care copays for a determined period of time (See your local Enrollment Coordinator for Hardship consideration).
<b>Waiver</b>	If there has been a significant change in income or significant expenses for medical care for Veteran or other family members, funeral arrangements or Veteran educational expenses. Waiver is for past debts only. See your local Revenue staff for additional information
<b>Offer in Compromise</b>	Offer for past debts only and acceptance of a partial payment in settlement and full satisfaction of debt. See your local Revenue staff for additional information
<b>Repayment Plans</b>	Payment of past debt over a period of 36 months. See your local Revenue staff for additional information

## 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.

## Private Health Insurance

Since many Veterans are medically co-managed by both VA and their local provider, VA encourages Veterans to retain any health care coverage they may already have—especially those in the lower enrollment priority groups described on pages 19 and 20, Enrollment Priority Groups. Veterans with private health insurance may choose to use these sources of coverage as a supplement to their VA benefits. It is important to note that VA health care is NOT considered a health insurance plan.

By law, VA is obligated to bill health insurance carriers for services provided to treat a Veteran's non-service-connected conditions. Veterans are asked to cooperate by disclosing all relevant health insurance information.

Eligible Veterans are not responsible for payment of VA medical services billed to their health insurance company that are not paid by their insurance carrier.

To ensure current insurance information is on file—including coverage through the Veteran's spouse—VA staff ensures that Veterans' health insurance information is updated during each visit. Identification of insurance information is essential to VA because collections received from insurance companies help supplement the funding available to provide services to Veterans. Veterans may now update any changes in their insurance by using the online Health Benefits Renewal (1010-EZR) form at [www.1010ez.med.va.gov/sec/vha/1010ez/Form/1010ezr.pdf](http://www.1010ez.med.va.gov/sec/vha/1010ez/Form/1010ezr.pdf).

*...VA encourages Veterans to retain any health care coverage they may already have...*

**CAUTION!**

Before cancelling health insurance coverage, enrolled Veterans should carefully consider the risks.

- There is no guarantee that in subsequent years Congress will appropriate sufficient funds for VA to provide care for all enrollment priority groups.
- Non-Veteran spouses and other family members generally do not qualify for VA health care.
- If participation in Medicare Part B is cancelled, it cannot be reinstated until January of the next year, and there may be a penalty for the reinstatement.
- Additional coverage for those Veterans that are medically co-managed by both VA and their local provider.

**Insurance Collections**

Since 1986, Veterans' health care services have been supplemented by funds collected from private health insurance companies. This supplement has allowed VA to provide services to numerous additional Veterans.

**Medicare Part D Prescription Drug Coverage/Creditable Coverage**

If you are eligible for Medicare Part D prescription drug coverage, you need to know that enrollment in the VA health care system is considered **creditable coverage** for Medicare Part D purposes. This means that VA prescription drug coverage is at least as good as the Medicare Part D coverage. Since only Veterans may enroll in the VA health care system, dependents and family members do not receive credible coverage under the Veteran's enrollment.

However, there is one significant area in which VA health care is NOT creditable coverage: Medicare Part B (outpatient health care, including doctors' fees). Creditable coverage for Medicare Part B can only be provided through an **employer**. As a result, VA health care benefits to Veterans are not creditable coverage for the Part B program. So although a Veteran may avoid the late enrollment penalty for Medicare Part D by citing VA health care enrollment, that enrollment would not help the Veteran avoid the late enrollment penalty for Part B.

VA does not recommend Veterans cancel or decline coverage in Medicare (or other health care or insurance programs) solely because they are enrolled in VA health care. Unlike Medicare, which offers the same benefits for all enrollees, VA assigns enrollees to enrollment priority groups, based on a variety of eligibility factors, such as service-connection and income. There is no guarantee that in subsequent years Congress will appropriate sufficient medical care funds for VA to provide care for all enrollment priority groups. This could leave Veterans, especially those enrolled in one of the lower-priority groups, with no access to VA health care coverage. For this reason, having a secondary source of coverage may be in the Veteran's best interest.

In addition, a Veteran may want to consider the flexibility afforded by enrolling in both VA and Medicare. For example, Veterans enrolled in both programs would have access to non-VA physicians (under Medicare Part A or Part B) or may obtain prescription drugs not on the VA formulary if prescribed by non-VA physicians and filled at their local retail pharmacies (under Medicare Part D).

Additional information on Medicare Part D prescription drug coverage can be found online at the Health and Human Services Medicare website at [www.medicare.gov](http://www.medicare.gov).

***...a Veteran may want to consider the flexibility afforded by enrolling in both VA and Medicare.***

## 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.

### ***What if I cannot keep an appointment?***

VA asks that you help us provide timely service. If you cannot keep your appointment, please notify your facility as soon as possible so they can schedule another appointment for you, and use your cancelled appointment slot for another Veteran.

### ***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.

### ***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%.

## ***For those Veterans who have more than one residence, which address is used for means testing under the geographically-based income thresholds?***

The address used to determine your geographically-based income threshold is your permanent address and typically is the location where you declare residency for voting and tax purposes. To view geographic income thresholds, visit [http://www.va.gov/healthbenefits/cost/income\\_thresholds.asp](http://www.va.gov/healthbenefits/cost/income_thresholds.asp).

## ***How frequently are the VA national income thresholds updated?***

VA national income thresholds, used for the Financial Assessment as well as for geographic adjustments for high cost-of-living areas, are updated annually. To view the current income thresholds, visit [http://www.va.gov/healthbenefits/cost/income\\_thresholds.asp](http://www.va.gov/healthbenefits/cost/income_thresholds.asp).

## ***Does Income Verification have access to my income tax return?***

No, VA does not have access to your tax return. The Internal Revenue Service (IRS) and the Social Security Administration (SSA) share earned and unearned income data reported by employers and financial institutions.

## ***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.

## ***If I decline to provide income and agree to make copays, will you still verify my income?***

No, if you have agreed to make copays for care, you are not required to provide your income information, and we will not make any further attempts to verify your income for that year. However, Veterans who have no special eligibility and decline to provide income information are denied enrollment.

## ***What happens if at the end of the process my income is verified to be higher than the income thresholds?***

Your copay status will be changed from copay exempt to copay required. VA facilities involved in your care will be notified of your change in status and to initiate billing for services provided during that income year. Your enrollment priority status may be changed if your financial status is adjusted by the income verification (IV) process. If your enrollment status is changed, you will be notified by mail.

### ***What if I receive a bill and cannot pay?***

If you are unable to pay your bill, you should discuss the matter with the Revenue Office at the VA health care facility where you received your care. There are four possible options that may be available to you

**Hardship Determination** – If a Veteran’s current year income is substantially reduced from the prior year. Future exemption from medical and hospital care copays for a determined period of time. (Must see Enrollment Coordinator for Hardship consideration.)

**Waiver** – If there has been a significant change in income or significant expenses for medical care for the Veteran or other family members, funeral arrangements or Veteran educational expenses. Waiver is for past debts only. See your local revenue staff for additional information

**Offer in Compromise** – Offer for past debts only and acceptance of a partial payment in settlement and full satisfaction of debt. See your local revenue staff for additional information

**Repayment Plans** – Payment of past debt generally over a period of 36 months. See your local revenue staff for additional information

You must contact the facility at which you received the care to request one of these options

### ***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. To obtain more information or to apply for any of these benefits, contact your nearest VA Regional Office at 1-800-827-1000 or visit us online at [www.va.gov](http://www.va.gov).



# 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

Veterans determined by VA to be unemployable  
due to VA service-connected conditions

## Priority Group 2

Veterans with VA service-connected disabilities 30% or 40% disabling

## Priority Group 3

Veterans who are Former Prisoners of War (POWs)

Veterans awarded a Purple Heart medal

Veterans awarded the Medal of Honor (MOH)

Veterans whose discharge was for a disability that was  
incurred or aggravated in the line of duty

Veterans with VA service-connected disabilities 10% or  
20% disabling

Veterans awarded special eligibility classification under  
Title 38, U.S.C., Section 1151, "benefits for individuals  
disabled by treatment or vocational rehabilitation"

## Priority Group 4

Veterans who are receiving aid and attendance or  
housebound benefits from VA

Veterans who have been determined by VA to be  
catastrophically disabled

## Priority Group 5

Non service-connected Veterans and noncompensable  
service-connected Veterans rated 0% disabled by VA with  
annual income and/or net worth below the VA national  
income threshold and geographically-adjusted income  
threshold for their resident location

Veterans receiving VA pension benefits

Veterans eligible for Medicaid programs

## Priority Group 6

Veterans who served in the Republic of Vietnam between  
January 9, 1962 and May 7, 1975.

Veterans who served in the Southwest Asia theater of  
operations from August 2, 1990 through November 11,  
1998.

Compensable 0% service-connected Veterans	Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
Project 112/SHAD participants	
Veterans who served in a theater of combat operations after November 11, 1998, as follows:	
<ul style="list-style-type: none"> <li>• Currently enrolled Veterans and new enrollees for five years post discharge</li> </ul>	
<b>Note:</b> After 5 years, Veterans will be assigned to the highest Priority Group they qualify for..	

## Priority Group 7

Veterans with gross income above the VA national income threshold, and below the geographically-adjusted income threshold (GMT) for their resident location and who agree to pay copays

## Priority Group 8

Veterans with gross household income above the VA national income threshold and the geographically-adjusted income threshold for their residence location and who agree to pay copays

<p><b>Veterans eligible for enrollment:</b> Noncompensable 0% service-connected and:</p> <ul style="list-style-type: none"> <li>• Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status</li> <li>• Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less</li> </ul>	<p><b>Veterans eligible for enrollment:</b> Nonservice-connected and:</p> <ul style="list-style-type: none"> <li>• Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status</li> <li>• Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less</li> </ul>
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**Veterans not eligible for enrollment:**  
Veterans not meeting the criteria above:

- Subpriority e: Noncompensable 0% service-connected
- Subpriority g: Nonservice-connected

# Copays

While many Veterans qualify for cost-free health care services based on a compensable service-connected condition or other qualifying factors, most Veterans are asked to complete an annual financial assessment, to determine if they qualify for cost-free services. Veterans whose income exceeds the established income threshold as well as those who choose not to complete the financial assessment must agree to pay required copays to be eligible for VA health care services.

## Types of Copays

### **Outpatient Copays\* — based on the highest of two levels of service on any individual day.**

Primary Care Services – Services provided in a primary care setting to address overall patient care	
Specialty Care Services – Services provided in Specialty Care area such as:	
Surgery	Radiology
Audiology	Optometry
Cardiology	
and specialty tests such as:	
magnetic resonance imagery (MRI)	computerized axial tomography (CAT) scan
nuclear medicine studies (highest level of service)	
<i>*There is no copay requirement for preventive care services such as screenings or immunizations.</i>	

### **Medication Copays\* — applicable to each prescription, including each 30-day supply or less of maintenance medications.**

*\*Includes an annual cap for enrollment priority groups 2 through 6.*

### **Inpatient Copays — in addition to a standard copay charge for each 90 days of care within a 365 day period regardless of the level of service (such as intensive care, surgical care or general medical care); a per diem (daily) charge will be assessed for each day of hospitalization.**

**Long-Term Care Copays\* — based on three levels of care (see Long-Term Care Benefits on page 31 for definitions).**

Community Living Centers (Nursing Home) Care/Inpatient Respite Care/Geriatric Evaluation	Adult Day Health Care/Outpatient Geriatric Evaluation/Outpatient Respite Care
Domiciliary Care	

*\*Copays for Long-Term Care services start on the 22nd day of care during any 12-month period—there is no copay requirement for the first 21 days. Actual copay charges will vary from Veteran to Veteran depending on financial information submitted on VA Form 10-10EC.*

**NOTE:** There are no copays for hospice care provided in any setting.

**Outpatient Copays**

**Primary Care Services** – services provided by a primary care clinician—\$15

**Specialty Care Services** – In general, services delivered in a specialty outpatient clinic provided by highly-specialized, narrowly-focused health care professionals—services provided by a clinical specialist—  
Specialty Copay –\$50

**Inpatient Copays**

There are two inpatient copay rates – the full rate and the reduced rate. The reduced inpatient copay rate, which is 80% of the full inpatient rate, applies to Veterans meeting specific income requirements. Both the full inpatient copay rate and the reduced inpatient copay rate are computed over a 365 - day period. Because the Inpatient Copay rates change each year, they are published separately and can be found on line at [www.va.gov/healthbenefits/cost/copays.asp](http://www.va.gov/healthbenefits/cost/copays.asp) or contact VA at 1-877-222-VETS (8387) between the hours of 8:00 AM and 8:00 PM ET, Monday - Friday for more information.

Recognizing that the cost of living can vary significantly from one geographic area to another, Veterans living in high cost areas may qualify for a reduced inpatient copay rate. Because the GMT copay rates change each year, they are published separately at [www.va.gov/healthbenefits/cost/copays.asp](http://www.va.gov/healthbenefits/cost/copays.asp), or contact VA at 1-877-222-VETS (8387) for more information.

**Medication Copays**

Currently, there is a \$8 copay (subject to change) for each 30-day or less supply of medication provided on an outpatient basis for treatment of a non-service-connected condition for Veterans in Priority Group 2 through 6, with an annual copayment cap of \$960, unless otherwise exempted. This copay is \$9 for Veterans in Priority Group 7 or 8 with no annual copayment cap.

**Long Term Care Copays**

Long term care copay are based on three levels of care

	Up to \$97 per day (Nursing Home, Respite, Geriatric Evaluation)
	\$15 per day (Adult Day Health Care, Respite, Geriatric Evaluation)
	\$5 per day

**What is the copay for a 90-day supply of medication?**

Even though a prescription may be written for 90 days, each 30-day or less supply is subject to that year's applicable medication copay rate. A 90-day supply would cost three times the applicable medication copay rate based on your Priority Group.

## Annual Changes to Copay Rates

Because the copay rates may change annually—including the annual cap on medication copays—they are published separately. Current year rates can be obtained at any VA health care facility or on the eligibility page on our Web site <http://www.va.gov/healthbenefits/assets/documents/publications/IB10-430.pdf>.

## Which Veterans Are Not Required to Make Copays?

### Many Veterans qualify for cost-free health care and/or medications based on:

- Purple Heart recipient (may take copay test to determine medication copay status)
- Former Prisoner of War Status, or (both are cost-free)
- 50% or more Compensable VA service-connected disabilities, (0-40% service-connected may take co-pay test to determine medication copay status) or
- Veterans deemed catastrophically disabled by a VA provider
- Veterans with income below the income threshold
- Other qualifying factors, including treatment related to their military service experience.

### Some of the Services Exempt from Inpatient and Outpatient Copays

- Special registry examinations offered by VA to evaluate possible health risks associated with military service
- Counseling and care for military sexual trauma
- Compensation and pension examinations are requested by the Veterans Benefits Administration (VBA). This is a physical exam to determine service-related illness or injuries for determination of a Veteran's entitlement to compensation and pension benefits.
- Care that is part of a VA-approved research project
- Care related to a VA-rated service-connected disability
- Readjustment counseling and related mental health services
- Care for cancer of head or neck caused by nose or throat radium treatments received while in the military
- Catastrophic Disability Exam
- Individual or Group Smoking Cessation or Weight Reduction services
- Publicly announced VA public health initiatives, for example, health fairs
- Care potentially related to combat service for Veterans that served in a theater of combat operations after November 11, 1998. This benefit is effective for 5 years after the date of Veteran's most recent discharge from active duty.
- Laboratory and electrocardiograms
- Hospice care

## Frequently Asked Questions

### ***I am a recently discharged combat Veteran. Must I pay VA copays?***

If the services are provided for the treatment of a condition that may be potentially related to your military service in a theater of combat operations, you will not be charged any copays. Combat Veterans have an enhanced enrollment health benefit period of five years from their most recent discharge from active duty.

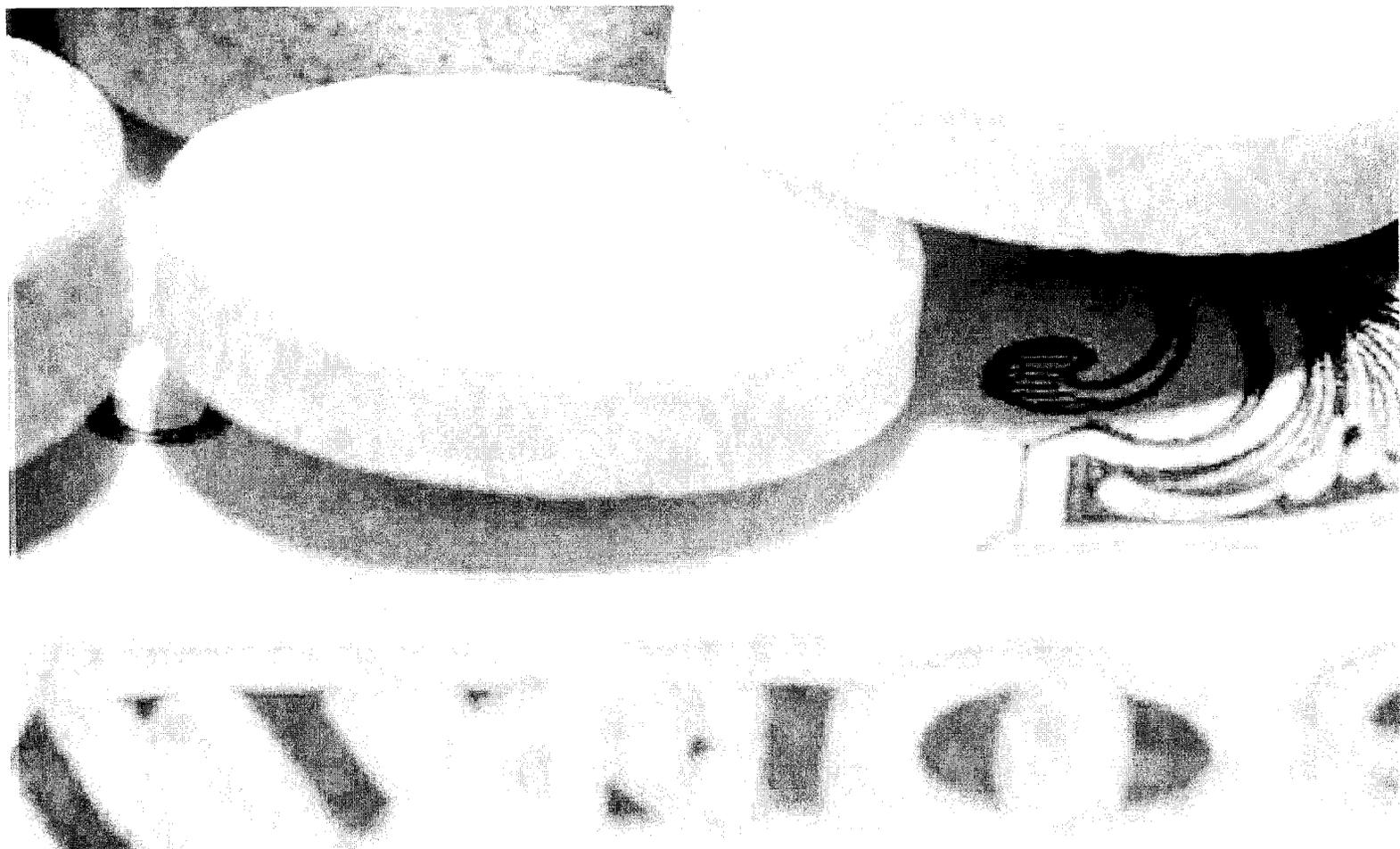
Veterans who qualify under this special eligibility are not subject to copays for conditions potentially related to their combat service. However, unless otherwise exempted, combat Veterans must either disclose their prior year gross household income OR decline to provide their financial information and agree to make applicable copays for care or services VA determines are clearly unrelated to their military service.

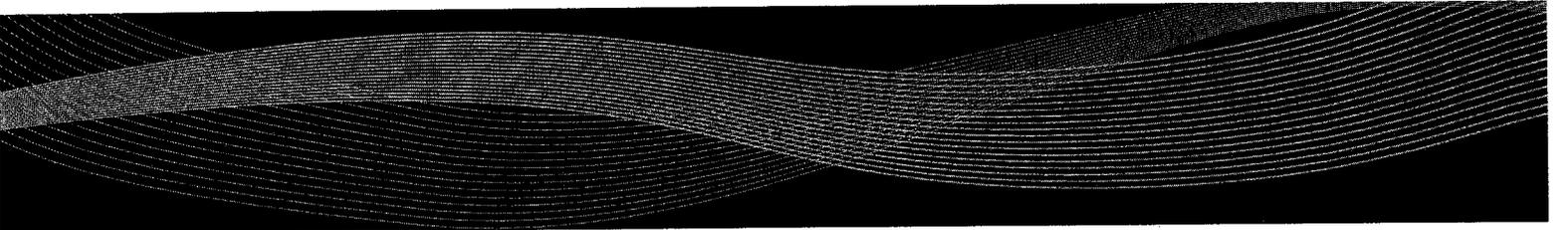
### ***How many copay charges may be assessed during a single day?***

Veterans may be charged no more than one outpatient copay per day, regardless of the number of health care providers seen in a single day. The amount of the outpatient copay will be based on the highest level of service received that day. For example, if the Veteran has a specialty care visit and a primary care visit on the same day, the Veteran will be charged only for the specialty care visit because it is a higher level of care. The number of medication copays charged depends on the number of each 30-day supply or less of medication filled. Inpatient copays are based on both a standard charge for each 90 days of care within a 365-day period as well as a per diem (daily) charge. Together, the inpatient copay charges cover all services, including medications. With the exception of medication copays for outpatients, long-term care copays are a single, all-inclusive charge

### ***Who qualifies for the annual cap on medication copays?***

The annual cap on medication copays applies to Veterans in Priority Groups 2 through 6 (Priority Group 1 is exempt from ALL copays). Because of their higher income, Veterans in Priority Groups 7 and 8 do NOT qualify for the medication copay annual cap. For those that qualify, once the annual limit is reached, all subsequent prescriptions filled during the calendar year will be free of the copay requirement.





# Covered Services/Acute Care Benefits

**VA provides a robust Medical Benefits Package of health services that is available to all enrolled Veterans**

## Standard Benefits

### Preventive Care Services

- Immunizations
- Physical Examinations (including eye and hearing examinations)
- Health Care Assessments
- Screening Tests
- Health Education Programs

### Ambulatory (Outpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

### Hospital (Inpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

### Prescription Drugs (when prescribed by a VA physician)

## Limited Benefits

The following care services (partial listing) have limitations and may have special eligibility criteria:

- Ambulance Services
  - Dental Care
  - Eyeglasses
  - Hearing Aids
  - Home Health Care
  - Maternity and Parturition (Childbirth) Services—usually provided in non-VA contracted hospitals at VA expense; care is limited to the mother and newborn. VA may furnish health care services to a newborn child of a woman Veteran who is receiving maternity care furnished by VA beginning with the date of birth plus the first seven calendar days after birth.
  - Non-VA Health Care Services
- 

## General Exclusions (partial listing)

- Abortions and abortion counseling
- Cosmetic surgery, except where determined by VA to be medically necessary for reconstructive or psychiatric care
- Gender alteration
- Health club or spa membership, even for rehabilitation
- In-vitro fertilization
- Drugs, biological and medical devices not approved by the Food and Drug Administration, unless part of formal clinical trial under an approved research program or when prescribed under a compassionate use exemption
- Medical 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 provide the care or services
- Services not ordered and provided by licensed/accredited professional staff
- Special private duty nursing

***Maternity and Parturition (Childbirth) Services—  
usually provided in non-VA contracted hospitals at VA expense;  
care is limited to the mother and newborn...***

## VA Foreign Medical Program (FMP)

A health care benefits program for U.S. Veterans with VA-rated service-connected conditions who are living or traveling abroad. Foreign benefits are administered by two separate offices, depending on where the health care services are obtained.

### Veterans in the Philippines

Address	Phone	Fax
U.S. Department of Veterans Affairs Manila Outpatient Clinic 1501 Roxas Blvd 1302 Pasay City Philippines	011-632-318-VETS (8387)	011-632-310-5957

### All other countries

Address	Telephone	Fax	Web site
Foreign Medical Program PO Box 469061 Denver CO 80246-9061	303-331-7590	303-331-7803	<a href="http://www.va.gov/hac">www.va.gov/hac</a>

To contact FMP online go to [www.va.gov/hac/contact](http://www.va.gov/hac/contact) - (see Foreign Medical Program)

## Frequently Asked Questions

### 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.

<b>If you:</b>	<b>You are eligible for:</b>	<b>Through</b>
Have a service-connected compensable dental disability or condition.	Any needed dental care.	Class I
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>	Class IV
Apply for dental care within 180 days of discharge or release from a period of active duty (under conditions other than dishonorable) of 90 days or more during the Persian Gulf War era	One-time dental care if your DD214 certificate of discharge does not indicate that a complete dental examination and all appropriate dental treatment had been rendered prior to discharge.*	Class II
Have a service-connected noncompensable dental condition or disability resulting from combat wounds or service trauma.	Needed care for the service-connected condition(s). A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth eligible for care.	Class IIA

Have a dental condition clinically determined by VA to be associated with and aggravating a service-connected medical condition.	Dental care to treat the oral conditions that are determined by a VA dental professional to have a direct and material detrimental effect to your service connected medical condition.	Class III
Are actively engaged in a 38 USC Chapter 31 vocational rehabilitation program.	<p>Dental care to the extent necessary as determined by a VA dental professional to:</p> <ul style="list-style-type: none"> <li>• Make possible your entrance into a rehabilitation program</li> <li>• Achieve the goals of your vocational rehabilitation program</li> <li>• Prevent interruption of your rehabilitation program</li> <li>• Hasten the return to a rehabilitation program if you are in interrupted or leave status</li> <li>• Hasten the return to a rehabilitation program of a Veteran placed in discontinued status because of illness, injury or a dental condition, or</li> </ul> <p>Secure and adjust to employment during the period of employment assistance, or enable you to achieve maximum independence in daily living.</p>	Class V
Are receiving VA care or are scheduled for inpatient care and require dental care for a condition complicating a medical condition currently under treatment.	Dental care to treat the oral conditions that are determined by a VA dental professional to complicate your medical condition currently under treatment.	Class VI
Are an enrolled Veteran who may be homeless and receiving care under VHA Directive 2007-039.	A one-time course of dental care that is determined medically necessary to relieve pain, assist you to gain employment, or treat moderate, severe, or complicated and severe gingival and periodontal conditions.	Class IIB

*\* Note: Public Law 83 enacted June 16, 1955, amended Veterans' eligibility for outpatient dental services. As a result, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be noncompensable are no longer eligible for Class II outpatient dental treatment.*

Veterans receiving hospital, nursing home, or domiciliary care will be provided dental services that are professionally determined by a VA dentist, in consultation with the referring physician, to be essential to the management of the patient's medical condition under active treatment.

For more information about eligibility for VA medical and dental benefits, contact VA at 1-877-222-VETS (8387) or [www.va.gov/healthbenefits](http://www.va.gov/healthbenefits).

***Am I limited to a specific number of inpatient days or outpatient visits during a given period of time?***

For acute care services (inpatient days of care and outpatient visits), there are no limits.

***Do I qualify for routine health care at non-VA facilities at VA expense?***

Generally no. To qualify for routine care at non-VA facilities at VA expense (otherwise known as **Fee Basis care**), you must first be given a written referral. Included among the factors in determining whether such care will be authorized is your medical condition and availability of VA services within your geographic area. VA copays may be applicable.

### ***Am I eligible for emergency care at a non-VA facility?***

An eligible Veteran may receive emergency care at a non-VA health care facility at VA expense when a VA facility or other Federal health care facility with which VA has an agreement is unable to furnish economical care due to the Veteran's geographical inaccessibility to a VA medical facility, or when VA is unable to furnish the needed emergency services.

An emergency is defined as 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. VA may directly refer or authorize the Veteran to receive emergency care at a non-VA facility at VA expense, or VA may pay for emergency care furnished certain Veterans by a non-VA facility without prior VA approval under certain conditions.

### ***Are there any payment limitations for non-VA emergency care?***

Emergency care must be pre-authorized by VA. When the emergency care is not authorized in advance by VA, it may be considered as preauthorized care when the nearest VA medical facility is notified within 72 hours of admission, the Veteran is eligible, and the care rendered is emergent in nature. Claims for non-VA emergency care not authorized by VA in advance of services being furnished must be timely filed; because timely filing requirements differ by type of claim, you should contact the nearest VA medical facility as soon as possible to avoid payment denial for an untimely filed claim.

Payment may not be approved for any period beyond the date on which the medical emergency ended, except when VA cannot accommodate transfer of the Veteran to a VA or other Federal facility. An emergency is deemed to have ended at that point when a VA physician has determined that, based on sound medical judgment, a Veteran who received emergency hospital care could have been transferred from the non-VA facility to a VA medical center for continuation of treatment.

### ***What type of emergency care can VA authorize in advance?***

Subject to eligibility and payment limitations described at the top of page 29, VA may preauthorize and issue payment for non-VA emergency care when treatment is needed for:	Inpatient Care	Outpatient Care
The Veteran's VA rated service-connected disability, or for a nonservice-condition that is associated with and aggravating the Veteran's service-connected condition	✓	✓
A disability for which the Veteran was released from active duty	✓	✓
Any condition of a Veteran who is rated by VA as Permanently and Totally disabled due to a service connected disability	✓	✓
Any condition of a Veteran who is an active participant in the VA Chapter 31 Vocational Rehabilitation program, who needs treatment medically determined to make possible the Veteran's entrance into a course of training, or prevent interruption of a course of training which was interrupted due to such illness, injury, or dental condition.	✓	✓
Any condition for a Veteran who has a VA service-connected disability rating of 50% or greater		✓
A condition for which the Veteran has been furnished VA hospital care, nursing home, domiciliary care, or medical services and who requires medical services to complete treatment incident to such care or services		✓
Any condition of a Veteran who is in receipt of increased VA pension, or additional VA compensation or allowances based on the need for regular aid and attendance or by reason of being permanently housebound		✓
Any condition for a Veteran of World War I		✓

A condition requiring emergency care that developed while the Veteran was receiving medical services in a VA facility or Contract Nursing Home or during VA authorized travel	✓	✓
Any condition that will obviate the need for hospital admission for a Veteran in the state of Alaska or Hawaii and US Territories, excluding Puerto Rico		✓
Any condition for women Veterans.	✓	
Any dental services and treatment, and related dental appliances, for Veterans who are former prisoners of war		✓

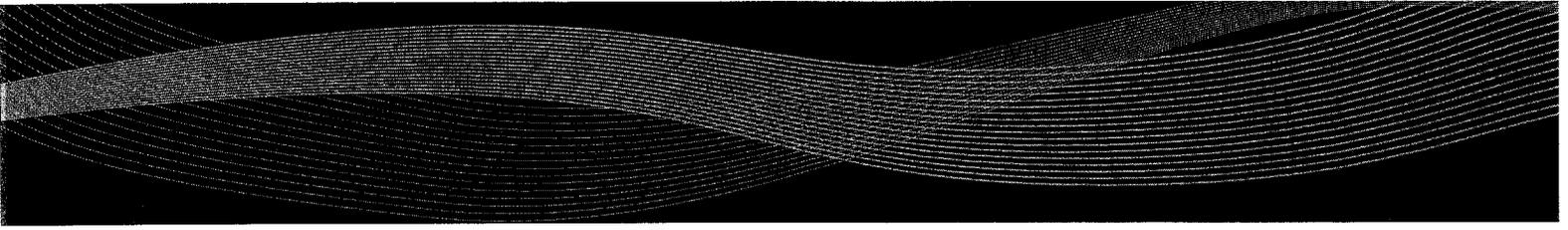
### **Can VA pay for non-VA emergency care that is not preauthorized?**

VA has limited payment authority when emergency care at a non-VA facility is provided without authorization by VA in advance of services being furnished or notification to VA is not made within 72 hours of admission. VA may pay for unauthorized emergency care as indicated below. Since payment may be limited to the point your condition is stable for transfer to a VA facility, the nearest VA medical facility should be contacted as soon as possible for all care not authorized by VA in advance of the services being furnished.

<b>For service-connected Veterans</b>	<b>For nonservice-connected conditions</b>
VA may only pay for emergency care provided in a non-VA facility for certain Veterans who are rated by VA with a service-connected disability. VA may pay for emergency inpatient or outpatient care when treatment is needed for:	VA may only pay for emergency care provided in a non-VA facility for treatment of a nonservice-connected condition only if <b>all</b> of the following conditions are met:
The Veteran's VA rated service connected disability, or for a nonservice-condition that is associated with and aggravating the Veteran's service-connected condition	The episode of care cannot be paid as an unauthorized claim for service-connected Veterans
A disability for which the Veteran was released from active duty	The Veteran is enrolled in the VHA health care system and received VA medical care within a 24 month period preceding the furnishing of the emergency treatment
Any condition of a Veteran who is rated by VA as Permanently and Totally disabled due to a service connected disability	The Veteran is personally liable to the health care provider for the emergency treatment which meets the prudent layperson definition of an emergency
Any condition of a Veteran who is an active participant in the VA Chapter 31 Vocational Rehabilitation program, who needs treatment medically determined to make possible the Veteran's entrance into a course of training, or prevent interruption of a course of training which was interrupted due to such illness, injury, or dental condition	The Veteran is not entitled to care or services under a health plan contract The Veteran has no other contractual or legal recourse against a third party that would, in whole, extinguish the Veteran's liability and the claim must be filed within 90 days from the date of discharge, or the date that the Veteran exhausted without success action to obtain payment from a third party.

### **Does VA offer compensation for travel expenses to and from a VA facility?**

If you meet specific criteria (see Medically Related Travel Benefits on page 6), you are eligible for travel benefits. Travel benefits are subject to a deductible. Exceptions to the deductible requirement include: 1) travel for a compensation and pension examination; and 2) travel by an ambulance or a specially equipped van. Because travel benefits are subject to annual mileage rate and deductible changes, we publish a separate document detailing these amounts each year. You can obtain a copy at any VA health care facility.



# Long-Term Care Benefits

## Standard Benefits

The following long-term care services are available to all enrolled Veterans.

## Geriatric Evaluation

Geriatric evaluation is the comprehensive assessment of a Veteran's ability to care for him/herself, his/her physical health and social environment, which leads to a plan of care. The plan could include treatment, rehabilitation, health promotion and social services. These evaluations are performed by inpatient Geriatric Evaluation and Management (GEM) Units, GEM clinics, geriatric primary care clinics and other outpatient settings.

## Adult Day Health Care

The adult day health care (ADHC) program is a therapeutic day care program, providing medical and rehabilitation services to disabled Veterans in a combined setting.

## Respite Care

Respite care provides supportive care to Veterans on a short-term basis to give the caregiver a planned period of relief from the physical and emotional demands associated with providing care. Respite care can be provided in the home or other non institutional settings.

## Home Care

Skilled home care is provided by VA and contract agencies to Veterans that are homebound with chronic diseases and includes nursing, physical/occupational therapy and social services.

## Hospice/Palliative Care

Hospice/palliative care programs offer pain management, symptom control, and other medical services to terminally ill Veterans or Veterans in the late stages of the chronic disease process. Services also include respite care as well as bereavement counseling to family members.

**NOTE:** There are no copays for hospice care provided in any setting.

***For those Veterans who do not qualify for cost-free services, the financial assessment for long term care services is used to determine the copay requirement.***

## Financial Assessment for Long-Term Care Services

For Veterans who are not automatically exempt from making copays for long-term care services (see Copays on page 16), a separate financial assessment (VA Form 10-10EC, APPLICATION FOR EXTENDED CARE SERVICES) must be completed to determine whether they qualify for cost-free services or to what extent they are required to make long-term care copays. Unlike copays for other VA health care services, which are based on fixed charges for all, long-term care, copay charges are individually adjusted based on each Veteran's financial status.

## Limited Benefits

### VA Community Living Centers (VA Nursing Home) Programs

While some Veterans qualify for indefinite Community Living Center (formerly known as nursing home care) services, other Veterans may qualify for a limited period of time. Among those that automatically qualify for indefinite community living care are Veterans whose service-connected condition is clinically determined to require nursing home care and Veterans with a service-connected rating of 70% or more and unemployable. Other Veterans may be provided short-term community living care, if space and resources are available.

## Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health maintenance care for Veterans who require some medical care, but who do not require all the services provided in nursing homes. Domiciliary care emphasizes rehabilitation and return to the community. VA may provide domiciliary care to Veterans whose annual income does not exceed the maximum annual rate of VA pension or to Veterans who have no adequate means of support.



## Frequently Asked Questions

### ***I already provided financial information on my initial VA application, why is it necessary to complete a separate financial assessment for long-term care?***

Unlike the information collected from the financial assessment, which is based on your previous year's income, the 10-10EC is designed to assess your current financial status, including current expenses. This in-depth analysis provides the necessary monthly income/expense information to determine whether you qualify for cost-free long-term care or a significant reduction from the maximum copay charge.

### ***Once I submit a completed VA Form 10-10EC, who notifies me of my long-term care copay requirements?***

The social worker or case manager involved in your long-term care placement will provide you with an annual projection of your monthly copay charges.

### ***Assuming I qualify for nursing home care, how is it determined whether the care will be provided in a VA facility or a private nursing home at VA expense?***

Generally, if you qualify for indefinite nursing home care, that care will be furnished in a VA facility. Care may be provided in a private facility under VA contract when there is compelling medical or social need. If you do not qualify for indefinite care, you may be placed in a community nursing home—generally not to exceed six months—following an episode of VA care. The purpose of this short-term placement is to provide assistance to you and your families while alternative, long-term arrangements are explored.

### ***For Veterans who do not qualify for indefinite VA Community Living Center care at VA expense, what assistance is available for making alternative arrangements?***

When the need for nursing home care extends beyond the Veteran's eligibility, our social workers will help family members identify possible sources for financial assistance. Our staff will review basic Medicare and Medicaid eligibility and direct the family to the appropriate sources for further assistance, including possible application for additional VA benefit programs.

## Additional VA Health Benefits

### Dependents and Survivors

#### CHAMPVA — a health care benefits program for:

Dependents of Veterans who have been rated by VA as having a service-connected total and permanent disability.

Survivors of Veterans who died from VA-rated service-connected condition(s), or who at the time of death, were rated permanently and totally disabled from a VA-rated service-connected condition(s).

Survivors of persons who died in the line of duty and not due to misconduct and not otherwise entitled to benefits under DoD's TRICARE program.

Address	Telephone	Fax
CHAMPVA PO Box 469063 Denver CO 80246-9063	800-733-8387	303-331-7804
To contact CHAMPVA online	<a href="http://www.va.gov/hac/contact">www.va.gov/hac/contact</a> (see CHAMPVA)	
Web site	<a href="http://www.va.gov/hac">www.va.gov/hac</a>	

#### Children of Women Vietnam Veterans Health Care Benefits

A program designed for women Vietnam Veterans' birth children who are determined by a VA Regional Office to have one or more covered birth defects.

Address	Telephone
Children of Women Vietnam Veterans PO Box 469065 Denver CO 80246-9065	888-820-1756
	Fax 303-331-7807
To contact CWVV online	Web site
<a href="http://www.va.gov/hac/contact">www.va.gov/hac/contact</a> (see CWVV)	<a href="http://www.va.gov/hac">www.va.gov/hac</a>

#### Spina Bifida Health Care Benefits

A program designed for certain birth children of Vietnam and Korea Veterans' birth children diagnosed with spina bifida and who are in receipt of a VA Regional Office award for spina bifida benefits.

Address	Telephone
Spina Bifida Health Care PO Box 469065 Denver CO 80246-9065	888-820-1756
	Fax 303-331-7807
To contact Spina Bifida online	Web site
<a href="http://www.va.gov/hac/contact">www.va.gov/hac/contact</a> (see Spina Bifida)	<a href="http://www.va.gov/hac">www.va.gov/hac</a>



## Our Mission

**Our Servicemembers and Veterans have sacrificed to keep our country - and everything it represents - safe. We honor and serve those men and women by fulfilling President Lincoln's promise *"to care for him who shall have borne the battle, and for his widow, and his orphan."***

**We strive to provide Servicemembers and Veterans with the world-class benefits and services they have earned, and will adhere to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship.**

**Thank you for your service.  
Now let us serve you.**

**Department of Veterans Affairs  
Veterans Health Administration  
Chief Business Office**

IB 10-185  
P95996  
Revised January 2012

For more information on VA health care  
Telephone (toll-free): 1-877-222-VETS (8387)  
Website: [www.va.gov/healthbenefits](http://www.va.gov/healthbenefits)  
To download a copy of this brochure, go to:  
[www.va.gov/healthbenefits/resources/publications.asp](http://www.va.gov/healthbenefits/resources/publications.asp)

# Veterans Health Benefits Guide



**VA**  
HEALTH  
CARE

Defining  
**EXCELLENCE**  
in the 21st Century

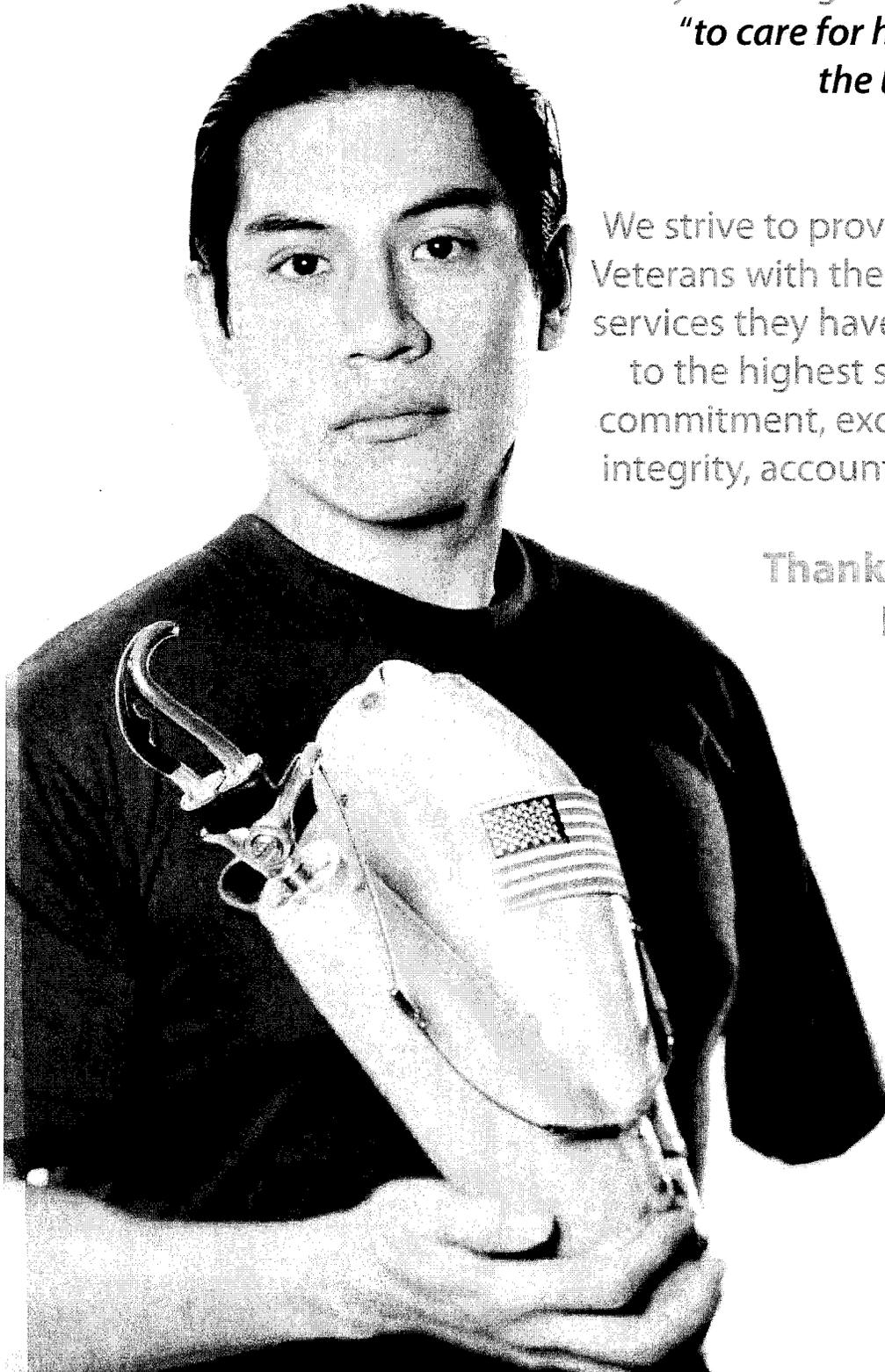
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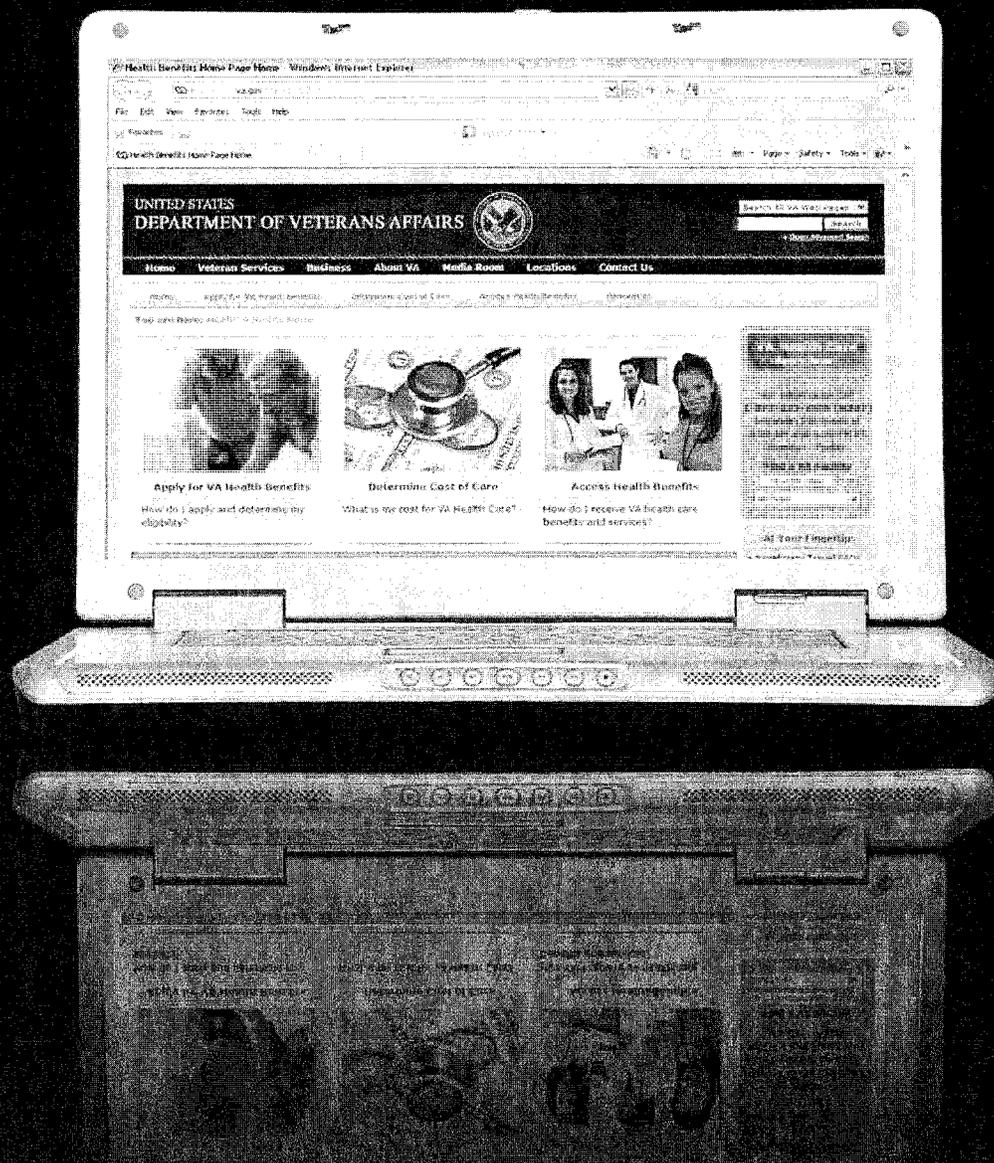
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# www.va.gov/healthbenefits

VA's Health Benefits Web site provides the latest information on VA health care services, providing tools to help you determine how, where and at what cost you can receive care and offering Veterans who are not already enrolled an opportunity to apply.



# Chapter 1

## Welcome

The goal of the VA health care system is to achieve excellence in patient care and customer satisfaction. Our mission is singular — to serve Veterans by providing the highest-quality health care available anywhere in the world. America's Veterans and their families deserve nothing less.

This Veterans Health Benefits Guide is designed to provide Veterans and their families with the information they need to understand VA's health care system—eligibility requirements, the enrollment process, enrollment Priority Groups, copayments that certain Veterans may be charged and the health benefits and services available to help Veterans.

Additionally, inside you will find helpful information about My HealtheVet, Creditable Coverage for Medicare Part D, Income Verification and medically related travel benefits.

This guide is not intended to provide information on all of the health services offered by VA. If we have not addressed your specific questions, additional assistance is available at the following resources:

- Your local VA health care facility's Enrollment Office
- [www.va.gov/healthbenefits](http://www.va.gov/healthbenefits)
- [www.myhealth.va.gov](http://www.myhealth.va.gov)
- VA toll-free 1-877-222-VETS (8387)

## Overview of VA's Nationwide Health Care System

You can expect VA's highly qualified and dedicated health care professionals to meet your needs, regardless of the treatment program, regardless of the location. New locations continue to be added to the VA system, with the current number of treatment sites now standing at more than 1,400 nationwide.

Today's Veterans receive a medical benefits package, which VA administers through a patient enrollment program. Enrollment in the VA health care system comes with the assurance that health and treatment services will be available when and where you need them.

VA's state-of-the-art electronic medical records allow your health care benefits to be completely portable throughout the system. If you are traveling or living temporarily at an address far away from your primary treatment facility, you can seek care at any VA health care facility across the country — without the hassle of having to reapply.

We have also developed a website — My HealtheVet — especially for Veterans. Through My HealtheVet (MHV), access to important information about your health is at your fingertips, 24 hours a day.

## Overview of VA's Medical Benefits Package

VA's comprehensive medical benefits package offers care and services that are designed to:

- Promote good health
- Preserve your current health
- Restore you to better health

This includes treating illnesses and injuries, preventing future health problems, improving functional abilities and enhancing quality of life.

We provide a full spectrum of medically necessary services, based on the judgment of your VA primary care provider and in accordance with generally accepted standards of clinical practice. These services include:

- Primary Care
- Health Promotion
- Disease Prevention
- Diagnosis
- Palliative Care
- Surgery
- Prescriptions For Medications
- Prosthetics
- Critical Care
- Mental Health Care
- Women's Health Care
- Orthopedics
- Radiology
- Physical Therapy
- Rehabilitation

## VA Provides Health Services at Facilities Across the Nation

VA strives to provide access to all needed services. This may be on-site during inpatient hospitalization, at one of our primary or specialty care clinics, at a Community Based Outpatient Clinic (CBOC) or Health Care Center (HCC), in a Community Living Center (formerly known as a VA nursing home), or in a residential care facility. However, all services may not be available at every location. Sometimes, there may be a need to travel to another VA facility or a community care facility to receive the necessary treatment. If that is the case, a VA provider will work to find the place best suited to provide the required services.

## What to Know About Primary Care

Primary Care serves as the foundation of the VA health care system. Through Primary Care, there is easy access to skilled medical professionals who are familiar with the health care needs of Veterans and who understand the importance of developing long-term relationships with patients.

Among other things, a Primary Care Team will:

- Educate you and your family about the health care services available.
- Coordinate care across a spectrum of treatment options.
- Keep you informed about disease prevention programs.

Once enrolled, a Veteran will be assigned a Primary Care Provider at the first Primary Care appointment. The Primary Care Provider will be a member of the trained Spinal Cord Injury (SCI) Primary Care Team if the Veteran has a spinal cord injury or disorder.

## Your Eligibility Information

The information in this Veterans Health Benefits Guide reflects the benefits and services available to enrolled Veterans at the time it was published. Since VA policies are governed by law, changes to programs or eligibility may occur. If you have questions, contact the Enrollment Coordinator at your local VA health care facility or call us at 1-877-222-VETS (8387).

## Health Benefits Are Different for Each Veteran

While all enrolled Veterans enjoy access to VA's comprehensive medical benefits package, certain benefits (for example, dental care) may vary from individual to individual, depending on each Veteran's unique eligibility status. This Veterans Health Benefits Guide contains general benefits information.

Important Phone Numbers	
Veterans Crisis Line	1-800-273-TALK (8255), Press 1
National Call Center for Homeless Veterans	1-877-424-3838
Health Enrollment Information or Questions about Bills for your VA Health Care	1-877-222-VETS (8387)
VA Compensation, Pension, Education and Loan Guaranty Programs	1-800-827-1000
Foreign Medical Program	1-877-345-8179
Health Care Coverage for Eligible Dependents of Veterans (CHAMPVA)	1-800-733-VETS (8387)

## Do you know your health benefits?

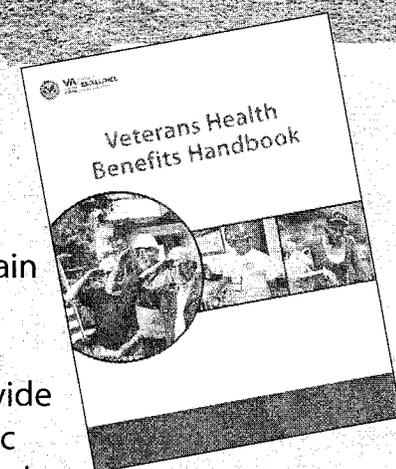
Veterans enrolled in the health care system of the Department of Veterans Affairs have begun to receive personalized booklets that explain their health care benefits and contain other useful information.

The new booklet, called a Veterans Health Benefits Handbook, will provide a personalized listing of health benefits based on each Veteran's specific eligibility. The handbook will also have contact information for their local VA medical facilities, appointment scheduling information, guidelines for communicating with their clinical team and, as applicable, information about copays.

Distribution of the handbooks began February 2012, with all 8.5 million Veterans enrolled in VA's health care system scheduled to receive their handbooks by 2013. Veterans will receive updates to their handbook to reflect changes to their benefits or eligibility.

VA operates 152 medical centers and more than 800 community-based outpatient clinics. Last year, inpatient facilities treated more than 690,000 patients, while outpatient clinics registered more than 79 million visits.

For more information about the Health Benefits Handbook, visit [www.va.gov/healthbenefits/vhbh](http://www.va.gov/healthbenefits/vhbh) or call VA's toll-free number at 1-877-222-VETS (8387).



## Chapter 2

### Eligibility

To ensure health care benefits are readily available to all enrolled Veterans, VA determines eligibility for the comprehensive medical benefits package through a patient enrollment system, which is based on Priority Groups 1 through 8. Eligibility for VA health benefits is based on each Veteran's unique eligibility factors.

Most Veterans must be enrolled to receive VA health care. While some Veterans are not required to enroll due to their special eligibility status, all Veterans, including those who have special eligibility, are encouraged to apply for enrollment. Enrollment in the VA health care system provides Veterans with the assurance that their health care services will be available when and where they are needed during that enrollment period. In addition to the assurance that services will be available, enrolled Veterans welcome not having to repeat the application process, regardless of where they seek their care or how often.

### Basic Eligibility

If you served in the active military, naval or air service and are separated under any condition other than dishonorable, you may qualify for health care benefits. Also, current and former members of the Reserves or National Guard who were called to active duty (other than for training only) by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA health care.

### Minimum Duty Requirements

Most Veterans who enlisted after September 7, 1980, or entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty to be eligible. This minimum duty requirement may not apply to Veterans who were discharged for a disability incurred or aggravated in the line of duty, were discharged for a hardship, received an "early out," or those who served prior to September 7, 1980. Since there are a number of other exceptions to the minimum duty requirements, VA encourages all Veterans to apply so that we may determine their enrollment eligibility.

## Enrollment Begins with the Application Process

The very first step in obtaining access to VA health care benefits is to apply:

- You may complete an application on line at <https://www.1010ez.med.va.gov/>. At any point in the application process, you can click “Show Help” to display specific information for the block your cursor is on or click “Show FAQ” for information on what information is needed.
- You may complete an application in person at any VA medical facility where eligibility personnel are available to answer your questions.
- You may call VA toll-free at 1-877-222-VETS (8387) to complete the application over the phone.

Once your application is successfully processed, VA will notify you of your enrollment Priority Group assignment and whether you are enrolled. If enrolled, we will send you a personalized Veterans Health Benefits Handbook, which will detail your assigned enrollment Priority Group, the VA health benefits you are eligible for, and will provide important information concerning your access to VA health care. You may be eligible for more than one enrollment Priority Group; in that case, VA will always place you in the highest Priority Group for which you are eligible. If you are not enrolled, you will receive a letter telling you so and providing you instructions on how to appeal the decision if you do not agree with it.

## Catastrophically Disabled Veterans

Veterans may be determined to be catastrophically disabled by VA, which for VA purposes only is defined as having a permanent, severely disabling injury, disorder, or disease that:

- Compromises the ability to carry out the activities of daily living to such a degree that one requires personal or mechanical assistance to leave home or bed; or
- Requires constant supervision to avoid physical harm to oneself or others.

Veterans found to be catastrophically disabled are enrolled in Priority Group 4, unless eligible for a higher Priority Group and exempt from inpatient, outpatient and medication copays.

## Combat Veterans

Veterans, including activated Reservists and members of the National Guard, who served on active duty in a theater of combat operations after November 11, 1998, and have been discharged under other than dishonorable conditions are defined as “Combat Veterans” by VA for enrollment purposes.

“Combat Veterans” are assigned to Priority Group 6, unless eligible for enrollment in a higher Priority Group, for a period of five years after discharge. During this time, VA provides cost-free (no VA copayments) health care services and nursing home care for conditions potentially related to service in the theater of operations.

Veterans will continue to be enrolled even after their “Combat Veteran” status has ended. At that time, VA will reassess the Veteran’s eligibility and make a new enrollment Priority Group determination.

## Financial Assessment (Means Testing)

While many Veterans qualify for enrollment and cost-free (no VA copayments) health care services based on a compensable, Service-connected condition or other qualifying factor, most Veterans will be asked to complete a financial assessment as part of their enrollment application process. Otherwise known as the means test, this financial assessment is based on the Veteran's previous year gross household income and is used to determine his or her eligibility for VA health care benefits and, in many cases, his or her Priority Group assignment.

## Income Verification

VA is required by law to verify Veterans' self-reported household income information. Income Verification (IV) is a process VA uses to match Veterans' self-reported household income information with the Internal Revenue Service (IRS) and Social Security Administration (SSA) records. Veterans who receive free medical care and/or medications based on their self-reported income are subject to this process. If a Veteran's self-reported income is below VA's income thresholds but the income information received from IRS/SSA indicates income above VA's income threshold, the Veteran and spouse, if applicable, will be notified by letter and given an opportunity to verify or dispute this information. The IV benefits case managers will assist the Veteran in reviewing all documents, including those that may further reduce the Veteran's reported total gross household income using authorized deductions. If the submitted information does not reduce the Veteran's self-reported income below VA's income threshold, the copayment status may be changed and the Veteran may be required to pay applicable copayments for care received.

## Enrollment Priority Groups

### Priority Group 1

- Veterans with VA Service-connected disabilities rated 50% or more.
- Veterans assigned a total disability rating for compensation based on unemployability.

### Priority Group 2

- Veterans with VA Service-connected disabilities rated 30% or 40%.

### Priority Group 3

- Veterans who are former Prisoners of War (POWs).
- Veterans awarded the Purple Heart Medal.
- Veterans awarded the Medal of Honor.
- Veterans whose discharge was for a disability incurred or aggravated in the line of duty.
- Veterans with VA Service-connected disabilities rated 10% or 20%.
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."

**Priority Group 4**

- Veterans receiving increased compensation or pension based on their need for regular Aid and Attendance or by reason of being permanently Housebound.
- Veterans determined by VA to be catastrophically disabled.

**Priority Group 5**

- Nonservice-connected Veterans and noncompensable Service-connected Veterans rated 0%, whose annual income and/or net worth are not greater than the VA financial thresholds.
- Veterans receiving VA Pension benefits.
- Veterans eligible for Medicaid benefits.

**Priority Group 6**

- Compensable 0% Service-connected Veterans.
- Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki.
- Project 112/SHAD participants
- Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975.
- Veterans of the Persian Gulf War that served in the Southwest Asia theater of combat operations between August 2, 1990, and November 11, 1998.
- Veterans who served in a theater of combat operations and discharged from active duty on or after January 28, 2003, for five years post discharge.

**Priority Group 7**

- Veterans with incomes below the geographic means test (GMT) income thresholds and who agree to pay the applicable copayment.

**Priority Group 8**

- Veterans with gross household incomes:
- above the VA Means Test thresholds who were enrolled as of January 16, 2003 and who agreed to pay the applicable copayment;
- or —
- not exceeding the VA Means Test thresholds or GMT income thresholds by more than 10% and who agree to pay the applicable copayment -- effective June 15, 2009.

## Chapter 3

### VA Health Benefits

VA Health Benefits are comprehensive and include all the necessary inpatient hospital care and outpatient services to promote, preserve, or restore health.

## Preventive Care Services

Health benefits include important preventive care services:

- Periodic medical exams (including gender-specific exams)
- Health education, including nutrition education
- Immunization against infectious disease
- Counseling on inheritance of genetically determined disease

## Inpatient Care Services

VA inpatient care includes a full spectrum of treatment services:

- Medical
- Surgical
- Mental Health
- Dialysis
- Acute care

Inpatient care also includes access to VA's specialized care units:

- Intensive Care Units (medical, surgical, mental health, cardiac)
- Transplant Care Units
- Spinal Cord Injury Centers
- Traumatic Brain Injury Units
- PolyTrauma Centers

## Ancillary Services

VA's health care providers may employ ancillary services to help diagnose or treat medical conditions. These services include:

- Audiology (hearing)
- Blind and Vision Rehabilitation
- Chiropractic Services
- Dental
- Diagnostic Laboratory
- Nutrition and Food Service
- Nuclear Medicine (imaging)
- Occupational Therapy
- Pharmacy
- Physical Therapy
- Prosthetics (artificial limbs, equipment, devices)
- Radiology (x-rays and imaging)
- Radiation Oncology (cancer care)
- Recreation and Creative Arts Therapies (music, art, dance and drama)
- Respiratory Therapy
- Social Work (housing, discharge planning, family support)
- Speech/Language Pathology (speech, language, voice, fluency, cognition, and swallowing)
- Traumatic Brain Injury

## Specialty Care Services

Through VA's specialty care services, there is access to expert knowledge that optimizes treatment in unique or complicated courses of care. Our specialty care providers focus on particular areas of care in which they have extensive training and education. VA medical and surgical specialty care services include:

- Anesthesiology
- Bariatric surgery (weight loss surgery)
- Cardiology – Vascular (heart and blood circulation)
- Chaplain (spiritual support)
- Critical Care Specialty
- Dermatology
- Diabetes and Endocrinology
- Geriatric Care
- Gynecology Care
- Infectious Disease
- Nephrology (kidney)

- Neurology (nerves)
- Mental Health
- Oncology (cancer)
- Optometry & Ophthalmology (eye care)
- Orthopedic Surgery
- Pacemaker (heart)
- Pain Management
- Podiatry (feet)
- Prosthetic and Orthotic (amputee care and custom orthotics)
- Pulmonary (lungs)
- Robotic-Assisted Surgery
- Spinal Cord Injury
- Transplant Surgery (heart, lung, liver, etc.)
- Urology
- Vascular Surgery
- Women's Care

## Mental Health Care

VA provides specialty inpatient and outpatient mental health services at its medical centers and community-based outpatient clinics (in addition, readjustment counseling services may be available at Vet Centers across the nation). Our goal is to support recovery and enable Veterans who experience mental health problems to live meaningful lives in their communities and to achieve their full potential.

VA provides cost-free (no VA copayments) military sexual trauma counseling and referral. This includes appropriate care and services to overcome psychological trauma resulting from a physical assault or battery of a sexual nature or from sexual harassment that occurred while the Veteran was on active duty or was on Active Duty for Training (ADUTRA).

Mental health services are available in specialty clinics, primary care clinics, nursing homes, and residential care facilities. Specialized programs, such as mental health intensive case management, day centers, work programs and psychosocial rehabilitation are provided for those with serious mental health problems. The list of services and programs that Mental Health supports include:

- Inpatient Care
- Residential Care
- Outpatient Mental Health Care
- Homeless Programs
- Programs for Incarcerated Veterans
- Specialized PTSD Services
- Military Sexual Trauma
- Psychosocial Rehabilitation & Recovery Services

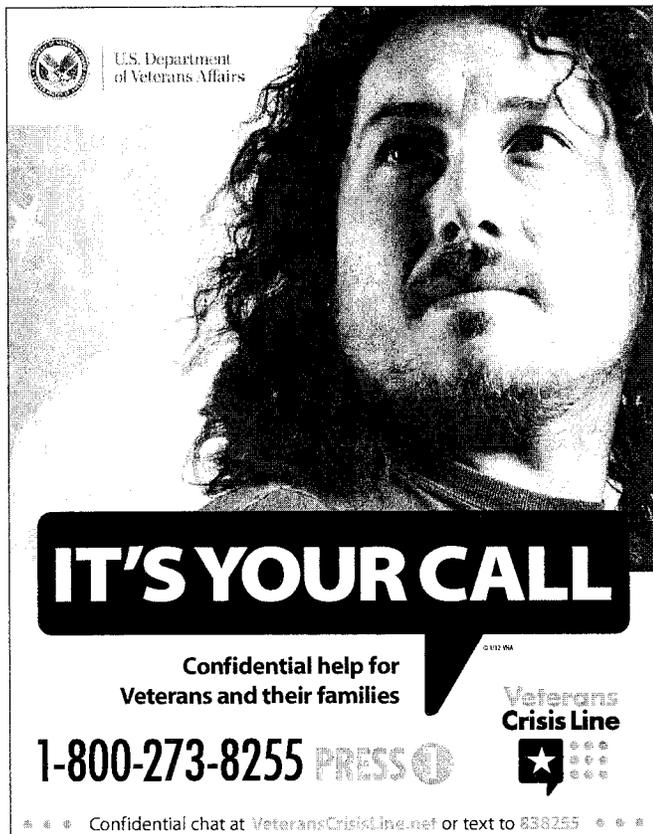
- Substance Use Disorders
- Suicide Programs
- Geriatrics
- Violence Prevention
- Evidence Based Psychotherapy Programs
- Mental Health Disaster Response/Post Deployment Activities

## Veterans Crisis Line (available to all Veterans regardless of enrollment status)

Pick up the phone and call for immediate help if you notice any of these signs:

- Thinking about hurting or killing yourself or others
- Experiencing an emotional crisis
- Hopelessness, feeling like there's no way out
- Talking or writing about death, dying, or suicide
- Engaging in self-destructive behavior, such as drug abuse

The number for the Veterans Crisis Line is 1-800-273-TALK (8255). Press 1 for Veterans and someone who can help you will answer right away.



U.S. Department of Veterans Affairs

**IT'S YOUR CALL**

Confidential help for Veterans and their families

1-800-273-8255 **PRESS 1**

Veterans Crisis Line

Confidential chat at [VeteransCrisisLine.net](http://VeteransCrisisLine.net) or text to 838255

### Additional Warning Signs

- Anxiety, agitation, sleeplessness, mood swings
- Feeling like there is no reason to live
- Extended periods of anger or rage
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

## Homeless Services

VA provides specialized homeless services at its medical centers and through community-based partners with a goal that no Veteran will have to become or remain homeless.

If you are homeless or at risk of becoming homeless pick up the phone and call for help. The number for the **National Call Center for Homeless Veterans is 1-877-424-3838**. The call center will connect you with the closest VA medical center to best address your specific needs.

## Women's Health

VA is committed to meeting women Veterans' unique needs by delivering the highest quality health care in a setting that ensures privacy, dignity, and sensitivity. VA facilities offer a variety of services, including:

- Women's gender-specific health care (menopause evaluation and symptom management, osteoporosis, incontinence, birth control, breast and gynecological care, maternity and limited infertility services)
- Screening and disease prevention programs (for example, mammograms, bone density screening, and cervical cancer screening)

Routine gynecologic services are available at VA facilities and include:

- Human Papilloma Virus (HPV) vaccinations
- Pelvic exams, ultrasounds
- Birth control counseling and management (medical and surgical)
- Pre-pregnancy care
- Treatment and prevention of sexually transmitted infections

A provider can assist with routine exams, diagnosis, and management of:

- Pelvic/abdominal pain
- Abnormal vaginal bleeding
- Vaginal symptoms (dryness/infections)
- Breast and other women's cancers
- Abnormal cervical screening results
- Infertility evaluation, including intrauterine insemination (IUI). VA is not authorized to provide or cover the cost of in-vitro fertilization (IVF)
- Sexual dysfunction

## Transplant Services

If the need arises, transplant services are available. Primary Care Teams coordinate these requests.

## Dental Services

Eligibility for VA dental benefits is based on specific guidelines and differs significantly from eligibility requirements for other types of medical care.

You are eligible for outpatient dental treatment if you meet one of the following criteria:

<b>If you:</b>	<b>You are eligible for:</b>
Have a Service-connected compensable dental disability or condition	Any needed dental care
Are a former Prisoner of War	Any needed dental care
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>(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>
Apply for dental care within 180 days of discharge or release (under conditions other than dishonorable) from a period of active duty of 90 days or more during the Persian Gulf War era	One-time dental care if your DD214 certificate of discharge does not indicate that a complete dental examination and all appropriate dental treatment had been rendered prior to discharge*
Have a Service-connected noncompensable dental condition or disability resulting from combat wounds or service trauma	Needed care for the Service-connected condition(s). A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth eligible for care
Have a dental condition clinically determined by VA to be associated with and aggravating a Service-connected medical condition	Dental care to treat the oral conditions that are determined by a VA dental professional to have a direct and material detrimental effect to your Service-connected medical condition

**\* Note:** Public Law 83 enacted June 16, 1955, amended Veterans' eligibility for outpatient dental services. As a result, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be noncompensable are no longer eligible for Class II outpatient dental treatment.

<p>Are actively engaged in a 38 USC Chapter 31 vocational rehabilitation program</p>	<p>Dental care to the extent necessary as determined by a VA dental professional to:</p> <ul style="list-style-type: none"> <li>• Make possible your entrance into a rehabilitation program</li> <li>• Achieve the goals of your vocational rehabilitation program</li> <li>• Prevent interruption of your rehabilitation program</li> <li>• Hasten the return to a rehabilitation program if you are in interrupted or leave status</li> <li>• Hasten the return to a rehabilitation program of a Veteran placed in discontinued status because of illness, injury or a dental condition, or</li> <li>• Secure and adjust to employment during the period of employment assistance, or enable you to achieve maximum independence in daily living</li> </ul>
<p>Are receiving VA care or are scheduled for inpatient care and require dental care for a condition complicating a medical condition currently under treatment</p>	<p>Dental care to treat the oral conditions that are determined by a VA dental professional to complicate your medical condition currently under treatment</p>
<p>Are an enrolled Veteran who may be homeless and receiving care under VHA Directive 2007-039</p>	<p>A one-time course of dental care that is determined medically necessary to relieve pain, assist you to gain employment, or treat moderate, severe, or complicated and severe gingival and periodontal conditions</p>

## Pharmacy

VA providers order medications and medical supplies as needed. Specific information about VA Pharmacy benefits can be found in Chapter 7.

## Health Promotion and Disease Prevention

Health promotion and disease prevention services are obtained from Primary Care Providers. These services include immunizations to prevent disease, screening tests to detect disease at an early stage, and behavioral counseling to avoid or reduce risk factors for disease. There are also health education programs available to help develop healthy living skills and manage health problems.

## Healthy Living

There has been a lot of research in recent years on the best ways to take care of yourself and stay healthy. We encourage you to make healthy living behaviors part of your daily life.

Check out the following websites for resources that are available to you:

- My HealtheVet Healthy Living Centers <http://www.myhealth.va.gov>.
- VA MOVE! Program website <http://www.move.va.gov/>
- Men: Stay Healthy at Any Age <http://www.ahrq.gov/ppip/healthymen.htm>.
- Women: Stay Healthy at Any Age <http://www.ahrq.gov/ppip/healthywom.htm>.

## What are VA's Health Registries?

VA maintains health registries related to environmental and occupational exposures of US Veterans during military service, including Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), Gulf War, Vietnam, World War II, and atomic test activities. These registries include a free specialized and comprehensive health examination provided by a VA Environmental Health (EH) clinician.

Visit the Environmental Agents Service (EAS) website [www.VA.gov/EnvironAgents](http://www.VA.gov/EnvironAgents), where you will also find links to newsletters covering related topics:

*Agent Orange Review*  
*Operations Iraqi Freedom/Enduring Freedom Review*  
*Gulf War Review*  
*Ionizing Radiation Review*

Another resource is VA's toll-free special health issues helpline, **1-800-349-8383**.

## Toxic Embedded Fragments

VA and the Department of Defense established the Depleted Uranium (DU) Follow-up Program at the Baltimore VA Medical Center to screen and monitor Veterans for health problems associated with exposure to depleted uranium. The DU Follow-up Program involves:

- Detailed physical exams
- Clinical tests of organ systems function
- Recommendations for treatment, including surgical removal of embedded fragments

Details on the DU Follow-up Program can be obtained from the Environmental Health Coordinator at the nearest VA health care facility. Another resource is VA's toll-free special health issues helpline, **1-800-749-8387**.

## Home Health Care

Home Health Care includes VA's Skilled Home Health Care Services (SHHC) and Homemaker and Home Health Aid Services (H/HHA).

### Skilled Home Health Care (SHHC) Services

SHHC services are in-home services provided by specially trained personnel, including nurses, physical therapists, occupational therapists, speech therapists, and social workers. Care includes clinical assessment, treatment planning, treatment provision, health status monitoring, patient and family education, reassessment, referral, and follow-up.

### Homemaker/Home Health Aide (H/HHA) Services

H/HHA services are personal care and related support services that enable frail or disabled Veterans to live at home.

## Family Caregivers Program

VA's Family Caregivers Program provides support and assistance to caregivers of post 9/11 Veterans and Service Members being medically discharged. Eligible primary Family Caregivers can receive a stipend, training, mental health services, travel and lodging reimbursement, and access to health insurance if they are not already under a health care plan. More information can be obtained from a Caregiver Support Coordinator at the nearest VA health care facility, by visiting <http://www.caregiver.va.gov>, or by calling 1-877-222-VETS (8387).

## Geriatrics and Extended Care Services

The mission of VA's Geriatrics and Extended Care is to advance quality care for aging and chronically-ill Veterans in the most efficient manner. Through research, education and evaluation of new clinical models, we have developed innovative and effective long-term care programs.

### Geriatric Evaluation

VA provides assessments and care plan recommendations for the complex problems of aging.

### Hospice Services

The primary goal of Hospice services is to provide comfort rather than cure for those with an advanced disease that is life-limiting. VA's interdisciplinary team of professionals and volunteers focuses on relief of suffering and maintenance of functional capacity as long as possible. Through integrated management of the physical, psychological, social and spiritual needs of the patient, these programs also give support to the patient's family or other caregivers, which includes bereavement counseling following the death of the patient.

## Respite Care Program

Respite Care is a program that provides short-term services to give the caregiver of a chronically-ill or disabled Veteran a period of relief from the demands of daily care.

Respite Care services may include a short stay by the Veteran in a VA Community Living Center (formerly known as a VA nursing home) or hospital; a short stay in a community nursing home; in-home services provided by a personal care aide; or services provided in an adult day health facility in the community.

Respite care is generally limited to 30 days per year.

## Domiciliary Care

VA offers two distinct types of Domiciliary Care: short-term rehabilitation and long-term health maintenance care. This program also provides a clinically appropriate level of care for homeless Veterans whose health care needs are not severe enough to require more intensive levels of treatment.

## Adult Day Health Care

Adult Day Health Care is an outpatient day program consisting of health maintenance, rehabilitative services, socialization, and caregiver support. Veterans receiving Adult Day Health Care are often frail, elderly and functionally impaired. Adult Day Health Care includes key program elements to address health needs, physical and cognitive functions and social support. The emphasis is on helping participants and their caregivers develop the knowledge and skills necessary to manage care at home.

## Nursing Home Placement

Placement in nursing homes, when clinically indicated, may be available either through VA's Community Living Centers (CLC) or contract nursing homes. The mission of the VA Community Living Centers (VACLC) program (formerly known as VA Nursing Home Care Units) is to provide compassionate care to Veterans with chronic stable conditions — those who suffer from dementia, who require rehabilitation or short-term specialized services (such as respite or intravenous therapy), or who need comfort and care at the end of life. VA nursing home care will be provided to Veterans who:

- Require nursing home care for a Service-connected disability;
- Are rated 60 percent Service-connected and unemployable and requires nursing home care for any condition;  
*or*
- Have a combined Service-connected percentage of 70 percent or more and requires nursing home care for any condition.

Otherwise, Veterans may be placed, if clinically indicated, based on space and availability.

## State Veterans Homes

The term “State Home” refers to a VA-recognized home established by a state, primarily for Veterans disabled by age or disease, whose disabilities render them incapable of earning a living. A State Home includes facilities for domiciliary and/or nursing home care. A State Home may also provide care to a Veteran’s spouse or to a parent who has suffered the loss of a son or daughter in service. Eligibility for State Home placement varies by state.

## Medically Related Travel, Lodging, and Per Diem

### Mileage Reimbursement

Reimbursement of 41.5 cents per mile may be received, subject to applicable deductibles, for travel related to obtaining VA health care services, if the Veteran is:

- Service-connected 30% or more
- Receiving a VA Pension
- Traveling for treatment of a Service-connected condition
- Traveling for a scheduled Compensation and Pension exam (exempt from deductible requirements)
- Reporting income below the maximum annual VA pension rate

### Specialized Transportation (Ambulances, Wheelchair Vans)

VA may arrange or provide reimbursement for specialized transportation related to obtaining VA health care services if eligible for mileage reimbursement (based on the above five criteria) and:

- The medical condition requires an ambulance or a specially equipped van as determined by a VA clinician; or
- The travel is pre-authorized (authorization is not required for emergencies if a delay would be hazardous to life or health)

### Lodging and Per Diem

VA may provide payment of the actual cost for meals, lodging, or both — not to exceed 50 percent of the amount allowed for government employees — is reimbursed when it is determined that an overnight stay is required for travel related to obtaining VA health care services. Factors VA may consider in making that determination include, but are not limited to:

- The distance you must travel;
- The time of day when VA scheduled your appointment;
- The weather, traffic, or other conditions affecting your travel; or
- The medical condition and its impact on ability to travel

## Hoptel Services

Hoptel is VA's term for temporary lodging. Temporary lodging may be furnished when receiving health care services or a Compensation and Pension examination at a VA health care facility. If undergoing extensive treatment or procedures (organ transplant, chemotherapy, surgical intervention, diagnostic work-up, etc.), the Veteran and a family member (and/or caregiver) may be furnished temporary lodging, at the discretion of the facility Director, for the duration of the treatment.

## Fisher Houses

The Fisher House Foundation, a non-profit organization, was created in 1990 by Zachary and Elizabeth Fisher. Fisher Houses are designed for use by family members of hospitalized Veterans. However, Veterans undergoing outpatient treatment who do not live within commuting distance of the VHA facility may also be accommodated at Fisher Houses.

## Medical Equipment/Prosthetic Items and Aids

VA Prosthetic & Sensory Aids Service (PSAS) furnishes properly prescribed prosthetic equipment, sensory aids and other devices to eligible Veterans. Regardless of cost, PSAS' purpose is to provide the most appropriate medically prescribed technology to a Veteran in a timely manner. Prosthetics serves as the case manager for the equipment needs of disabled Veterans.

### Does VA Provide Eyeglasses?

Service-connected Veterans receiving compensation, former Prisoners of War, Purple Heart Recipients, or Veterans in receipt of VA's Aid and Attendance or Housebound benefits and receiving VA care or services, are provided eyeglasses based on clinical need.

Otherwise, VA provides eyeglasses only in special circumstances. However, Veterans otherwise receiving VA care or services may be eligible because of medically compelling reasons, as determined by a VA eye care practitioner. These circumstances may include vision impairment that results from:

- Diseases or medical conditions for which you are receiving VA care, or which result from treatment of such conditions;
- A significant functional or cognitive impairment that causes problems with activities of daily living, not including normally occurring vision loss; or
- Vision impairment severe enough to interfere with your ability to actively participate in your health care

### Does VA Provide Hearing Aids?

Service-connected Veterans receiving compensation, former Prisoners of War, Purple Heart Recipients, or Veterans in receipt of VA's Aid and Attendance or Housebound benefits and receiving VA care or services, are provided hearing aids based on clinical need.

Otherwise, VA provides hearing aids only in special circumstances. However, Veterans otherwise receiving VA care or services may be eligible because of medically compelling reasons, as determined by a VA audiologist. These circumstances may include hearing impairment that results from:

- Diseases or medical conditions for which you are receiving VA care, or which result from treatment of such conditions;
- A significant functional or cognitive impairment that causes problems with activities of daily living, not including normally occurring hearing loss; or
- Hearing impairment severe enough to interfere with your ability to actively participate in your health care
- 0% Service-connected hearing impairment disabilities that meet certain medical criteria

## **Automobile Adaptive Equipment Program**

VA's Automobile Adaptive Equipment program provides equipment and training to enter, exit, or operate a motor vehicle for Service-connected Veterans whose Primary Care Provider decides that it is necessary to drive safely and comply with State licensing laws. Please note that only certain Service-connected conditions qualify. Veterans may also be eligible for financial assistance, in the form of a grant, to purchase a new or used automobile (or other conveyance).

## **Automobile Access Equipment**

If you are Nonservice-connected, VA may provide automobile access equipment (for example, items such as power lifts, power door openers, turning seats) if you need assistance to enter or exit a motor vehicle. You may be eligible, as determined by your VA Primary Care Provider. For more information, contact the Prosthetic Representative at the local VA health care facility.

## **Home Improvement and Structural Alteration (HISA) Grants**

A Home Improvement and Structural Alteration Grant may be awarded for improvements or structural alterations needed to access home or essential bathroom facilities.

## **Clothing Allowance Benefit**

Service-connected Veterans who must wear a prescribed device that causes their clothing to wear or tear, or if clothing is damaged due to use of a topical ointment, may receive an annual clothing allowance payment. For more information, contact the Prosthetic Representative at the local VA health care facility.

## **Dependents' Health Care**

Dependents may qualify for VA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). They must not have eligibility under TRICARE and must be dependents of a:

- Veteran who has been rated by VA as having a Service-connected total and permanent disability.
- Veteran who died from VA rated Service-connected condition(s), or who, at the time of death, was rated

permanently and totally disabled from a VA rated Service-connected condition(s).

- Veteran who died on active duty and in the line of duty (not due to misconduct).

For more information, call 1-800-733-8387 or go to <http://www.va.gov/hac/forbeneficiaries/champva/champva.asp>.

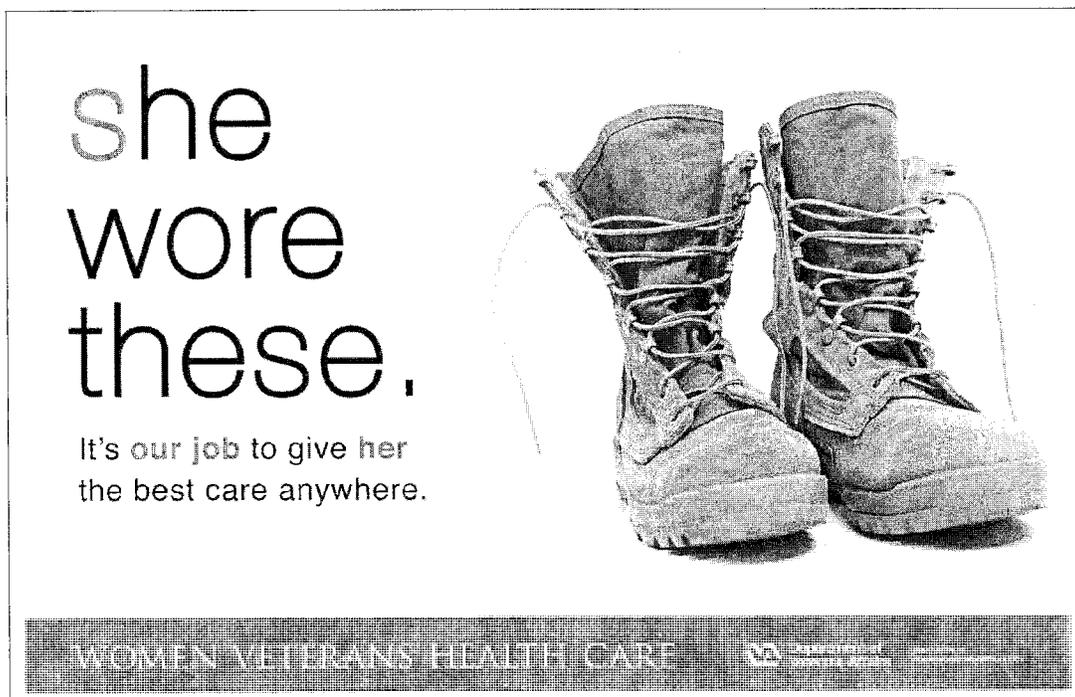
## Spina Bifida/Children of Women Vietnam Veterans

VA provides monetary allowances, vocational training and rehabilitation, and VA-financed health care benefits to certain Korean and Vietnam Veterans' birth children who have been diagnosed with spina bifida. For the purpose of this program, spina bifida is defined as all forms or manifestations of spina bifida (except spina bifida occulta). For more information, call 1-888-820-1756 or go to <http://www.va.gov/hac/forbeneficiaries/spina/spina.asp>.

## Medical Benefits Package Exclusions

The following health care services are not included in the VA Medical Benefits Package:

- Abortions and abortion counseling
- Cosmetic surgery, except where determined by VA to be medically necessary
- Gender alteration
- Health club or spa membership
- In-vitro fertilization
- Drugs, biological, and medical devices not approved by the Food and Drug Administration, unless part of formal clinical trial under an approved research program or when prescribed under a compassionate use exemption
- Inpatient hospital or outpatient care for a Veteran who is either a patient or inmate in an institution of another government agency, if that agency has a legal obligation to provide the care or services



she  
wore  
these.

It's our job to give her  
the best care anywhere.

WOMEN VETERANS HEALTH CARE



## Chapter 4

# Getting Started with VA Health Care

## The First Appointment

When applying for enrollment, Veterans may request an appointment. Otherwise, enrolled Veterans may request an appointment either in person or by calling their local VA health care facility. Female Veterans may also request an appointment through the local Women Veteran Program Manager (WVPM), who will assist with coordination of care.

## How to Get a Veterans Identification Card

The Veterans Identification Card (VIC) is the gateway to quick access to benefits at VA health care facilities. After enrollment, Veterans may go to their local VA health care facility to have a picture taken. VA will then mail the VIC within a few days.

### Is a VIC Like an Insurance or Credit Card?

No. VIC is not a credit card or an insurance card, and it does not authorize or pay for care at non-VA facilities.

Although the VIC does not contain a Social Security number, date of birth or other sensitive information on the face of the card, that information is coded into the magnetic stripe and barcode — ***so be careful! Take precautions to safeguard your VIC.***

## How Can My HealtheVet Improve Quality of Care?

My HealtheVet is a website created especially for Veterans. It can be used to:

- Get accurate health information from trustworthy sources.
- Link to VA benefits and services.
- Refill VA prescriptions and get information about medicines.
- Read VA news and feature stories.
- Create a personal health journal.

## Why Should I Keep a Personal Health Journal?

A personal health journal is the record of your health history and needs. You can use it to do any of these things:

- Keep track of all your providers.
- Keep track of your military health information.
- Record your personal health history.
- Keep track of your current vital readings, such as blood pressure or blood sugar, and monitor them over time.
- Keep a list of your medicines.
- Record your physical activity or food intake each day.
- Record your emergency contacts.

## What if I Move or Live in More Than One Location?

VA encourages Veterans to receive the majority of their care through their local health care facility and Primary Care Provider. However Veterans may receive care at any VA health care facility.

If a Veteran travels a lot or lives in more than one location, he or she may need to arrange for care at two or more VA facilities. When planning extended travel outside the usual VA care area, remember to give the Primary Care Team and pharmacy:

- A temporary address and phone number.
- The starting date at the new address and the expected date of return.

VA can mail prescription refills to a temporary address. Be sure to allow plenty of time — approximately two weeks — for the refills to arrive.

## Chapter 5

### Accessing VA Health Care Services

To obtain important VA Health Care Facility Locations and Phone Numbers, visit VA's website at <http://www2.va.gov/directory/guide/home.asp>.

## Scheduling an Appointment and Canceling Appointments

VA is committed to providing high-quality, clinically appropriate health care — when it is wanted and needed. This commitment includes the ability to make appointments that meet the needs of our Veterans, with no undue waits or delays. We monitor the wait times for scheduled appointments, and give our Veterans the opportunity to complete a survey to tell us whether an appointment was available at a preferred time.

### How to Schedule or Cancel Appointments

Enrolled Veterans may call the Primary Care/specialty clinic during regular business hours to:

- Make an appointment,
- Change an appointment, or
- Cancel an appointment.

### Are There Walk-in Appointments?

Although VA providers will evaluate a Veteran's condition if he or she decides to "walk in" to a Primary Care clinic without a scheduled appointment, there may be a wait, depending on the severity of the medical situation.

## Emergency Care and Non-VA Facilities

In case of emergencies, Veterans should always call 911. VA does not have to be contacted in advance. Veterans should always go to the nearest emergency room whether it's a VA or private facility. If transported by ambulance, the paramedics generally will go to the closest emergency room.

## Urgent and After-Hours Care (Evenings, Nights, Weekends, Federal Holidays)

Enrolled Veterans may call the after-hours telephone advice care line to get advice about health concerns. This line is staffed by registered nurses who will discuss medical concerns and work to determine the necessary care.

## Social Work Services

VA social workers are assigned to all patient treatment programs, including community-based outpatient clinics. They provide social and clinical services to Veterans and their families in resolving the social, emotional, and economic problems associated with the stresses of illness. Social workers bring skills in individual, group, and family treatment to the care of Veteran patients as they move through the continuum of care.

VA Social Work Service has responsibility for the Fisher House Program, the Temporary Lodging Program, policies on reporting suspected abuse and neglect, and family support for polytrauma patients.

## Interpreter Services

If foreign language (or American Sign Language) services would help you or your family understand your medical or health care benefits, there are interpreter services available. Please contact the Patient Advocate at your nearest VA health care facility.

## Chapter 6

### Coordination of Care

## How Does VA Coordinate Care for Veterans Who are Traveling or Living at a Temporary Address?

Generally, the VA Primary Care Team is responsible for care for Veterans traveling or temporarily experiencing a change of address — such as living in one state during the winter and another during summer. Any VA provider seen while traveling will share information and coordinate treatment options with the Primary Care Team.

## Coordination of Care with Providers Outside the VA Network (Co-managed/Dual Care)

We strongly encourage enrolled Veterans to receive all their health care through VA. However, if private doctors continue to provide treatment, VA will work with them to meet health care needs and coordinate effective treatment. We call this Co-managed Care or Dual Care, which means that the VA and private doctors will work together to provide safe, appropriate, and ethical medical care.

VA's Primary Care Team is responsible for managing all aspects of care and services available through the VA system. Under no circumstances can the VA provider simply re-write prescriptions, or order diagnostic tests from an outside provider, without first making a professional assessment that a particular test or drug prescription is medically appropriate. If the VA provider does not follow the recommendations of a private provider, she or he will communicate the reasons for such decisions and may offer alternative treatment recommendations.

## Coordination of Care Among VA Facilities

Veterans may receive medical attention in a variety of VA settings — clinic, hospital, emergency room, Community Living Center (formerly known as VA nursing home), or their own residence. Care will be provided by professionals who offer diverse specialized treatments and services. In order to manage the different aspects of care effectively, the Primary Care Team will use VA's electronic medical record system to ensure the coordination of care.

## Specialized Outpatient Care Not Offered at the Local Health Care Facility

If required care is not offered at the local health care facility, the Primary Care Team can arrange care at other VA health care facilities or in the community, as appropriate. Generally, the Primary Care Provider will coordinate the care at both locations.

## Disagreements Between VA Providers and Private Providers

VA will work to ensure that health care needs and preferences are met, and that there is an understanding of all available options. VA providers have the final say about how VA will meet your health care needs, including whether or not to order tests or write prescriptions.

### **Wherever you go, VA is there for you.**

- Are you planning to travel, either within the U.S. or abroad?
- Are you interested in receiving treatment from private doctors, as well as your VA Primary Care team?
- Do you have questions about your health care benefits?

For answers to these questions and others, contact your local VA medical facility or call 877-222-VETS (8387).



## Chapter 7

### Pharmacy Services

## What is VA's Prescription Benefit?

VA's Prescription Benefit provides safe, effective, and medically necessary medications to ensure the highest quality care for our nation's Veterans.

## VA's Drug Formulary

### Does VA Maintain a List of Preferred Medications?

Yes. This list of medications is called a drug **formulary**. The organization that accredits America's hospitals requires all health care organizations to develop a list of preferred medications that they keep in stock at all times. Health care organizations prefer formulary medications because they are:

- High quality
- Effective
- Safe
- A good value

VA's National Drug Formulary ensures that Veterans across the country have access to the same medications at all VA facilities.

### How Do Enrolled Veterans Know if a Medication is on VA's National Formulary?

The VA National Formulary lists medications alphabetically by generic name, not by brand name. For instance, Zocor would not be listed for cholesterol. Rather one would look for simvastatin instead. A medication can also be looked up by drug class. For example, using the VA Class Index, one would look for penicillin under antimicrobials. A list of the medications on the VA National Formulary can be found at the Pharmacy Benefit Management (PBM) Website: <http://www.pbm.va.gov/NationalFormulary.aspx>.

### Are There Some Drugs on the VA National Formulary That Should Not be Substituted with Another Drug?

Yes. In rare instances, there may be a medication that is not recommended for substitution with another drug. The **Do Not Substitute List** can be found on the VA PBM Internet site: <http://www.pbm.va.gov/NationalFormulary.aspx>.

## Can Enrolled Veterans Receive a Drug That is Not on the VA National Formulary?

Yes. There is a process that permits a VA health care provider to prescribe a “non-formulary” drug if special needs require it. The process assures that a decision to use a non-formulary drug is based on evidence that the preferred drug is safe and effective.

## Why Doesn't VA Provide the New Medications Seen on Television?

While some new drugs offer important improvements over older drugs, the new drugs are not always better or safer than older drugs. VA has established a process to review the safety and effectiveness of VA National Formulary medications. This process includes comparing several drugs within the same class (such as the statin class for lowering cholesterol or ACE inhibitors for lowering blood pressure). Only those drugs that prove to be the safest and most-effective and that offer the best value are listed on the National Formulary. If a formulary medication is not appropriate, however, each VA medical center has procedures in place to help identify an alternative, non-formulary medication.

Drug makers heavily promote their new drug through advertising and other publicity. But some new drugs are not studied in large groups of people or over long periods of time. As a result, we cannot always know the safety of these medications. When more is known about the safety and effectiveness of newer medications, VA may consider adding them to the National Formulary.

## Non-VA Physicians and Prescriptions

VA will fill non-VA prescriptions for Veterans who are in receipt of Aid and Attendance or Housebound benefits. These Veterans may contact, or have their non-VA physician contact, their local VA facility's Pharmacy Service for more information.

Otherwise, VA is not authorized to fill prescriptions unless they are written by a VA provider. This ensures that VA is able to provide and track the complete medical care for all Veteran patients. The total medication management for a prescription is the responsibility of the provider who writes that prescription.

If the Veteran is receiving care from a non-VA physician, the VA providers need to know about all of the medications (prescription, over-the-counter, and herbal supplements) being taken. The private provider must also be aware of the medical treatment and medications received from VA.

If a non-VA physician has prescribed a medication that is not on the VA National Formulary (that is, a “non-formulary” medication), the VA physician may elect to re-write that prescription for a VA National Formulary medication. If this switch is made, it is because the VA health care provider believes the VA National Formulary drug offers the best safety, effectiveness, and overall value.

If the VA health care provider believes that the VA National Formulary medication should not be prescribed, an alternative will be sought. The VA health care provider may need to contact the non-VA physician to obtain access to medical documents that support using a non-formulary medication.

## Tips for Understanding Your Medication

### Always Read Your Prescription Label Carefully

When you receive your medication, make sure that you read the instructions on the prescription label carefully and take your medication exactly as directed. Also, look for any stickers that have been placed on the bottle for additional instructions. These may include whether to take with food, or whether there are any activities to avoid. If you have any questions, contact your pharmacy at the number listed on the label.

### Why am I Taking This Medication?

Understanding why you are taking a medication is extremely important. Some medications are given only for a specific period of time (for example, an antibiotic taken for a short time for an infection), while others need to be taken regularly on a long-term basis (for example, diabetes or high blood pressure). If you are not sure why you are taking a medication or for how long you should take it, ask!

### How Will I Know Whether the Medication is Working?

Some medications are used to treat something you can feel (pain, allergy symptoms), while others are for conditions that may not have any noticeable symptoms (high blood pressure, high cholesterol). With many conditions, your provider will be able to determine whether your medication is working — by doing a physical exam or procedure, or by checking your lab tests. Whether or not you feel that it is working, do not stop taking your medication or change the dosage without talking to your pharmacist or provider. Otherwise, they will not be able to provide the care you need.

### What if I Think My Medication is Causing a Side Effect or a Drug Interaction?

Sometimes, medications prescribed to help treat a certain condition can also cause negative side effects. If you think you are having a side effect to a medication or are experiencing a drug interaction, tell your pharmacist or provider immediately. You can then discuss whether it is something that is tolerable, or whether there is another medication that can be used instead.

Some side effects are mild or go away with continued use, but others can be serious. In certain cases, medications may interact with other drugs, supplements, or food in undesirable ways. Common side effects and drug interactions are generally included in the information that comes with your prescription. If you think you are experiencing a serious side effect, contact your provider immediately or call for emergency medical care.

### **How VA Ensures the Quality of Medications for Veterans**

The VA National Formulary includes medications approved by the U.S. Food and Drug Administration (FDA), as well as over-the-counter (OTC) medications and supplies. The VA Pharmacy Benefits Management Services (PBM), in conjunction with VA physicians and pharmacists, reviews the information about a drug's safety and effectiveness, and discusses the drug's risks and benefits compared to other available treatments. VA then considers the cost of the drug, relative to other treatment options. All the information about the drug is then sent to expert doctors, pharmacists, and other VA providers across the United States. Observations and suggestions from these experienced health care professionals help VA decide how best to use the medications to treat Veteran patients.

## Chapter 8

# Respect and Nondiscrimination

## Respect and Nondiscrimination

As part of our service, we are committed to improving the health and well-being of our Veterans. In addition to making visits or stays as pleasant as possible, our employees will respect and support patient rights.

As a Veteran enrolled in the VA health care system, some of the patient rights and responsibilities which would apply to your care are outlined here:

- You will be treated as an individual — with dignity, compassion, and respect. You will receive care in a safe environment. We will honor your personal and religious values, and your privacy will be protected.
- You — and any persons you choose — will be involved in all decisions about your care. You can agree to or refuse treatment, and consider options. Refusing treatment will not affect your rights to future care, but you take responsibility for the possible results.
- You may allow a family member, friend, or other individual to be present with you for emotional support during your hospital stay. (NOTE: The presence of a support individual of your choice is allowed, unless that individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. This individual may or may not be your surrogate decision maker or legally authorized representative.)
- You will be given the name and title of all providers involved in your care, including students and trainees. If you believe you cannot follow the treatment plan, you have a responsibility to notify your provider or treatment team.
- You have the right to have your pain assessed, to receive treatment to manage your pain, and to participate in developing a pain management plan.
- You have the right to choose whether you will participate in any research project related to your treatment.
- You will be involved in resolving any ethical issues about your care — including participation in decision-making and care at the end of life — and you may seek guidance from your health care facility's Medical Ethics Consultation Service.
- In order to maintain a safe environment in all VA health care facilities, we expect you to show respect for others — whether patients, residents, or staff — and to follow the facility's rules.
- Veterans Health Administration (VHA) prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

## Keeping Health Information Private and Secure

VA keeps all of the information in medical records confidential. No information will ever be released without consent unless required or authorized by law.

As a Veteran enrolled in the VA health care system, some of the privacy rights which would apply to your care are outlined here:

- Right to a Notice of Privacy Practice – You have a right to know how VA uses and discloses your information. VHA's Notice of Privacy Practice outlines all the general purposes for which VA uses or discloses your information. A copy of this Notice can be found at [http://www.va.gov/vhapublications/viewpublication.asp?pub\\_id=1089](http://www.va.gov/vhapublications/viewpublication.asp?pub_id=1089).
- Right to Request Amendment – You have a right to request that information about you be amended, if you feel that it is incorrect or inaccurate, not timely, or not relevant to the services you receive from VA. If you request an amendment and it is not approved, you have the right to appeal that decision to the VA Office of General Counsel.
- Right to Access Record – You have a right to access your records. VA will provide you with access to these records in any reasonable format, or will have a VA employee show you your record on a VA computer.
- Right to Request Restriction – You have a right to request that your information not be shared with certain individuals or organizations. (There are some individuals or organizations that VA cannot withhold information even if you request it, such as reporting required by law.) If your restriction request is not granted, VA will let you know and provide you with appeals rights.
- Right to Confidential Communication – You have a right to request that VA provide you with a confidential means of getting information. This may be in the form of a specific address that you wish VA to use or a particular phone contact number for calls.
- Right to Opt-out of Facility Directory – If you are admitted to a VA health care facility as an inpatient, you have the right to request that you not be included in the facility directory. If you opt-out of the directory, VA will not acknowledge that you are admitted to that hospital. However, if you do not want to acknowledge you have been admitted, VA will not be able to share any information as to your whereabouts -- with even your family -- or accept mail or other packages or flowers. Your VA facility will explain this more fully to you if you are admitted as an inpatient.
- Right to an Accounting of Disclosures – You have a right to request a list of all disclosures of your information made to anyone outside of VA. We keep a record of all disclosures so that it can provide you with an accounting upon request.
- Right to File a Privacy Complaint - If you believe that your privacy rights have been denied, or that VA has not protected your information according to the law, you have a right to file a complaint in various ways. You may complain to the Privacy Officer at your local VA Medical Center, or you can complain to the VHA Privacy Officer, whose contact information is in the Notice of Privacy Practices. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights if you believe that your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule have been denied.

Protect your own privacy. Never just throw away a prescription bottle or papers. Never give out your Social Security Number over the telephone – even if someone claiming to be from VA calls you. VA will never ask you for your Social Security Number over the telephone. If you request copies of your records, keep them in a safe and secure place; people could learn things about you or your care that you do not want them to know.

## Partnering in Care

VA is committed to providing Veteran-centered care. We will focus our efforts on giving Veterans what they need. We will coordinate care to make sure each Veterans receives the right care, at the right time, in the right setting. In addition to explaining health problems and treatment options in easily understandable language, our care providers will educate about self-care and explain how to manage health problems.

We know that patients who are actively involved in their health care will experience better results and feel more satisfied with their care. There are many ways for Veterans and their VA providers to work together, and the approaches to treatment may change over time. By keeping the communication channels open, we can build a partnership that meets patient needs and offers our Veterans the best possible outcomes.

## Concerns, Complaints, and Compliments

While at the local VA health care facility, we encourage you to seek help from a Patient Advocate if:

- You have problems
- You have complaints
- You feel that you have been neglected
- You feel that you have been abused
- You feel that you have been exploited

### Patient Advocate

The Patient Advocate's job is to help resolve your issues. We want you and your family to have someone to go to for open discussion about your concerns and complaints — or to offer a compliment.

## Family Involvement in Your Health Care

Support from family members can help you recover from or manage serious health problems, and they can assist you in maintaining healthy living habits. It is up to you to make the decision on who you choose to rely on for emotional support or involvement in your care.

## **Can My Family Take an Active Role in My Treatment Decisions?**

Yes. Once enrolled in the VA health care system, family members can help you prepare for your VA appointments and help you think of questions you need to ask. If you wish, a family member can accompany you to your medical appointments. Having another person there to hear explanations, receive instructions, and ask questions can be reassuring.

At home, they can remind you to follow the treatment plan. We encourage you to give permission to your providers to discuss aspects of your health problems or health care with your family. When you are able to make your own treatment decisions, your family can help you as much or as little as you choose. You're in charge.

## **How Can My Family Members Share Their Concerns or Complaints About My Care?**

Your family members can seek help from a Patient Advocate if they have concerns or complaints about your care. They may complain verbally or in writing through the Patient Advocate.

## **What if I am an Inpatient at a VA Medical Facility or a Community Living Center (Formerly Known as a VA Nursing Home) Resident?**

Once you enroll, if you are an inpatient or Community Living Center resident, you have the right to communicate freely and privately. You may receive or refuse visitors, and you will have access to public telephones. Additionally:

- You have the right to social interaction and regular exercise. If you choose, you will have the opportunity to worship in accordance with your beliefs and to request spiritual support.
- You may participate in civic activities, such as exercising your right to free speech or to vote in elections.
- You can organize and take part in resident groups in the facility, and your family can meet with the families of other residents.
- You are to avoid unsafe acts that may place you or others at risk for accidents or injuries. You may wear your own clothes and keep personal items, as appropriate, depending on your medical condition.
- You or someone you choose has the right to keep and spend your money. You will receive an accounting of any funds VA holds for you.
- While providing treatment, we will respect your personal freedoms. In rare cases, medication or physical restraints may be used, if all other efforts to keep you or others free from harm have not worked.

## Advance Directives: What Are They and Why Are They Important?

If a Veteran is not able to make his or her own treatment decisions, then someone must stand in and make decisions on his or her behalf. The best way for you to make sure that your wishes are followed is to set up directives in advance, while you are able to make your wishes known.

An Advance Directive is a written statement regarding your preferences about future health care decisions if you are unable to make them yourself. This helps your providers and family understand your wishes about your health care, and it can help them decide about treatments if you are too ill to decide for yourself.

There are two types of Advance Directives:

- Durable Power of Attorney for Health Care
- Living Will

### What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care lets you name a person you trust to act as your health care agent — to make health care decisions for you if you cannot make them yourself. That person should be someone who knows you well and is willing to serve as your health care agent. If you do not choose a health care agent, your doctor will select the appropriate person to make decisions for you, based on an established order as follows:

1. Legal guardian or special guardian
2. Next-of-kin (a close relative, 18 years of age or older, in the following order of priority: spouse; child; parent; sibling; grandparent; grandchild) or close friend.

### What is a Living Will?

A living will is a type of Advance Directive in which you indicate your personal preferences regarding future treatment options. A living will typically includes your preferences about life-sustaining treatment, but it may also include preferences about other types of health care.

### Should I Have an Advance Directive?

It's up to you to decide if you want an Advance Directive. An Advance Directive helps protect your right to make your own choices — to make sure your values and wishes are respected if you can't speak for yourself. Some people name a health care agent and also complete a living will. You can decide how general or specific you want your instructions to be.

### What Should I Do with My Advance Directive?

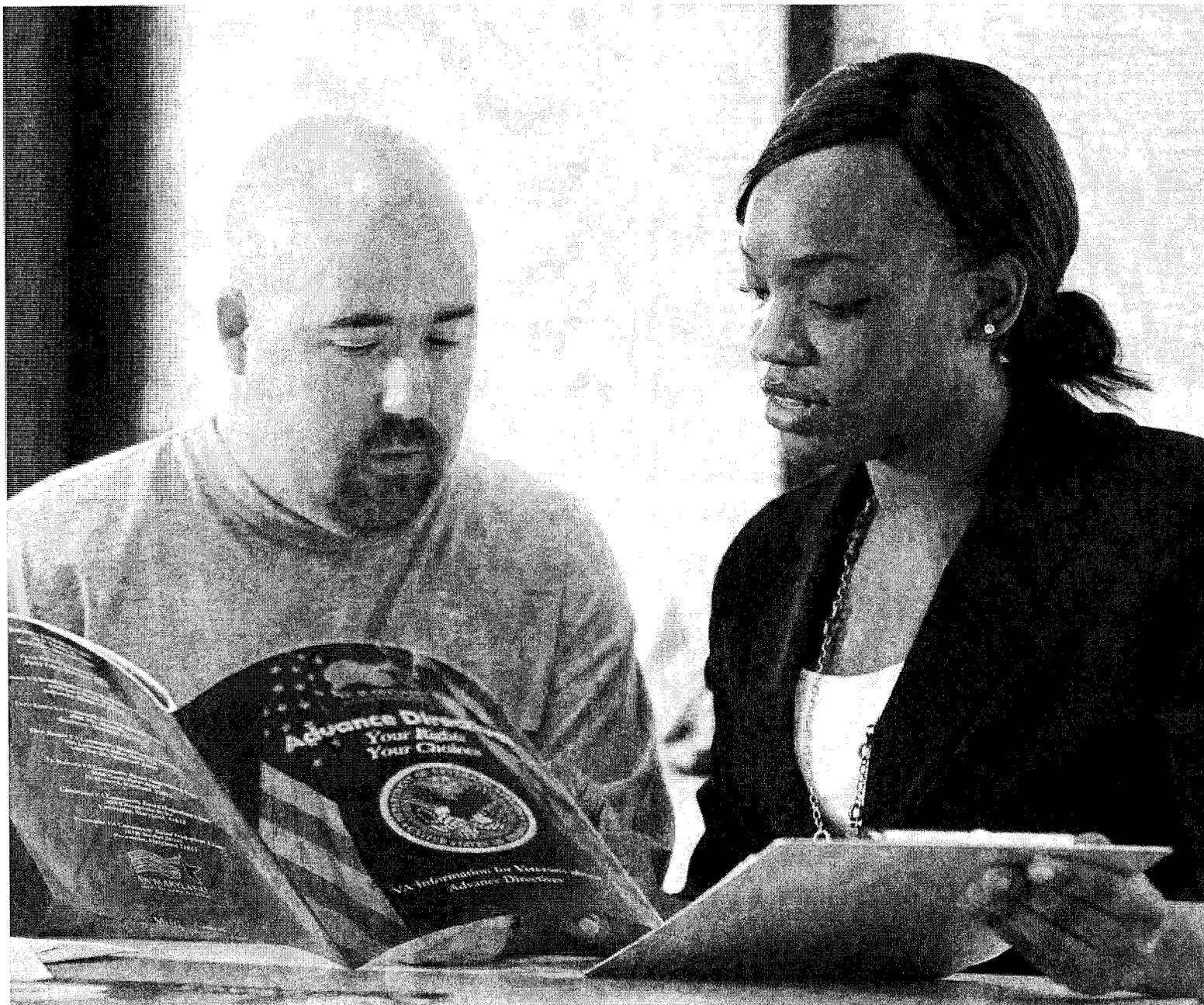
Give a copy of your Advance Directive to your health care agent and your health care providers so that it can be placed in your medical record. You should also keep a copy for yourself — along with your other important papers — in a safe place.

## Can My Advance Directive be Changed?

Yes, but only by you. You may change or revoke it at any time. If you make changes, give the new version to the people listed above.

## Where Can I Get the Advance Directive Form?

VA's Advance Directive form (VA Form 10-0137, VA Advance Directive) can be downloaded from the VA website: <http://www.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf> or at the My HealtheVet website: <http://www.myhealth.va.gov>.



## Chapter 9

### VA Copayments and Insurance

## Overview of Copayments

While many Veterans qualify for free healthcare services based on a VA compensable Service-connected condition or other qualifying factor, most Veterans are asked to complete an annual financial assessment, to determine if they qualify for free services. Veterans whose income exceed the established VA Income Thresholds as well as those who choose not to complete the financial assessment must agree to pay required copays to become eligible for VA healthcare services.

Outpatient Services	
Basic Care Services Services provided by a Primary Care clinician	\$15/visit
Specialty Care Services Services provided by a clinical specialist such as a surgeon, radiologist, audiologist, optometrist, cardiologist and specialty tests such as magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan and nuclear medicine studies	\$50/visit
*The total copayment due is limited to a single charge per visit, regardless of the number of health care providers seen in a single day. The copayment due is based on the highest level of service received during the visit. There is no copayment for preventive care services such as screenings and immunizations.	

Inpatient Services	
<i>Priority Group 8</i>	
Inpatient copayment for the first 90 days of care during a 365-day period	\$1,156.00
Inpatient copayment for each additional 90 days of care during a 365-day period	\$578.00
Per diem charge	\$10/day
<i>Priority Group 7</i>	
Inpatient copayment for the first 90 days of care during a 365-day period	\$231.20
Inpatient copayment for each additional 90 days of care during a 365-day period	\$115.60
Per diem charge	\$2/day

Pharmacy	
As applicable, Veterans in Priority Groups 2, 3, 5 and 6, for each 30-day or less supply of medication for treatment of Nonservice-connected conditions <b>(Annual medication cap is \$960)</b>	\$8
Veterans in Priority Groups 7 and 8, for each 30-day or less supply of medication for treatment of Nonservice-connected conditions <b>(No annual medication cap)</b>	\$9

Long-Term Care	
Nursing Home Care/Inpatient Respite Care/Geriatric Evaluation	Maximum of \$97/day
Adult Day Health Care/Outpatient Geriatric Evaluation/Outpatient Respite Care	Maximum of \$15/day
Domiciliary Care	Maximum of \$5/day
*Copayments for Long-Term Care services start on the 22nd day of care during any 12-month period - there is no copayment requirement for the first 21 days. Actual copayment charges will vary from Veteran to Veteran, depending upon financial information submitted on VA Form 10-10EC.	

## Insurance and Other Third Party Payments: Why Does VA Bill Insurance Companies?

### Overview of VA Billing

Federal law requires VA to bill a private health insurance provider for medical care, supplies, and prescriptions for treatment of any Nonservice-connected condition. You are required to provide information on your health insurance coverage, including coverage provided under policies of your spouse. You are not responsible for paying any remaining balance of VA's insurance claim that is not paid or covered by your health insurance. As applicable, any payment received by VA may be used to offset "dollar for dollar" your VA copayment responsibility.

### Does VA Bill for Service-Connected Conditions?

No. If you are Service-connected, VA will not bill your private health insurance carrier for treatment or services for any Service-connected condition.

### Does VA Bill Medicare?

No. While VA does not bill Medicare, your Medicare supplemental health insurance may be billed for treatment of a Nonservice-connected condition.

### Offsetting Your VA Copayments with Insurance Premiums

VA will apply payment from your private health insurance carrier "dollar for dollar" to your VA bill, which may eliminate or reduce your VA copayment.

## TRICARE

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families and survivors. VA bills TRICARE for Nonservice-connected medical treatment. There are four options for health care: TRICARE Prime, TRICARE Extra, TRICARE Standard and TRICARE for Life. Each of these options has specific benefits, exclusions, copayments and deductible requirements.

### Do VA medical centers accept TRICARE?

Most VA medical centers accept TRICARE under certain conditions. Contact the local VA Enrollment Office or enrollment coordinator for more information.

### Where can I get more information about TRICARE?

For more information about TRICARE, visit the TRICARE website at <http://www.tricare.mil/> or call, toll-free, 1-877-874-2273.

## How Do I Pay My VA Bill?

Any VA bills can be paid online by credit card or check. You may go to [www.pay.gov](http://www.pay.gov) and select Department of Veterans Affairs on the agency list. This service is available at no cost.

Bills can also be paid in person, by contacting the Agent Cashier office at the local VA health care facility. Bills can also be paid by calling the number on the billing statement or a check or money order payable to "VA" can be sent to:

Department of Veteran Affairs  
PO Box 530269  
Atlanta, GA 30353-0269

## Retroactive Award of Service-Connection or VA Pension Benefit

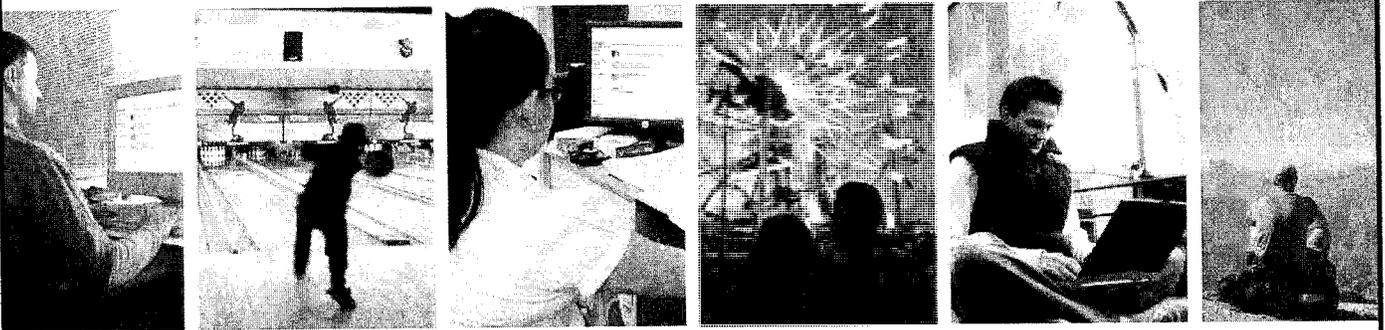
If you have recently received an award of a Service-connected condition, an increase in percentage of your Service-connected rating, or a VA pension benefit, you may be eligible for reimbursement for VA copayments you have already paid. For information, contact your local Revenue Office or call VA at 1-877-222-VETS (8387).

Enrolled Veterans may also be eligible for beneficiary travel payments back to the effective date of your award. You must apply within 30 days of the date you became eligible for travel benefits. For more information, contact your local Enrollment Coordinator or call the VA at 1-877-222-VETS (8387).



## SAVE TIME...PAY ONLINE! It's free, confidential, and secure!

- Step 1** Log on to <https://www.pay.gov/>
- Step 2** Under Frequently Used Forms select "Department of Veterans Affairs - VA Medical Care Copayment" on the right side of the screen.
- Step 3** Click "VA Medical Care Copayment" and fill out the form, entering your account number exactly as it appears on your monthly billing statement. Click "Submit Data."
- Step 4** To process your payment, you may enter your credit/debit card information or your checking or savings account information.



**VA offers a fast, confidential and secure way to  
pay your account balances online.**

***www.pay.gov***

Pay.gov allows Veterans to pay their bills online from their home computers using a check, credit card or debit card. Just log in, enter your statement account number and your payment information, and you are done. Why spend time standing in line or mailing a check? Save time ... pay online with Pay.gov.

***Fast... Free... Done!***

## Chapter 10

### Care Outside the VA System: What VA Covers

VA may refer enrolled Veterans to a non-VA provider in the community for a portion of care, under certain limited circumstances.

## Pre-Authorized Non-VA Care

Non-emergency health care provided in non-VA facilities at VA expense (such as Fee Basis care) must always be pre-authorized. That is, VA must authorize in advance the services being furnished. VA may pre-authorize health care at a non-VA facility, or other Federal facility with which VA has an agreement.

However, VA may authorize non-VA emergency care — even though it was not authorized in advance — when (a) the nearest VA medical facility is notified within 72 hours of admission; (b) the care rendered is for a medical emergency; (c) VA or other Federal facilities are not feasibly available; (d) and the Veteran meets the eligibility requirements.

## Emergency Care

A medical emergency is generally defined as a condition of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health.

An enrolled Veteran may receive emergency care at a non-VA health care facility at VA expense when a VA facility (or other Federal health care facility with which VA has an agreement):

- Cannot furnish economical care due to the patient's distance from the facility; or
- When VA is unable to furnish the needed emergency services.

## VA Payment for Emergency Care of Service-Connected Conditions Without Prior Authorization

Since payment may be limited to the point when a condition is stable enough for travel to a VA facility, an enrolled Veteran needs to contact the nearest VA medical facility as soon as possible. An emergency is deemed to have ended at the point when a VA provider has determined that, based on sound medical judgment, the patient should be transferred from the non-VA facility to a VA medical center.

## **VA Payment for Emergency Care of Nonservice-connected Conditions Without Prior Authorization**

VA may pay for emergency care provided in a non-VA facility for treatment of an enrolled Veteran's Nonservice-connected condition only if all of the following conditions are met:

- The episode of care cannot be paid under another VA authority, and
- Based on an average knowledge of health and medicine (prudent layperson standard) there was a reasonable expectation that delay in seeking immediate medical attention would have been hazardous to life or health, and
- A VA or other Federal facility/provider was not feasibly available, and
- VA medical care has been received within a 24-month period preceding the non-VA emergency care, and
- The Veteran is financially liable to the health care provider for the emergency care, and
- The services were furnished by an Emergency Department or similar facility held out to provide emergency care to the general public, and
- There is no other coverage under a health plan (including Medicare, Medicaid and Worker's Compensation), and
- There is no contractual or legal recourse against a third party that would, in whole, extinguish the Veteran's liability, and
- There is a 90 day timely filing limit.

## **Veterans Who are Living or Traveling in a Foreign Country**

VA will pay for medical services for treating Service-connected disabilities, or any disability that is associated with and aggravates a Service-connected disability, for enrolled Veterans who live or travel outside the United States. This program will also reimburse you for certain treatment of medical services while outside the United States, if needed as part of the VA-approved vocational rehabilitation program. For more information, call the Foreign Medical Program Office at 1-877-345-8179.

## Chapter 11

### Appeals

## Administrative Appeals

An appeal is a request for VA's Board of Veterans' Appeals to review a decision about health care benefits. An appeal may be filed if a Veteran does not agree or is not satisfied with a VA decision. Specific information about the appeals process is available on VA Form 4107 "Your Rights to Appeal our Decision" which is available at <http://www1.va.gov/opa/publications>.

### Can I Appeal an Administrative Determination That Denies Me a Health Care Benefit?

Yes. If you believe you have been denied a health care benefit for which you are eligible, you may write VA a letter telling us why you disagree with that decision. Within one year of the date of the initial decision, send the letter — called a Notice of Disagreement — to the VA health care facility where the decision was made.

### Can I Request Reconsideration of a VA Decision?

As part of the Appeal process, you may ask VA to reconsider a decision. Within one year of the date of the initial decision, you may submit a "reconsideration" request in writing to the health care facility where the decision was made. A reconsideration decision will be made by the immediate supervisor of the initial VA decision-maker.

You may also request a meeting with the immediate supervisor of the initial VA decision-maker. This is not a formal hearing, but it provides an opportunity for you (and your representative, if desired) to discuss the issues. You can request that the meeting be taped and transcribed, and a copy of the transcript will be provided to you. After reviewing all the information, the immediate supervisor of the initial VA decision-maker will issue a written decision that either upholds, reverses, or modifies the initial decision. If the decision to deny is upheld, you may still proceed with your appeal.



## Chapter 12

### Vet Centers

## Introduction to Vet Centers

The Vet Center Program was established by Congress in 1979 in response to the readjustment problems that a significant number of Vietnam-era Veterans were continuing to experience after their return from combat. In subsequent years, Congress extended eligibility to WW II and Korean Combat Veterans, and to Veterans who served in conflicts after Vietnam: Lebanon, Grenada, Panama, the Persian Gulf, Somalia, Kosovo/Bosnia, Operation Enduring Freedom, Operation Iraqi Freedom, and other operations within the Global War on Terrorism.

## What Services Do Vet Centers Provide?

If you served in any combat zone (Vietnam, Southwest Asia, Operation Enduring Freedom, Operation Iraqi Freedom, etc.), you are eligible for Vet Center services. These services are available regardless of whether or not you are enrolled in the VA health care system. Community-based Vet Centers provide a broad range of counseling, outreach, and referral services to help Veterans make a satisfying post-war readjustment to civilian life:

- Individual counseling
- Group counseling
- Post-traumatic stress disorder (PTSD) counseling
- Marital and family counseling
- Bereavement counseling
- Medical referrals
- Assistance in applying for VA benefits
- Employment counseling
- Guidance and referral
- Alcohol/drug assessments
- Information and referral to community resources
- Military sexual trauma counseling and referral
- Outreach and community education

*Vet Center services are provided at no cost to Veterans or their families.*

# How Do I Gain Access to Vet Center Services?

VA's readjustment counseling is provided at community-based Vet Centers located near Veterans and their families. Vet Center staff are also available toll-free during normal business hours at 1-800-905-4675 (Eastern) and 1-866-496-8838 (Pacific). For more information or to locate the Vet Center nearest you, go to <http://www.vetcenter.va.gov/>.

The image displays three overlapping screenshots of the Department of Veterans Affairs website, specifically the Vet Center services page. The top screenshot shows the 'ELIGIBILITY: War Zone Veteran - all eras, including...' section, which lists various military operations and campaigns. The middle screenshot shows a 'Center Combat Call Center' banner with a photo of a man. The bottom screenshot shows the 'Facility Locator by Zip Code' tool, which includes a search form and a map of the United States with state initials. The website header includes 'UNITED STATES DEPARTMENT OF VETERANS AFFAIRS' and navigation links like 'Home', 'Veteran Services', 'Business', 'About VA', 'Media Room', 'Locations', and 'Contact Us'. A search bar is visible in the top right corner of each screenshot.

**ELIGIBILITY: War Zone Veteran - all eras, including...**

- WORLD WAR II - Three eligible categories: European, African-Middle Eastern, Campaign Medal (7 Dec. 1941 to 6 Dec. 1945); Pacific Campaign Medal (7 Dec. 1941 to 6 Dec. 1945); Asiatic Campaign Medal (7 Dec. 1941 to 6 Dec. 1945).
- OPERATION JOINT ENDEAVOR, OPERATION JOINT GUARD, & OPERATION JOINT FORGE - Veterans who participated in one or more of the three successive operations in the former Yugoslavia (Bosnia, Herzegovina and Croatia) aboard U.S. Naval vessels operating in the Adriatic Sea, or air spaces above those areas).
- OPERATION ENDURING FREEDOM - Veterans who served or have served in Kosovo either in its waters or airspace after March 24, 1999, and before a terminal date yet to be established.
- OPERATION PROMISE - Veterans who serve or have served in an area designated as a combat terrorism or other area of interest to the Department of Defense.

**Facility Locator by Zip Code**

Facility:  All levels

Find:  nearest 5 facilities  Within 50 miles

Search in Facility Directory:

Zip Code:  Go

Click on the state initials to view facilities in that state. [Flash Version](#)

This site is a storehouse of facility and key staff information within 1727 VA facilities, maintained on a regular basis by editors and administrators nationwide throughout the VA network. Designed for ease-of-use, this site categorizes information for browsing by state and administration, as well as by viewing through an interactive map of the United States.

Links to various VA services and policies are also available.

VA Home | Privacy | FOIA | Regulations | Web Policies | ACP/EAR Act | Site Index | USA.gov | White House | National Resource Directory | Inspector General

You may also be eligible to enroll in Medicare. Because each Veteran's situation is unique, VA cannot provide a single answer to the question of whether you should enroll in Medicare, but we offer the following information to assist you in weighing your options.

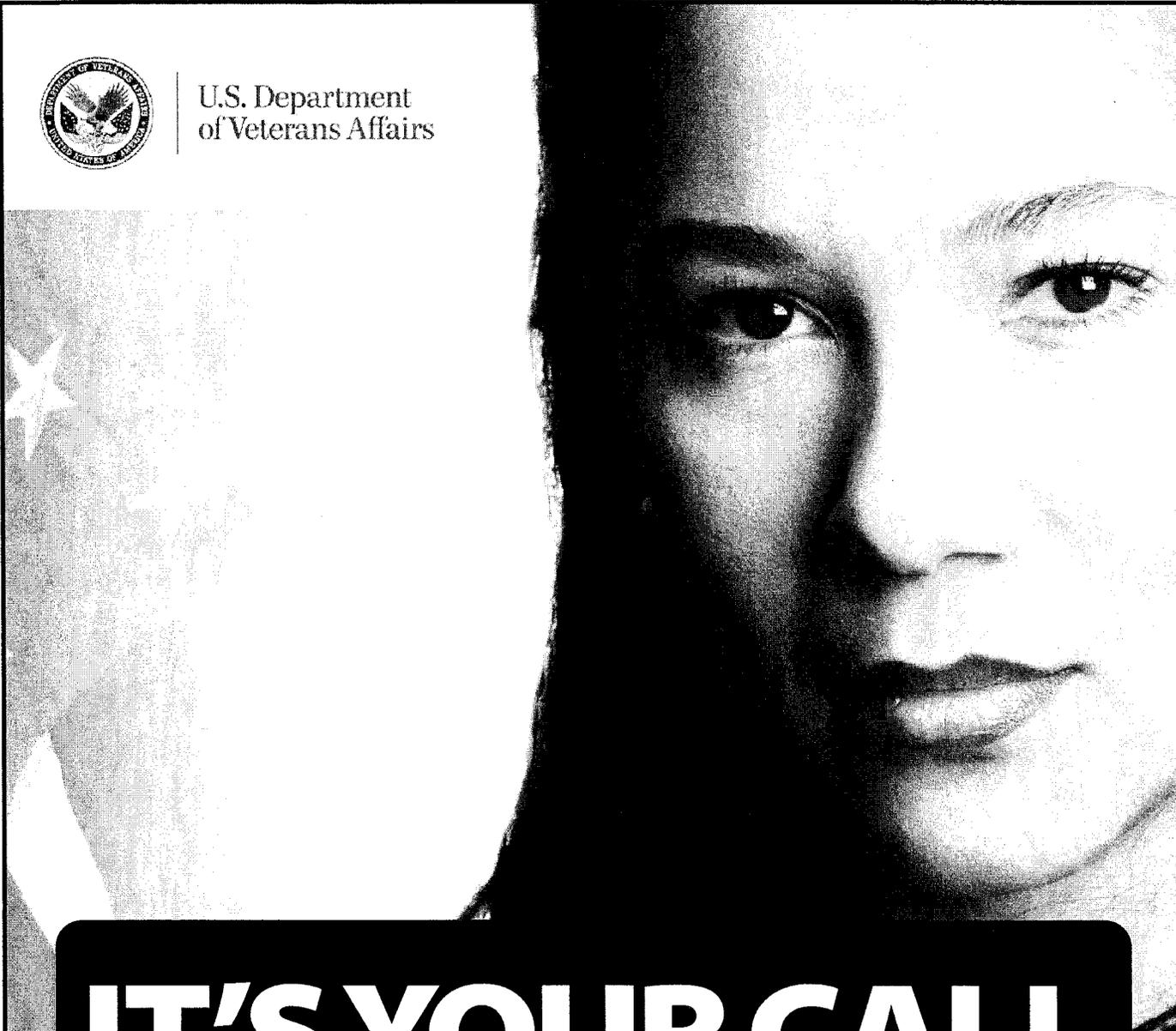
Here are some key points about the two programs:

- Remember, VA health care benefits are separate from Medicare. You may be enrolled in both programs, but the enrollment process (and the eligibility criteria) is different for each.
- Medicare offers three types of coverage: inpatient ("Part A"), outpatient ("Part B"), and prescription drug ("Part D"). You can decide whether to participate in one "part" or all three.
- VA does not recommend that you cancel or decline coverage in Medicare (or other health care or insurance programs) solely because you are enrolled in VA health care. There is no guarantee that in the years to come, Congress will appropriate sufficient funds for VA to provide care for all enrollment Priority Groups. If you are enrolled in one of the lower Priority Groups, this could leave you with no access to VA health care coverage. For this reason, signing up for Medicare as a secondary source of coverage may be in your best interest.
- Enrolling in both VA and Medicare gives you greater flexibility. For example, if you are enrolled in both programs, you will have access to non-VA physicians (under Parts A and B); or you may obtain prescription drugs (under Medicare Part D) — prescribed by your non-VA physicians and filled at your local retail pharmacies — that are not on the VA formulary.
- Medicare allows enrollment (typically at age 65) during a yearly enrollment period. You may be subject to a penalty if you don't enroll when you first become eligible for some Medicare programs. You can delay enrollment in Part D (prescription drugs) without penalty if you are enrolled in a prescription drug plan (like VA's) that is considered "creditable coverage" — that is, prescription drug coverage that provides a benefit at least as good as Medicare's. However, "creditable coverage" for Part B (outpatient/doctor coverage) can only be received through an employer; so you cannot claim VA enrollment as "creditable coverage" for the outpatient Medicare program.
- Take time to understand your options under the Medicare program, and read all information received from Medicare or the Social Security Administration carefully. Action on your part may be required.
- For example, you are required to sign and return a card if you choose not to enroll in Medicare Part B. Failure to return the card could result in automatic enrollment and deduction of the Part B premium from your Social Security check.

For more information on the Medicare Program, visit <http://www.medicare.gov/> or call 1-800-Medicare (1-800-633-4227).



U.S. Department  
of Veterans Affairs



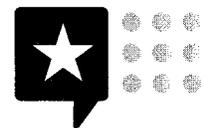
# IT'S YOUR CALL

Confidential help for  
Veterans and their families

© 1/12 VHA

1-800-273-8255 PRESS 

Veterans  
Crisis Line



• • • Confidential chat at [VeteransCrisisLine.net](http://VeteransCrisisLine.net) or text to 838255 • • •

## Glossary

**Adjudication** - Refers to the process of obtaining and reviewing the facts in a particular claim to make a decision whether to grant benefits in view of the laws governing these benefits.

**Aid and Attendance** - The increased compensation and pension paid to Veterans, their spouses, surviving spouses, and parents. A&A may be provided if the Veteran needs the regular aid and attendance of another person.

**Appeal** - A person's disagreement with a determination by VA to deny a benefit, request for reconsideration of the determination, or direct appeal to a higher level, such as the Board of Veterans Appeals (BVA).

**Applicant** - A person who has submitted a written request for VA health care benefits and/or for enrollment in the VA Health Care System.

**Automobile Adaptive Equipment** - Items and/or devices necessary to permit safe operation of, or permit access to and egress from an automobile or other conveyance.

**Beneficiary** - A person determined eligible for VHA benefits.

**Carrier** - The insurance company; the insurer.

**Catastrophically Disabled** - A permanent, severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others. NOTE: The complete definition can be found at 38 Code of Federal Regulation (CFR), section 17.36(e).

**Claimant** - A Veteran who received services (or his/her guardian) or the hospital, clinic, or community resource that provided the services, or the person other than the Veteran who paid for the services.

**Clinician** - A Physician, Physician Assistant (PA), Nurse Practitioner (NP), Psychologist, or other independent licensed practitioner.

**Combat Veteran** - A Veteran whose service includes receipt of an expeditionary medal or other Department of Defense (DOD) authorized combat-related medal, service in a location designated by an Executive Order as a combat zone, service in a qualified hazardous duty area as defined by Federal Statute that deems such service by a member of the Armed Forces to be the equivalent if service in a combat zone for pay or a tax-related purpose, receipt of DOD Hostile Fire or Imminent Danger pay for serving in the area subject to hostilities, or other factor(s) as may be defined in policy and regulation by the Secretary of Veteran Affairs.

**Community Living Center** - formerly known as VA Nursing Home.

**Compensable** - A VA determination that a Service-connected disability is severe enough to warrant monetary compensation.

**Copayment** - Copayment is a specific monetary charge for either medical services or medications provided by VA to Veterans.

**Cost-Free** – No VA copayments or premiums.

**Coverage** - The extent of benefits provided under a health care policy.

**Domiciliary** - VA facilities that provide care on an ambulatory self-care basis for Veterans disabled by age or disease who are not in need of acute hospitalization and who do not need the skilled nursing services provided in a nursing home.

**Emergency Department (ED)** - A unit that is dedicated to providing resuscitative therapy and stabilization in life threatening situations. It is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and psychiatric disorders, regardless of the level of severity. Care is provided in a clearly defined area dedicated to the ED and operates 24 hours a day, 7 days a week (24/7).

**Emergency Treatment** - Treatment 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).

**Enrollment** - The process established for managing categories of Veterans for whom VA will provide services.

**Financial Assessment** - Financial assessment is the process used by VA to assess a Veteran's attributable income and assets. The financial assessment determines Veterans' copay responsibilities and helps to determine enrollment priority and eligibility for beneficiary travel.

**Geographic Means Test (GMT)** - The financial assessment used to determine if a Veteran may be enrolled in Priority Group 7.

**Hardship** - Refers to a temporary decrease in a Veteran's household income justifying enrolling a Veteran in a higher Priority Group than would otherwise be the case, and resulting in exemption from current and future copays from date of approval until a new means test is required.

**Health Care** - The performance of diagnostic, therapeutic, and preventive services and procedures by health care providers to persons who are sick, injured, or concerned about their health status.

**Health Insurance** - A contract between the policyholder and an insurance carrier or government program to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care rendered by health care professionals.

**Insurance Carrier** - The insurance company (insurer) that sells the policies and administers the contract.

**Means Test (MT)** - The financial assessment process used by VA to assess a Veteran's attributable income and assets. The MT determines Veterans' co-payment responsibilities and assists in determining enrollment Priority Group assignments. VA uses the appropriate MT threshold for the current calendar year to determine whether the Veteran is considered unable to defray the expenses of necessary care.

**Medical Benefits Package** - The health care that is available to enrolled Veterans.

**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.

**Nearest VA Medical Facility** - The closest VA facility properly equipped and staffed to provide the care and treatment medically indicated by the patient's condition.

**Non-compensable Disability** - A VA determination that a Service-connected disability is not severe enough to warrant monetary compensation.

**Nonservice-Connected (NSC) Pension** - The NSC pension is a monetary benefit awarded to permanently and totally disabled, low-income veterans with 90 days or more of active military service, of which, at least 1 day was during wartime.

**Nonservice-Connected (NSC) Veteran** - A Veteran who does not have a VA determined service-related condition.

**Plan** - A term that refers to the types of coverage offered by an insurance company.

**Policy** - The legal document issued by a company to the policyholder that outlines the conditions and terms of the insurance, also called a policy contract or contract.

**Primary Care Provider** - Physicians, nurse practitioners, and physician assistants who provide ongoing and comprehensive primary care as defined by their privileges or scope of practice and licensure to a panel of assigned patients.

**Service-Connected (SC)** - A VA determination that the illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

**Specialized Transportation** - Ambulance, ambulette, air ambulance, wheelchair van, or other mode of transportation specially designed to transport disabled persons (this would not include a mode of transportation not specifically designed to transport disabled persons, such as a bus, subway, taxi, train, or airplane). A modified, privately-owned vehicle, with special adaptive equipment and/or capable of transporting disabled persons is not a special mode of transportation.

**United States** - The states, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

**Urgent Care** - Care that does not require immediate admission, but one for which there is a pressing need for medical attention.

**VA** – Department of Veteran Affairs.

**VA Facility** – A VA Medical Center (VAMC), VA Outpatient Clinic (OPC), or VA Community Based Outpatient Clinic (CBOC).

**VA Form 10-10EZ (Application for Health Benefits)** – This form must be completed by a Veteran in order to apply for VA health care benefits or enrollment in the VA Health Care System.

**VA Form 10-10EZR (Health Benefits Renewal Form)** - The form that Veterans may use to update their personal, insurance, and financial information.

**Veteran** – A person who served in active military, naval or air service and was discharged or released from service under conditions "other than dishonorable".

**Veteran Identification Card (VIC)** - An identification card issued to a verified eligible Veteran for the specific purpose of identifying the Veteran when seeking VA health care benefits and assisting VHA staff with administrative processing. The VIC is for VA official business only and is only issued to a Veteran after the Veteran's eligibility has been verified.

**VHA** – Veterans Health Administration, a principal unit within VA.



## **For more information on VA Health Care**

**Telephone (toll-free): 1-877-222-VETS (8387)**

**Website: [www.va.gov/healthbenefits](http://www.va.gov/healthbenefits)**

**To download a copy of this book, go to:**

**<http://www.va.gov/healthbenefits/resources/epublications.asp>**

**IB 10-465  
February 2012**

**To learn more about VA Health Care,  
scan this with your smart phone.**



## Emergency Care Provisions

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.

## Enrollment 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.

38 CFR 17.37

Enrollment not required - provision of hospital and outpatient care to veterans

38 CFR 17.37 Enrollment not required - provision of hospital and outpatient care to veterans

§ 17.37 Enrollment not required—provision of hospital and outpatient care to veterans.

Even if not enrolled in the VA healthcare system:

(a) A veteran rated for service-connected disabilities at 50 percent or greater will receive VA care provided for in the “medical benefits package” set forth in § 17.38.

(b) A veteran who has a service-connected disability will receive VA care provided for in the “medical benefits package” set forth in § 17.38 for that service-connected disability.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002]

§ 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, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose

## 38 CFR 17.38 Medical benefits package

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(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]

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, hearings 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).**

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 perpetualized. *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 sub-specialty 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  
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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 en, that it creates, receives, maintain 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 HANDBOOK 1907.01 August 25, 2006 66

*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.

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.

## 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 4

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 VistA Web/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

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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

# FW: schedule

**From:** Fasano, Joseph (Joseph.Fasano@va.gov) You moved this message to its current location.  
**Date:** Thu 11/14/13 3:22 PM  
**To:** Thomesen, Richard (Richard.Thomesen@va.gov)  
**From:** joesepe@msn.com (joesepe@msn.com)

**From:** Schramm, Carl  
**Sent:** Thursday, November 14, 2013 3:21 PM  
**To:** Mirone, Nancy M.; Fasano, Joseph  
**Cc:** Walters, Richard J; Duryea, Margaret  
**Subject:** RE: schedule

Ms. Mirone

Please be advised that Joseph Fasano, one of NFFE's BUE's, has requested union representation for this meeting. With the current climate of this situation NFFE and 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 and the National Federation of Federal Employees, Article 2: Union Rights and Representation, Section 1 & Section 2 and 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, to attend this meeting to represent Mr. Fasano. This meeting will have to be rescheduled. Thank You.

Carl Schramm BSN RN-BC

Vice President

NFFE Local 387



**From:** Mirone, Nancy M.  
**Sent:** Thursday, November 14, 2013 2:29 PM  
**To:** Fasano, Joseph  
**Cc:** Walters, Richard J; Duryea, Margaret; Schramm, Carl  
**Subject:** RE: schedule

This is not a disciplinary meeting. This is a welcome to the service and explaining what you will be doing and introductions.

**From:** Fasano, Joseph  
**Sent:** Thursday, November 14, 2013 2:27 PM  
**To:** Mirone, Nancy M.  
**Cc:** Walters, Richard J; Duryea, Margaret; Schramm, Carl  
**Subject:** RE: schedule

Ok but I would prefer to have union representation to accompany me.

**From:** Mirone, Nancy M.  
**Sent:** Thursday, November 14, 2013 2:25 PM  
**To:** Fasano, Joseph  
**Subject:** RE: schedule

How is 11am tomorrow in my office?

**From:** Fasano, Joseph  
**Sent:** Thursday, November 14, 2013 2:24 PM  
**To:** Mirone, Nancy M.  
**Subject:** RE: schedule

Ok.

**From:** Mirone, Nancy M.  
**Sent:** Thursday, November 14, 2013 2:23 PM  
**To:** Fasano, Joseph  
**Subject:** RE: schedule

I have consulted with HR and the EEO office and they have advised me that you are not entitled to 36 straight hours off AA. HR advises that there is currently no disciplinary action to warrant the use of AA.

You also need to be specific on your EEO activities to substantiate the need for the time. The request at this time is denied.

We would like to welcome you to the department and integrate you into our service and team as we would any other employee. You are officially a Business Office employee and as with any other staff we need to communicate.

I would like to meet with you and April together tomorrow so we can start planning your training and acclimate you to our service.

**From:** Fasano, Joseph  
**Sent:** Thursday, November 14, 2013 1:41 PM  
**To:** Mirone, Nancy M.  
**Subject:** RE: schedule

Ok thanks.

**From:** Mirone, Nancy M.  
**Sent:** Thursday, November 14, 2013 1:40 PM  
**To:** Fasano, Joseph  
**Subject:** RE: schedule

I will let you know shortly if your AA will be approved for Friday and Monday. Please include April Esposito on your messages.

**From:** Fasano, Joseph

**Sent:** Thursday, November 14, 2013 11:15 AM  
**To:** Mirone, Nancy M.  
**Cc:** Thomesen, Richard; Duryea, Margaret; Schramm, Carl; Walters, Richard J  
**Subject:** RE: schedule

Ok thanks.

**From:** Mirone, Nancy M.  
**Sent:** Thursday, November 14, 2013 11:14 AM  
**To:** Fasano, Joseph  
**Cc:** Thomesen, Richard; Duryea, Margaret; Schramm, Carl; Walters, Richard J  
**Subject:** RE: schedule

I did speak to the Chief of HR and they will submit the 52. Chief, Fiscal has been contacted to change your T&L to 416.

**From:** Fasano, Joseph  
**Sent:** Thursday, November 14, 2013 10:44 AM  
**To:** Mirone, Nancy M.  
**Cc:** Thomesen, Richard; Duryea, Margaret; Schramm, Carl; Walters, Richard J  
**Subject:** schedule

Please be advised that I request AA on Friday 11/15/13 and Monday 11/18/13 to participate and prepare for the following protected activities:

\*IAW VHA handbook 5021 and the NFFE Master Agreement (Article 26 Section 3 Part B #2) I am entitled to preparatory time to respond to Major Adverse Actions such as reassignments and transfers.

\*IAW VHA handbook 0700 I am entitled to preparatory time to respond to AIBs; especially since the agency refuses to release a copy of the report justifying above Major Adverse Action and the status of the AIB is quite nebulous with this "external review."

\*IAW CFR 1614 I am entitled to preparatory time for continued participation in EEO(C) activities.

\*I consider the "reporting in demands" and "checking in" on my constant whereabouts a form of a proxy time card.

\*Since no sort of paper work or information has been furnished other than a Return to Work letter and Reassignment Letter with precious little details and in the absence of a form 52 being formally cut, I am still task organized under Extended Care, thus making leave requests in EMT impossible, therefore until such time that this supervisory/ task organizational issue is clarified in writing I will communicate leave requests by e-mail.

I request AA on Thursday 11/21/13 from 1300 – 1630 to participate in a Stony Brook University School of Nursing speaking engagement/event that I get invited to every semester.

I request AL on Wednesday 11/27/13 and Friday 11/29/13.

I can be reached at ext. 7732 currently.

Thank you in advance for your cooperation and support.

**SUBJECT:** Notification of Reportable Event to the VISN

**1. PURPOSE AND SCOPE:** To delineate the notification procedures for the communication of incidents. Notification serves two functions:

A. It provides timely information on an emerging situation so that senior management at the facility and at the Network are prepared to address critical questions posed by members of Congress, the press, stakeholders, or others;

B. It allows for consultation and direction on managing the situation from senior management.

**2. POLICY:**

A. Medical Center and Network management are to be notified of any incident reflecting potential risk management and/or safety issues.

B. Management and Network management must be notified immediately (within an hour or two of the occurrence).

**3. DEFINITION: A NETWORK REPORTABLE EVENT** is any clinical event involving significant adverse patient outcome (e.g. suicide, attempted suicide, unexpected death, assault/injury/elopement depending on the circumstances). In addition, any other incident, event or issue that could be potentially controversial or newsworthy or could negatively impact VA's image as a healthcare provider or employer meets this definition.

**4. PROCEDURES/RESPONSIBILITIES FOR REPORTING:**

**A. DURING ADMINISTRATIVE HOURS** (Monday through Friday:  
8:00 A.M. - 4:30 P.M.)

1.) When a reportable incident (as described above) occurs during administrative hours, the employee first aware of the incident will communicate the information to his/her Service Chief.

2.) The Service Chief will gather the immediate pertinent facts and notify the Associate Director, Chief of Staff and Local Unions as appropriate.

3.) A management representative (Director, Associate Director, Chief of Staff) will contact the Office of the Network Director immediately. This notification will be made by telephone and will include a brief report of the event, the action(s) being taken, and an indication of any media or Congressional interest. A Patient Safety Registry Report with a brief description of the issue/incident will be prepared by the Performance Improvement Manager, for the

signature of the Medical Center Director, and will be faxed or sent electronically via Outlook to the mail group "V03 Adverse Event Notification" to the Office of the Network Director following the telephone call. The Patient Safety Registry Report will be retained in the Performance Improvement office.

B. DURING NON-ADMINISTRATIVE HOURS (WHEN – weekends, holidays, evenings, nights):

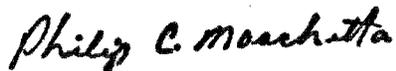
1.) The employee first aware of an incident will communicate the information to the Administrative Officer of the Day (AOD) at extension 2655.

2.) The AOD will gather the immediate pertinent facts, prepare a summary and time line for Top Management review at Morning Report. Within one hour from the time of the incident, the AOD will notify:

- a.) Director
- b.) Associate Director
- c.) Chief of Staff

3.) The Medical Center Director will notify the Network Director either at the Network Office or at home depending on the time of notification.

**5. RESCISSION:** Center Memorandum 00-113, Notification of Reportable Event to the VISN, dated [February 23, 2009] is hereby rescinded.



PHILIP MOSCHITTA  
Director

DISTRIBUTION: B

RESPONSIBLE SERVICE: (00PI)

**SUBJ: PATIENT SAFETY IMPROVEMENT PROGRAM**

1. **PURPOSE:** Prevent inadvertent harm to patients' consequent to their medical care.

2. **BACKGROUND:** VHA began to put special focus on patient safety improvement in 1997, and began operation in February 1999 of the National Center for Patient Safety (NCPS) to develop and implement VHA's patient safety programs. In late 1999, the Institute of Medicine (IOM) published the "To Err is Human" report, which brought national attention to the problem of adverse events in health care, and included the estimate that adverse events were causing from 44,000 to 98,000 deaths per year. The first version of the VHA Patient Safety Improvement Handbook was developed in 1998. An updated version was distributed in 1999 to provide guidance on preventing adverse events through implementing new methods at Department of Veterans Affairs (VA) medical centers to better understand and address local problems. Then and now, it is necessary for VA administrative and clinical staff members to have a clear picture as to what is actually happening in their health care settings so that appropriate steps can be taken to prevent harm to patients.

3. **POLICY:** This policy delineates what types of events are to be considered within the patient safety program and how they should be addressed, as well as defining the disposition of other adverse events resulting from a criminal act; a purposefully unsafe act; an act related to alcohol or substance abuse by an impaired provider or staff; or events involving alleged or suspected patient abuse of any kind.

4. **DEFINITIONS:**

A. Adverse Events: Adverse Events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, other VHA facility.

1.) Adverse events many result from acts of commission or omission (e.g., administration of the wrong medication, failure to make timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment).

2.) Some examples of more common adverse events include: patient falls, adverse drug events, procedural errors or complications, completed suicides and missing patient events.

B. Sentinel Event: Sentinel Events are a type of Adverse Event defined by The Joint Commission (TJC) which are unexpected occurrences involving death, serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes.

1.) Sentinel Events signal the need for immediate investigation and response. Immediate investigations may be an RCA, or, in the case of an intentionally unsafe act, administrative action.

2.) Some examples of reviewable Sentinel Events include:

a.) Hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities.

b.) Surgery on the wrong patient or wrong body part,

c.) Unintended retention of a foreign object in a patient after surgery or other procedure

d.) Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge

e.) There are six other types of sentinel events presently identified by TJC (Attachment A).

C. Close Call: A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as “near miss” incidents.

- 1.) An example of a close call would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of identification, but caught prior to the procedure.
- 2.) Close calls are opportunities for learning and afford the chance to develop preventive strategies and actions; they receive the same level of scrutiny as adverse events that result in actual injury. They require reporting and documentation in the Patient Safety Information System (PSIS).

D. Intentionally Unsafe Acts:

- 1.) Intentionally unsafe acts, as they pertain to patients, are any events that result from:
  - a.) A criminal act,
  - b.) A purposefully unsafe act,
  - c.) An act related to alcohol or substance abuse by an impaired provider and/or staff, or
  - d.) Events involving alleged or suspected patient abuse of any kind.
- 2.) Intentionally unsafe acts must be dealt with through avenues other than those defined in this policy (i.e. Administrative Investigation Boards (AIB) or other administrative methods) as determined by the Director and by applicable directives and regulations. Acts must be reported immediately to the Chief of Staff and Director.
- 3.) If an event involves what appears to be an intentionally unsafe act, an AIB or similar review may be appropriate and an RCA may be inappropriate. However, in some cases it may be appropriate to do both types of reviews, e.g., an AIB might review a procedure or aspect of care performed by a provider who might not have the appropriate credentials or privileges, and an RCA on the same topic might review the local processes for credentialing and privileging. An AIB cannot use information from an RCA. If there is an intention to perform both types of reviews on the same incident, the RCA should normally be performed after the completion of AIB. In the event that an AIB is performed after an RCA is started, members of the RCA team are not to serve on the AIB team or review group to ensure that the confidentiality of the RCA process is appropriately maintained and that the perception of the integrity of the RCA process is preserved.
- 4.) After an AIB is completed in response to an adverse event or close call that had been initially referred for RCA, the AIB is to be reviewed by the facility PSM. The PSM is to consult with the RCA team, if one had been initially convened to review the adverse event or close call. If the PSM or RCA team are not satisfied that the AIB has identified systems issues for follow up, then the PSM needs to communicate with the Director to recommend that an RCA Team be convened or reconvened. The purpose of the ensuing RCA is to identify any systems issues that may not have been identified in the AIB.
- 5.) If a crime is suspected to have been committed, appropriate officials (e.g., VA Police and Security) must be notified as soon as possible.
- 6.) Information regarding actual, or possible, violations of criminal laws related to VA programs, operations, facilities, or involving VA employees, where the violation of criminal law occurs on VA premises, must be reported to the VA police.

E. Patient Safety: Patient Safety is ensuring freedom from accidental or inadvertent injury during health care processes.

F. Root Cause Analysis (RCA): Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. An RCA is a specific type of focused review that is used for all adverse events or close calls requiring analysis. Consistent use of RCAs further refines the implementation and increases the quality and consistency of focused reviews.

To avoid confusion, the term RCA is used to denote this type of focused review and must adhere to the procedures provided in this policy. RCAs need to be initiated with a Director's specific charter memorandum, and the term "Root Cause Analysis" needs to be used in documents so that they are protected and deemed confidential under 38 U.S.C. 5705, and its implementing regulations.

1.) RCAs have the following characteristics:

- a.) The review is interdisciplinary in nature with involvement of those knowledgeable about the processes involved in the event.
- b.) The analysis focuses primarily on systems and processes rather than individual performance.
- c.) The analysis digs deeper by asking "what" and "why" until all aspects of the process are reviewed and the contributing factors are considered.
- d.) The analysis identifies changes that could be made in systems and processes through either redesign or development of new processes, and systems that would improve performance and reduce the risk of the adverse event or close call recurrence.

2.) To help adhere to these characteristics, the following five guidelines need to be considered when developing root cause statements:

- a.) Root cause statements need to include the cause and effect,
- b.) Negative descriptions are not to be used in root cause statements,
- c.) Each human error has a preceding cause,
- d.) Violations of procedure are not root causes, but must have a preceding cause, and
- e.) Failure to act is only a root cause when there is a pre-existing duty to act.

3.) To be thorough, an RCA must include:

- a.) A determination of the human and other factors most directly associated with the event or close call and the processes and systems related to its occurrence.

There is rarely only one underlying cause.

- b.) Analysis of the underlying systems through a series of "why" questions to determine where redesigns might reduce risk.
- c.) Identification of system vulnerabilities or risks and their potential contributions to the adverse event or close call.
- d.) Determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

4.) To be credible, an RCA must:

- a.) Included participation by the leadership of the organization (this can range from chartering the RCA team, to direct participation on the RCA team, to participation in the determination of the corrective action plan) and by individuals knowledgeable about the processes and systems.

- b.) Exclude individuals directly involved in the adverse event or close call under review. In the interest of objectivity, these individuals are not to be part of the RCA team. However, their experience and knowledge of the situation is vital to the RCA process, so they need to be interviewed as part of the RCA process and asked for suggestions about how to prevent the same or similar situations from

happening again.

c.) Be internally consistent (i.e., not contradict itself or leave obvious questions unanswered).

d.) Include consideration of relevant literature.

e.) Include corrective actions, outcome measures, and top management approval.

f.) Meet the Nation Council Patient Safety (NCPS) and The Joint Commission (TJC) requirements. NCPS provides a computer assisted tool, that must be used to guide RCA teams, document the RCA, and communicate to NCPS and VISN.

5.) Minimum Thresholds for Aggregated Reviews and Individual RCAs: To reduce harm to patients, minimum annual thresholds for Aggregated Reviews and individual RCAs that must be completed by each VA Medical Center and reported to NCPS have been established.

a.) The Facility Director is responsible for ensuring a minimum of eight patient safety analysis processes, i.e., RCAs and Aggregated Reviews, are completed each fiscal year.

(1) At least four of the analyses must be individual RCAs with the balance being Aggregated Reviews or additional individual RCAs. The fiscal year to which the activity is attributed is determined by the date of the facility Director's signature on the completed document.

b.) Requirements for Individual RCAs:

(1) At a minimum, each facility must conduct four individual RCAs a year.

(2) Determination of whether or not to conduct an individual RCA continues to be guided by the SAC.

c.) Requirements for Aggregated Reviews:

(1) Every fiscal year, each facility must conduct at least one Aggregated Review per quarter in each of four required areas, and in the following order: Falls, Missing Patients, Adverse Drug Events, and Para suicides and Outpatient Suicides.

(2) A fifteen (15) day "close out period" is available immediately following the data cycle for each of the four categories of Aggregated Review. The 15 calendar days are intended to allow PSMs to finalize and organize data that has been received during the previous twelve (12) months.

(3) If a facility has zero events in one of the four Aggregated Review categories, an Individual RCA or "wild card" Aggregated Review may be performed to achieve the minimum number of eight Individual RCAs or Aggregated Reviews. If only one event is reported in one of the four aforementioned categories then an individual RCA must be performed on the reported event. wild card aggregated review may be completed on the same schedule as the aggregated review for which it is being substituted, or may be completed at another time during the fiscal year.

(4) "Wild Card" Aggregated Reviews are those completed on a category of adverse event other than one of the four Aggregated Review categories. These may be done on a category of adverse event of the facility's choosing. When the actual or potential SAC score is three for an even that is not in one of the four Aggregated Review categories an RCA must be chartered; the adverse event may not be assigned to a "wild card" Aggregated Review.

6.) Root Cause Analysis (RCA) Reporting:

a.) Completed RCA is submitted to VISN and NCPS.

b.) Reporting to TJC is optional and is not required by the VHA Patient Safety Program. Reporting to TJC entails consultation with the VISN. In either case, the event receives an RCA and results are reported to the PSIS and, if previously reported to TJC, to them as well. The report of the RCA's outcome must be completed within forty-five (45) calendar days.

c.) The RCA report is retained by the facility even after the results have been entered into the PSIS so that the report can be made available for future review and learning as appropriate. For detailed and relevant information on recordkeeping see VHA Records Control Schedule (RCS) 10-1 (RCS 10-1).

d.) All adverse events and close calls must be entered into PSIS using the "SPOT" software system. In this way all events reported are captured in the PSIS, even if they have SAC scores less than three. Those that receive a score of three (actual or potential) must receive RCA or aggregate review. Only patient safety events, and not intentionally unsafe acts, are to be entered into SPOT.

e.) The Office of Medical Inspector (OMI) and the POG monitor RCAs and AIs to assess their adequacy and to identify problems with processes of care that warrant attention. The OMI may conduct reviews and site visits at the request of the Secretary of Veterans Affairs, the Under Secretary for Health for Operations and Management, OIG, veterans and their families, the VISNs and medical facilities, and to other stakeholders, such as Congress and Veterans Service Organizations. The OMI may also conduct reviews and site visits based on its own judgment.

G. Proactive Risk Assessment: Proactive Risk Assessment is a method of evaluating a products or process to identify systems vulnerabilities, and their associated corrective actions, before an adverse event occurs. Proactive Risk Assessment models include Healthcare Failure Mode and Effects Analysis (HFMEA) and Failure Mode Effect Analysis (FMEA).

**5. GOALS:** The Patient Safety Program's goal is to prevent harm to patients, visitors, and personnel. This is accomplished by taking small steps in the way things are done so that the level of faith and trust in the VHA patient safety system is established and behaviors designed to prevent adverse events become a part of all employee behavior. Building blocks for accomplishing this goal are:

A. Identifying and reporting adverse events (including Sentinel Events), and close calls

B. Reviewing adverse events and close calls to identify underlying causes and implementing changes needed to reduce the likelihood of recurrence. The determination of cause is aimed at the system issues and is not to be used as a punitive tool. The requirements for initiating a review is determined by the prioritization method defined by Safety Assessment Category (SAC) (Appendix B)

C. Completing at least one Proactive Risk Assessment per year for each TJC accredited program.

D. Implementing practices appropriate to VA settings that have shown to be effective in preventing adverse events elsewhere. These include practices from other VA medical centers, or in non-VA hospitals, as described in the published literature, in communications from NCPS (such as through "toolkits" and the NCPS web page), or through publications, notices, and web sites from other organizations.

E. The PSIS must be used to track and monitor reported adverse events. Data concerning the reported events must be entered into the PSIS by designated staff to ensure the accuracy of data recorded.

## **6. IDENTIFICATION AND REPORTING OF ADVERSE, SENTINEL EVENTS, AND CLOSE CALLS AND HOW TO ADDRESS INTENTIONALLY UNSAFE ACTS:**

A. Facility staff must report any unsafe conditions of which they are aware, even though the conditions have not yet resulted in an adverse event or close call to the Quality Manager. Quality Manager (QM) reviews reports with Patient Safety Manager.

B. The PSM uses the SAC Matrix to determine what action is required. The SAC is determined by the Patient Safety Manager or designee. This action could range from reporting to the VISN, NCPS, and TJC with the

associated RCA performed and corrective action plan, to a decision to do nothing at the present time due to the low priority accorded the event from its SAC score.

C. Any report of an adverse event or close call as defined in this policy received by the Quality Manager, PSM, or designee, is protected from disclosure under 38 U.S.C. 5705, as part of a Medical Quality Assurance Program. The only exceptions to this protection would be in cases of an intentionally unsafe act as defined as a criminal act; an act related to alcohol or substance abuse by an impaired provider or staff; or events involving alleged or suspected patient abuse.

D. Incident Reporting and Analysis: Incident Reporting is every employee's responsibility and is an important factor in Northport's commitment to patient safety and quality of care. The emphasis is on improving systems and processes, supporting a culture of no blame and accountability in an effort to improve patient safety and quality of care. The accurate and timely reporting of incidents to Patient Safety and Quality Management is a collaborative effort that must be supported by all staff, services and supervisors.

- 1.) Event occurs or there is a discovery of an event (includes Adverse Event, no harm or close call (near miss).
- 2.) Ensure intervention as indicated to protect patient. (All patients with potential for injury including physical, psychological and/or emotional responses must have medical evaluation).
- 3.) Incident Report (10-2633) must be completed by the person who witnessed/discovered the event or the most clinical person whom the incident has been reported to.
  - a.) The incident report can be located as a paper copy in each service area or on the Northport Web-page.
  - b.) Complete *all sections* on the form. Tell the story (who, what, when, where and how.)
  - c.) [Completed Incident Reports must include the date and time of the report, the printed name and signature of the person completing the report and the supervisor on duty. Include a contact number/extension.
  - d.) Notify Manager, Supervisor and/or NOD of all allegations of abuse or Level 3 injuries. Service Chiefs must be notified.
  - e.) Every effort must be made to have the incident report completed prior to the end of your tour/shift. If unable to ensure complete incident report prior to end of tour/shift, notify supervisor. Fax to the Performance Improvement Department at 631-544-5313, or hand deliver incident report.
  - f.) The original/completed report must be delivered to QM/Patient Safety within 24 business hours. **NOTE:** *Sequester any equipment or product that is suspected to have malfunctioned and notify supervisor.*
- 4.) Quality Management/Patient Safety will review and initiate immediate actions as required.
- 5.) Patient Safety Manager or designee to determine SAC score. All incidents will be entered into the Patient Safety Information System (PSIS).
- 6.) QM is responsible for Incident Reporting follow-up. Follow-up actions may include;
  - a.) Incident Review: The need for an Incident Review [or Fact Finding] will be determined by QM/Patient Safety [or designee]. [Fact Finding must be  [completed  within seventy-two (72) business hours.
  - b.) Individual or Aggregate Root Cause Analysis (RCA).

c.) Referral to appropriate service area/department for communication and follow-up as determined by supervisor.

d.) Consideration/Recommendation for Institutional Disclosure.

7.) The completed incident report is forwarded to the [Chief of Performance Improvement (PI)] and the Director for review/signature when an RCA is to be chartered.

8.) Staff who submit adverse event reports/close call reports that result in an RCA [may] receive feedback from the Patient Safety Manager on the actions being taken as a result of their report.

## **7. INFORMING PATIENTS ABOUT ADVERSE EVENTS:**

A. Clinicians and organizational leaders must work together to ensure that disclosure is a routine part of the response to adverse events. Telling patients that their health has been harmed rather than helped by the care provided is never easy, and disclosure must be undertaken with skill and tact. Nonetheless, VHA requires disclosure to patients who have been injured by adverse events.

B. Disclosing adverse events to patients and their families is consistent with VHA core values of trust, respect, excellence, commitment, and compassion. Clinicians are ethically obligated to be honest with their patients. Honestly discussing the difficult truth that an adverse event has occurred demonstrates respect for the patient and a commitment to improving care.

C. VHA policy requiring disclosure is consistent with TJC requirements that hospitalized patients and their families be told of “unanticipated outcomes” of care.

D. Despite the general obligation to disclose adverse events to patients, there are legal restrictions that limit disclosures that violate patient privacy.

1.) Specifically, the Privacy Act limits disclosures to families, and 38 U.S.C. 7332 limits disclosures related to the patient’s treatment for substance abuse (including alcohol, sickle cell anemia disease, and Human Immunodeficiency Virus (HIV) status even after a patient’s death.

2.) Similarly, there are legal limitations on disclosure of information obtained from RCAs and other quality improvement activities protected under 38 U.S.C. 5705. VHA may not disclose U.S.C. 5705 to patients and families.

## **8. PROCEDURES FOR INFORMING PATIENTS ABOUT ADVERSE EVENTS:**

Background Information:

A. Compensation for [Injured] Patients: The two primary options available to injured patients or their survivors are claims for compensation under 38 U.S.C., Chapter 11, Section 1151, and tort claims under the Federal Tort Claims Act, Title 28 U.S.C., sections 1346 (b), 2671-2680.

1.) Claims under 38 U.S.C. Section can result in payment of monthly benefits for additional disability or death incurred as the result of VHA facility care, medical or surgical treatment or examination, if the disability or death was proximately caused by negligence or an unforeseen event. Claims under section 1151 provide for the payment of a monthly benefit based on the percentage of disability and eligibility for VA medical care. Claims for 1151 benefits are processed by Veterans Benefits Administration (VBA) Regional Offices.

2.) Tort claims may result in a settlement by Regional Counsels, General Counsel, United States Attorney, or in a judgment if a Federal Court determines that negligence by medical practitioners caused injury or death (and jurisdictional requirements are met). The claimant frequently receives money in a lump sum payment, but structured settlements, which can include annuities, medical trusts, future payments, and reversionary interests, are also used where appropriate. Tort claims can result in monetary awards for pain and suffering,

which are not necessarily included in veteran's benefits. Tort settlements or judgments can also be used to provide for family members in ways that veteran's benefits statutes do not allow. However, an attorney is usually retained, and attorney fees capped at 20 (administrative settlements) to 25 (litigation) percent of the damages reduce the award the veteran or survivors receive. Tort claims are processed by the Regional Counsels.

3.) Veterans and survivors may pursue both section 1151 and tort claims.

4.) New York State Licensing Board and National Practitioner Data Bank issues will be coordinated with the Office of the Director of Medical/Legal Affairs.

**9. PROCEDURE FOR MEDICAL DEVICE REPORTING:**

A. Serious Injury includes at least one of the following:

- 1.) Is life threatening
- 2.) Results in permanent impairment of a body function or permanent damage to the body structure; or
- 3.) Necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure (irreversible damage or impairment that is not trivial).

B. Medical Personnel is an individual who is licensed, registered or certified to administer healthcare, who have received a diploma or a degree in a professional or scientific discipline, or who are responsible for receiving medical complaints or adverse event reports, or who supervise such persons.

C. Reportable Medical Device Related Incident: Medical centers are required to report to the FDA and manufacturer when made aware of information that reasonably suggests that a medical device has or may have caused or contributed to a patient death, and to the manufacturer when a device has or may have caused or contributed to a serious illness or serious injury as defined by the Safe Medical Devices Act of 1990.

- 1.) Manager refers to the Supervisor on duty during regular business hours as well as the evening/weekend on-call administrative designee.
- 2.) When an employee has acquired information that reasonably suggests that a Medical Device Reportable Event has occurred, that employee is required to immediately inform Supervisor/Management.
- 3.) If the employee discovers or witnesses the event:
  - a.) The employee who is present will first ensure that the patient receives immediate, appropriate medical assistance.
  - b.) The employee will immediately notify the Supervisor and complete Report10-2633.
  - c.) The Supervisor will immediately conduct a preliminary assessment of the event and complete an Adverse Event Investigation Form.
  - d.) Any device that is suspected to have caused or contributed to the event will be isolated and preserved until Chief Bio-Medical Engineering and the Medical Director determine the appropriate disposition of the equipment.
  - e.) The PI Manager will ensure communication with the Medical Director, Administrative Services, [] the Medical Supplier, Legal Counsel, and other entities as appropriate to determine whether the event meets the criteria for reporting as defined in Safe Medical Device Act (SMDA).
  - f.) If the event is reportable, the Supervisor/Manager will ensure that the Confidential Medical Device Incident Investigation Form is completed within twenty-four (24) hours and faxed to the PI Manager.

**D. WHAT TO DO IN CASE OF AN EQUIPMENT-RELATED ACCIDENT OR INCIDENT:**

1.) User facility means a hospital, ambulatory surgical facility, nursing home, outpatient diagnostic facility, or outpatient treatment facility. Home Healthcare is considered to be an outpatient treatment facility.

2.) An Adverse Event related to equipment means a death or serious injury that was or may have been caused by a medical device, or that a medical device was or may have been a factor in a death or serious injury/illness, including events occurring as a result of:

- a.) Failure,
- b.) Malfunction,
- c.) Improper or inadequate design,
- d.) Manufacturer,
- e.) Labeling, or
- f.) User error

3.) Facilitate equipment-related accident control and investigation by taking the following actions immediately after every significant incident:

- a.) Undertake emergency measures to minimize and care for injury, discomfort, and threat to life (e.g., thermal burns, electric shock, contusions, lacerations or fractures, cardiac arrhythmias, interruption of normal respiration loss of consciousness) in patients or personnel.
- b.) Undertake appropriate action to minimize damage to equipment and the environment.
- c.) Notify the attending physician who has the legal responsibility for the victim.
- d.) During normal working hours, notify the Chief of Engineering, or his or her designee. During WHEN hours notify Nursing Officer of the Day (NOD) who will notify Chief Engineering as required.
- e.) Sequester all equipment attached to or continuous to the injured party in the same room or area. Do not disconnect or change the relative physical positions of equipment or connecting cables, except as absolutely necessary to avoid further injury or damage. Retain and preserve any disposable products that may have been involved (e.g., drapes, electrodes), as well as their packaging materials.
- f.) Call and report the device problem to Clinical Engineering, including which equipment was involved in an incident. Make sure to include an accurate and unique identification of the device in question (i.e., property number).
- g.) Complete incident form, PI staff will submit required reports to the Food and Drug Administration (FDA) or other manufacturer.
- h.) Biomed Engineer and PI Manager will coordinate a multidisciplinary evaluation of the incident to determine the contribution of the device to the incident and, therefore, if the incident is reportable to the Food and Drug Administration (FDA). When necessary, a multidisciplinary review team including risk management, clinical engineering, a nurse, a physician, a representative of department initiating the incident report, and additional professional staff, as necessary, will review the incident to determine if it is reportable according to the Safe Medical Devices Act (SMDA). If the evaluation determines that an SMDA report is required, it will be completed by the evaluation team and forwarded to the manufacturer of the device and/or the FDA, as required by law, and any other agencies. Findings will be reported to the department involved, the Medical Center Environment of Care Committee, Director, Performance Improvement, and Patient Safety as appropriate.

**10. EDUCATION:** The Performance Improvement Manager and Patient Safety Officer will provide guidance and education to the Medical Center staff in implementing this policy and training of Administrative Investigation Board members prior to their conducting a Board of Investigation. The Patient Safety Officer will assure that:

A. All employees receive orientation in regard to the provisions of this Center Memorandum and the procedures to be followed, by their service. All employees receive an annual update during the yearly mandatory training. Training opportunities available through NCPS are made available to appropriate staff.

B. All members of a Root Cause Analysis receive orientation and training on the procedures to follow in regard to conducting a Root Cause Analysis.

**11. ANNUAL PATIENT SAFETY REPORT:** A written report is prepared annually summarizing system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences. This report is communicated to Senior Management through appropriate and applicable committees.

**12. REFERENCES:**

- A. Center Memorandum 00-154 Disclosure of Adverse Events to Patients.
- B. VHA Handbook 0700, Administrative Investigations
- C. VHA National Patient Safety Handbook 1050.1
- D. Center Memorandum 05-46, "Patient Abuse".
- E. Center Memorandum 001-126, "Safety Management Program".
- F. VHA Handbook 1907.01 Health Information Management and Health Records August 25, 2006
- G. Center Memorandum 00-135 Safe Medical Devices Act Reporting Policy.
- H. Center Memorandum 00-136 Product Recalls, Hazard Alerts and Safety Notices.
- [ I. Center Memorandum 00-128 Quality Management and Patient Safety Activities that can Generate Confidential Documents.]

**13. RESCISSION:** Center Memorandum 00-134, Patient Safety Reporting Program (Potential/Actual Events) dated [May 18, 2010].

**14. ATTACHMENTS:**

- A. The Joint Commission (TJC)
- B. Patient Safety Assessment Code (PSAC) Matrix and Probability Categories
- C. Review and Preliminary Fact Finding Report
- D. Administrative Investigation Boards
- E. Employee Rights and Obligation Statement
- F. Patient Incident Reporting Process

PHILIP C. MOSCHITTA  
Director

Dist: A  
Responsible Service: Patient Safety Officer (00)

**ATTACHMENT A**

## **THE JOINT COMMISSIONS'S DEFINITION OF REVIEWABLE SENTINEL EVENTS THAT MAY BE REPORTED TO THE JOINT COMMISSION**

The following criteria define the subset of Sentinel Events that, at the facility's discretion, are voluntarily reportable, to the Joint Commission (TJC). **NOTE:** As TJC policies are dynamic, it is important to be sure that the most recent TJC Sentinel Event Policies and definitions are used in making any determination. The following text was taken from TJC web page at: <http://www.jointcommission.org/SentinelEvents>; *this site needs to be checked periodically for updates or changes in policies.*

1. Only those Sentinel Events that affect recipients of care (i.e., patients, clients, and Veterans Health Administration (VHA) nursing home and domiciliary residents) and that meet the following criteria fall into the subset of Sentinel Events that are voluntarily reportable to TJC:

A. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or

B. The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- 1.) Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting, or within seventy-two (72) hours of discharge;
- 2.) Unanticipated death of a full-term infant;
- 3.) Abduction of any patient receiving care, treatment, and services;
- 4.) Discharge of an infant to the wrong family;
- 5.) Rape;
- 6.) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;
- 7.) Surgery on the wrong patient or wrong body part;
- 8.) Unintended retention of a foreign object in a patient after surgery or other procedure;
- 9.) Severe neonatal hyperbilirubinemia (bilirubin more than (>) 30 milligram per deciliter);
- 10.) Prolonged fluoroscopy with cumulative dose >25 percent above the planned radiotherapy dose.

2. TJC provides detailed footnotes on several of the preceding types of events in their document on sentinel events. Links and a guide to up-to-date TJC policies regarding Sentinel Events and Reportable Sentinel Events are on-line at the National Center for Patient Safety Intranet site: <http://vaww.ncps.med.va.gov/>.

**ATTACHMENT B**

## THE SAFETY ASSESSMENT CODE (SAC) MATRIX

The Severity Categories and the Probability Categories that are used to develop the Safety Assessment Category (SACs) for Adverse Events and Close Calls are presented below, and are followed by information on the SAC Matrix.

### SEVERITY CATEGORIES

A. Key factors for the severity categories are: extent of injury; length of stay; level of care required for remedy, and; actual or estimated physical plant costs. These four categories apply to actual Adverse Events and potential events (Close Calls). For actual Adverse Events, the PI Manager will assign severity based on the patient's actual condition.

B. If the event is a Close Call, assign severity based on a reasonable "worst case" systems level scenario.

**NOTE:** For example, if you entered a patient's room before they were able to complete a lethal suicide attempt, the event is catastrophic, because the reasonable "worst case" is suicide.

<p><b>Catastrophic</b></p> <p><u>Patients with Actual or Potential:</u> Death or major permanent loss of function (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying condition (i.e., acts of commission or omission). Or any of the following: A. Suicide (inpatient or outpatient) B. Rape C. Hemolytic transfusion reaction D. Surgery/Procedure on the wrong patient or wrong body part E. Infant abduction or infant discharge to the wrong family</p> <p><u>Visitors:</u> A death; or hospitalization of 3 or more visitors. <u>Staff:</u> A death or hospitalization of 3 or more staff. <u>Fire:</u> Any fire that grows larger than an incipient stage.</p>	<p><b>Major</b></p> <p><u>Patients with Actual or Potential:</u> Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying conditions (i.e., acts of commission or omission) [or any of the following: A. Disfigurement B. Surgical intervention required C. Increased length of stay of more than 3 patients D. Increased level of care for more than 3 patients</p> <p><u>Visitors:</u> Hospitalization of 1 or 2 visitors <u>Staff:</u> Hospitalization of 1 or 2 staff or 3 or more staff experiencing lost time or restricted duty injuries or illnesses. <u>Equipment or facility:</u> Damage equal to or more than \$100,000.</p>
<p><b>Moderate</b></p> <p><u>Patients with Actual or Potential:</u> Increased length of stay or increased level of care for 1 or 2 patients. <u>Visitors:</u> Evaluation and treatment for 1 or 2 visitors (less than hospitalization). <u>Staff:</u> Medical expenses, lost time or restricted duty injuries or illness for 1 or 2 staff. <u>Equipment or facility :</u> Damage more than \$10,000 but less than \$100,000. <u>Fire:</u> Incipient stage or smaller.</p>	<p><b>Minor</b></p> <p><u>Patients with Actual or Potential:</u> No injury, nor increased length of stay nor increased level of care <u>Visitors:</u> Evaluated and no treatment required or refused treatment. <u>Staff:</u> First aid treatment only with no lost time, nor restricted duty injuries nor illnesses. <u>Equipment or facility:</u> Damage less than \$10,000. or loss of any utility without adverse patient outcome (e.g., power, natural gas, electricity, water, communications, transport, heat and/or air conditioning).</p>

### PROBABILITY CATEGORIES

**A. Probability Categories**

- 1.) Like the severity categories, the probability categories apply to actual adverse events and close calls.
- 2.) In order to assign a probability rating for an adverse event or close call, it is ideal to know how often it occurs at your facility. Sometimes the data will be easily available because they are routinely tracked (e.g., falls with injury, Adverse Drug Events (ADEs, etc.). Sometimes, getting a feel for the probability of events that are not routinely tracked will mean asking for a quick or informal opinion from staff most familiar with those events. Like the severity categories, the probability categories apply to all actual adverse events and close calls.
- 3.) In order to assign a probability rating for an adverse event or close call, it is ideal to know how often it occurs at your facility. Sometimes the data is easily available because the events are routinely tracked (e.g., falls with injury, ADEs, etc.). Sometimes, getting a feel for the probability of events that are not routinely tracked will mean asking for a quick or informal opinion from staff most familiar with those events. Sometimes it will have to be the best educated guess.

- a.) **Frequent** - Likely to occur immediately or within a short period of time (may happen several times in 1 year).
- b.) **Occasional** - Probably will occur in time (may happen several times in 1 to 2 years).
- c.) **Uncommon** - Possible to occur in time (may happen sometime in 2 to 5 years).
- d.) **Remote** - Unlikely to occur (may happen sometime in 5 to 30 years).

**B. How the Safety Assessment Codes (SAC) Matrix Looks**

Severity & Probability	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

**C. How the SAC Matrix Works**

A severity category with a probability category for either an actual event or close call, will get a ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk). These ranks for doing comparative analysis and for deciding who needs to be notified about the event.

**D. Reporting**

- 1.) All known reporters of events, regardless of SAC score (one, two, three,), must receive appropriate and timely feedback.
- 2.) The Patient Safety Manager, or designee, must refer adverse events or close calls related solely to staff, visitors, or equipment and/or facility damage to relevant facility experts or services on a timely basis, for assessment and resolution of those situations.

**1. Review and Preliminary Fact Finding Report** – Based on the initial assessment of an incident, when appropriate the Performance Improvement Manager will conduct a fact finding and/or plan corrective action to improve safety process and/or qualify the SAC. Fact finding will include:

- A. A Chart Analysis and information obtained from 10-2633: The following questions will be addressed after chart analysis and conversations with relevant witnesses to the event:
- B. What exactly was the adverse event? Describe, using objective data, exactly what was witnessed by the recorder (individual completing the 10-2633).
- C. Utilizing processes of chart analysis, establish an overview of the documented chain of events that occurred prior to the adverse event?
- D. What were the causes (direct) of the adverse event and each error?
- E. Did any of the errors involve an inadequate system or system failure? (i.e. communication and/or work flows)
- F. Is there a need to reassess the SAC score and/or relevant systems?
- G. Were immediate actions taken by staff in responding to the adverse event particularly helpful?
- H. Should any peer review actions be initiated?
- I. Are there lessons learned that may be helpful to other staff?

If in the course of conducting a Preliminary Fact Finding it appears that the event under consideration is the result of an Intentional Unsafe Act the team and/or staff member will immediately refer the event to the Facility Director for appropriate action. In such a situation the Performance Improvement Manager will then discontinue their efforts, since the facility director will have assumed the responsibility for any further fact finding or investigation, while still maintaining the information they have already collected confidential as per Title 38 United States Code (U.S.C.) 5705.

## ADMINISTRATIVE INVESTIGATION BOARDS

1. Administrative Investigation Boards: Involve testimony under oath and their documents are not considered to be confidential quality assurance documents under Title 38 U.S.C. 5705 and its implementing regulations.

A. The following factors should be considered in determining whether to convene an Administrative Board of Investigation

- 1.) Impact of the matter on the facility, VA, government, Veterans, and public interests generally, including financial impact;
- 2.) Risk of adverse consequences from recurrence;
- 3.) Need for objective, expert review and analysis of the matter;
- 4.) Seriousness of any suspected misconduct, neglect, etc;
- 5.) Degree to which the cause and essential facts of the matter are known, subject to dispute, or unknown, and the potential for an investigation to determine additional relevant information;
- 6.) Need for evidence to support corrective or disciplinary action or claims for or against VA (see Chapter, Section C paragraph 3 above regarding tort claims against VA);
- 7.) Potential for adverse public, governmental, or media interest; and
- 8.) Other investigations being conducted into the same or closely related subject matter, and the availability and adequacy of those investigations to meet VCA's informational needs.

B. The appointment of the board will be by memorandum and will identify:

- 1.) Type of incident involved
- 2.) Scope of the investigation
- 3.) Size, composition and membership of the board
- 4.) Time-frame for completion of the investigation

C. The individual(s) on the board will not have had any direct or indirect involvement in the incident under investigation.

- 1.) The Director, or designee, will insure there is appropriate professional/non-professional peer representation of any Administrative Board of Investigation. Peer representation is defined as; if Clinical Service personnel are an integral part of an incident, then a knowledgeable Clinical Service employee will be a member of the board; the same applies for Administrative and Support Service personnel.
- 2.) Should the need arise to extend the investigation beyond the scope of authority delegated by the Director, the investigation will cease and the Medical Center Director will determine whether the board should expand the scope of the investigation. The need for investigations should normally proceed independently of any legal or administrative actions.
- 3.) When an investigation is conducted, the board will obtain testimony from witnesses under oath or affirmation which may be recorded, and transcribed verbatim. The transcribed testimony will be reviewed by the testifier who will make any corrections before signing. The employee will be provided a copy of Employee Rights and Obligations (Attachment E) which will be explained to him/her and signed by the employee prior to giving testimony. If the witness declines to have his/her testimony recorded, the board members will query the witness and render their written opinion of the responses made by the employee. The

witness may not be privy to the board members' opinion of the witness' testimony.

4.) Any interviews or formal testimony of bargaining unit employees must be conducted in accordance with rights to union and other representation which may arise under statute or local or national collective bargaining agreement, or union contract. FOR AFGE PROFESSIONAL AND NON-PROFESSIONAL BARGAINING UNIT EMPLOYEES: Employees have the right to be represented by the Union while being questioned in a formal investigation or while being required to provide written or sworn statement. Before such questioning begins or a statement given, employees will be informed of the reasons they are being questioned or asked to provide a statement. The union representative may not answer questions for the witness nor coach the witness prior to their response to a question. When an employee has requested Union representation in an investigative proceeding, the union representative may fully and actively represent the employee and is not limited to the role of an observer.

5.) The report of the investigation will be prepared in the following format:

- a.) Authority
- b.) Purpose
- c.) Scope
- d.) Exhibits
- e.) Findings
- f.) Conclusions
- g.) Recommendations

D. Recommendations resulting from investigations which show a need for quality improvement will be incorporated into the local quality management system. Follow-up to assure implementation of accepted recommendations will be documented.

- 1.) The Investigation Report will include an objective description of the event of the patient/employee, outcomes, (description of injuries or lack of injuries) and corrective action plans initiated.
- 2.) All reports are forwarded to the Patient Services/designee who will review the Adverse Event reports and request any necessary follow-up from appropriate personnel.
- 3.) Notification of Chief of Staff – regarding all injuries – elopements and alleged abuse
- 4.) The original Reports (Investigational Report) and any associated follow-up will be forwarded to the Performance Improvement Manager who will retain all originals on file.
- 5.) The Performance Improvement Department will make an analysis of all events and organizational processes identify priorities for possible improvement and forward this information back to the Director on a quarterly or as needed basis.

**SAMPLE FORMAT OF EMPLOYEE RIGHTS AND OBLIGATIONS STATEMENT**

1. As a Department of Veterans Affairs (VA) employee, you are required to furnish all information or evidence in your possession and to testify freely and honestly concerning your knowledge of the matter under investigation. Any refusal on your part to cooperate, or any concealment of a material fact, or any inaccurate testimony knowingly and willingly given, may be grounds for disciplinary action against you personally.
2. You are not required, however, to give testimony against yourself in any matter in which there is an indication you were involved personally in a violation of the law and there is a possibility testimony would be self-incriminating.
3. Your right to refuse to answer a question on the ground that your response might tend to incriminate you is a personal right. You do not have the right to refuse to answer a question on the ground that your response might incriminate a person other than yourself.
4. You have the right to representation. If at any time during questioning you feel that your rights as an employee are being violated, you may request that questioning be suspended to afford you an opportunity to seek advice from your personal representative in accordance with the rules and regulations of VA, and any applicable collective bargaining agreements.
5. A copy of your own personal testimony will be provided to you upon your request. You will be given the opportunity to read and sign your testimony or affidavit if and when it is transcribed or summarized and to make additions or corrections. If you refuse to have your responses recorded during the investigation, a summary statement is constructed by the investigators. This summary is not available to you for review or modification.

I HAVE READ OR HAVE HAD READ TO ME THE RIGHTS AND OBLIGATIONS OF A VA EMPLOYEE AS OUTLINED ABOVE AND FULLY UNDERSTAND THEM.

\_\_\_\_\_  
Print of Type Name of Employee

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

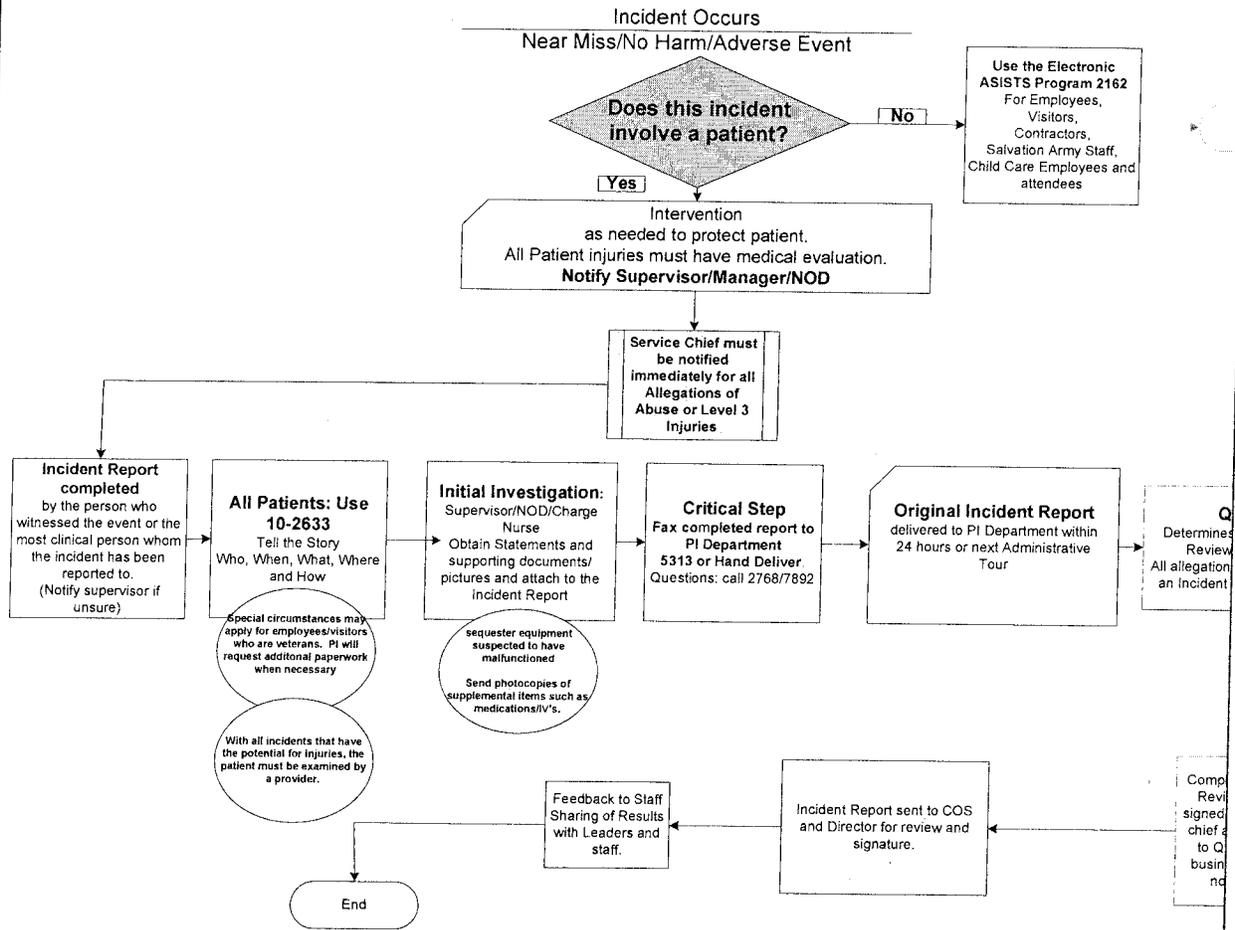
\_\_\_\_\_  
Print or Type Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**ATTACHMENT F**

# Patient Incident Reporting Process (10-2633)



**SUBJ: PATIENTS' RIGHTS/RESPONSIBILITIES/CLINICAL APPEALS PROCESS**

**1. PURPOSE AND SCOPE:** To provide policies and procedures establishing patient rights and responsibilities and to create a mechanism for both internal and external appeals. This mechanism is designed to establish responsibilities and procedures for handling patient issues and/or concerns when an impasse occurs between a patient (or the patient's representative) and the patient's healthcare provider pertaining to the following:

A. Provision of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.

B. Denial of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.

[]

**2. POLICY:**

A. It is the policy of the Medical Center to recognize the basic rights of patients as human beings. Freedoms of expression, decision and action will be guaranteed, as well as a concern for personal dignity; cultural, psychosocial, and spiritual values; and human relationships. Patients/residents/family/guardians shall participate in decisions regarding all aspects of care. Treatment programs shall maintain the fundamental human, civil, constitutional and statutory rights of the individual patient. It is policy of the Medical Center for the organization's code of ethical behavior and business practices to support patient rights (see Attachment A). It is the responsibility of the Medical Center Director and all employees to assure that these rights are preserved.

B. It is the policy of the Medical Center to remain responsive to patient concerns, complaints and questions about their medical care and the services provided. The Northport VAMC encourages patients to bring complaints to the attention of staff for immediate resolution.

C. It is the policy of the Medical Center to make the veteran's visit or stay as pleasant as possible. As part of our service to veterans and to the nation, we are committed to improving healthcare quality. Northport VAMC will train future healthcare professionals, conduct research, and support our country in times of national emergency. In all of these activities, employees will respect and support the veteran's rights as a patient.

D. In providing care, the Medical Center has the right to expect responsible behavior on the part of patients, their relatives and visitors. Patients and visitors are required to abide by VA regulations and Medical Center policies and procedures.

E. It is the policy of the Medical Center that staff members will be educated on patient rights,

and staff's role in supporting those rights.

F. It is the policy of the Northport VAMC that the patients (or patient's representative) have access to a fair and impartial review of disputes regarding clinical determinations or services that is not resolved at the point-of care level. *NOTE: This supports the vital concept that patients will be actively involved in all aspects of care that influence clinical outcomes, including decisions regarding referrals, transfers, discharge planning, and other factors which influence the clinical outcomes of care.*

### **3. RESPONSIBILITIES AND PROCEDURES:**

#### **A. Patient Rights and Responsibilities:**

1.) Health Administration Services (HAS) personnel will issue the Patient Handbook to all first time patients and all admissions to the hospital. The unit administration clerk will issue a copy of the Patient Handbook to all patients who are directly admitted to the patient care unit.

2.) For patients in psychiatric care the admitting physician is responsible for providing to and discussing with each voluntary patient, at the time of admission to Psychiatry, the written Notice of Status and Rights of Voluntary Patients. The physician must sign two (2) copies, giving one copy to the patient and the other for the patient's medical file. For patients who are incapable of understanding their rights, the procedure for involuntary psychiatric treatment/commitment will be followed. *NOTE:* The Patient Handbook is issued by the unit administration clerk to each patient admitted. In cases where the treatment team assesses that the patient is unable to understand his/her rights and responsibilities, the family or guardian (surrogate decision maker) will be issued these materials by the Social Worker.

3.) [The Unit clerk will provide Extended Care residents and their families with a copy of their rights and responsibilities specifically related to the Extended Care Program and the registered nurse will review the Resident Handbook with the resident.] Information will also be provided regarding external protective services. The resident will be informed of any changes in these rights or facility rules during his/her hospital stay. The physician shall assess whether the resident is capable of understanding his/her rights and responsibilities and enter this in the medical record. *NOTE:* For residents in Extended Care who are deemed incompetent, and/or are found by his/her physician to be medically incapable of understanding these rights and responsibilities, or who exhibit a communication barrier, the resident's guardian or next of kin, or other legally authorized responsible person is also permitted to exercise these rights on behalf of the resident. In the event that the resident has no next of kin or other legally authorized responsible person, the Chief of Staff will be appointed legal guardian and will accept knowledge of resident's rights. The Unit Social Worker will be available if needed to assist patients/families/guardians with their understanding of or concerns regarding the resident rights and resident's and family's responsibilities. Staff will ensure that the resident is aware of these rights and responsibilities at the level he or she is capable of

understanding. **NOTE:** Receipt of resident rights and responsibilities will be documented in the medical record verifying that these rights were explained and understood by the recipient and a copy given to him/her. The resident or his/her representative acknowledges, in writing, receipt of this information and any changes to it. In the event the family representative is not here in person to receive a copy of the rights and responsibilities, they will be sent by certified mail to their current address with return receipt requested. A follow-up call within seven days to the representative will verify that the family representative understands the rights and responsibilities. Documentation of follow-up call will be found in the medical record.

4.) Patients are responsible for following their treatment plan. This may include complying with instructions from doctors, nurses, and allied health personnel as they implement the coordinated plan of care. Patients are responsible for their actions. Employees will report abuse by patients upon other patients, visitors and staff to their immediate Supervisor, and complete a 2633.

B. Northport VAMC Clinical Appeals Process:

1.) Clinical Services – Responsibilities and Procedures:

a.) The Clinical Service where treatment was rendered to the patient is the first point of contact to attempt to resolve clinical disputes. Every effort will be made to resolve dispute as close to the point of care as possible.

b.) The Service Chief is responsible for patient concerns, answering questions, and resolving problems at the Service level. The Patient Advocate serves as liaison between patients and the institution, and seeks solutions to problems, perceived problems, concerns or unmet needs. Patients and families will be assisted in obtaining solutions to problems by having the Patient Advocate act on their behalf with any service or section, identifying those who need to be involved in the resolution, coordinating among services when necessary, and recommending alternative policies/procedures to improve service to patients. The Service Chief *will not* refer a patient to the Director's Office unless *all* potential resolutions have been pursued, and the Patient Advocate contacted.

c.) Upon receipt of a patient issue and/or concern, the Clinical Service Chief responsible for the episode of care will conduct a preliminary review in order to determine whether the patient can be maintained safely in the current environment of care. If it is determined that the patient cannot be safely maintained in the current environment of care, the Service Chief will arrange for immediate transfer of the patient to an appropriate setting.

d.) Clinical Service Chiefs will assure clinical disputes are handled through a fair and impartial review process. When this occurs, the Service Chief/Designee who initially reviews the case will invoke national evidence-based standards. When there is an

absence of a national evidence based standard for treatment, the local community based standards *will prevail*.

e.) Clinical Services will have procedures in place for written notification regarding provision/denial of clinical care. The Service Chief/Designee will provide written notification of the Service Chief's final determination to the patient or their representative within seven (7) calendar days after the receipt of the patient issue and/or concern. In addition, this notification will describe the Northport VAMC Clinical Appeals Process. The patient will be advised that in the event he/she is not satisfied with the determination, he/she may appeal the clinical decision, in writing to the Northport VAMC Director.

## 2.) VAMC Northport – Responsibilities and Procedures:

a.) The Performance Improvement Office acts on behalf of the VAMC Director to provide oversight of the VAMC Clinical Appeals Process [(Attachment B).]

b.) Upon receipt of a Clinical Appeal from the patient, or their representative, the Performance Improvement Office will conduct a preliminary review in order to determine whether the:

(1) Patient can be maintained safely in the current environment of care. If it is determined that the patient cannot be safely maintained in the current environment of care, the Performance Improvement Office will arrange for the immediate transfer of the patient.

(2) Clinical area of jurisdiction (point of care) where care was provided had an opportunity to formally address the issue. If the clinical area of jurisdiction has not attempted resolution, the request for review will be forwarded to the Patient Advocate for action.

(3) Dispute is appropriate for the VAMC Clinical Appeals Process. **NOTE:** *Issues that fall outside the scope of that process (i.e. administrative disputes, other complaints) will be referred to the appropriate office or location. This policy does not impact other appeals processes available to veterans, specifically the reconsideration process and appeals to the Veterans Benefits Administration.*

c.) Once a clinical dispute is accepted as an Internal Clinical Appeal, the Performance Improvement Office will request documentation and supporting arguments from both the clinical area where care was rendered and the patient, or patient's representative as appropriate. The Performance Improvement Office will either independently review the documentation, or convene an impartial VAMC Clinical Panel to review the documentation and make a recommendation.

d.) In order to expedite the Performance Improvement Office's review of the care, all paperwork (documentation and supporting documents) pertinent to the clinical review of the case will be forwarded within forty-eight (48) hours of request by the Performance Improvement Office. ***NOTE:*** *Decisions rendered will be founded on national evidence-based standards. Where there is an absence of a national evidence-based standard for treatment, the local community standard prevails.*

e.) The Medical Center Director will assure clinical disputes are handled through a fair and impartial hearing. Clinical appeals will be reviewed and a decision provided to the patient within thirty (30) days after receipt of the appeal request.

f.) The Performance Improvement Office will render a written final decision to the patient or patient's representative and to the Clinical Service/Service Chief where the dispute originated, within thirty (30) days after the initial receipt of the Clinical Appeal. In addition, this notification will describe the VAMC Clinical Appeals Process. The patient will be advised that in the event he/she is not satisfied with the determinations, he/she may appeal the clinical decision to the Veterans Integrated Services Network 3 (VISN 3) Chief Medical Officer at the following address:

Chief, Medical Officer  
VISN 3  
130 West Kingsbridge Road  
B16  
Bronx, NY 10468

g.) The Performance Improvement Office will assure on a timely basis that the Facility Patient Advocate has entered the Clinical Appeals into the national computerized Patient Complaint database. All details and decisions must be included in the final documentation before the case is closed. The national computerized Patient Complaint database is to be used for documenting Clinical Appeals and producing quarterly reports for the Northport VAMC Director and the Network Chief Medical Officer, with tracking and trending of all issues.

h.) The Northport VAMC will have educational patient brochures in place for the following components of the administration of clinical care.

i.) Eligibility Criteria/Explanation of Benefits: Educational Patient Brochures must be available for distribution and updated as necessary regarding eligibility for services provided in the Comprehensive medical benefits Package on the patient's eligibility category.

3.) Veterans Integrated Service Network (VISN) Director Responsibilities and Procedures. The VISN Director, or designee, is responsible for:

a.) Administering an internal clinical appeals process regarding clinical determinations or services that are not resolved at the facility level (Attachment C).

b.) Reviewing clinical appeals and providing a decision to the patient within 30 days after receipt of the appeal request. That time frame may be extended to 45 days, should the VISN request an external clinical review. VHA facilities and VISNs render decisions that are founded on national evidence-based standards.

c.) When an independent external review is requested, the clinical record, the statement of appeal, and other relevant documentation and/or information produced by an internal review, must be forwarded to the Office of quality and Performance (OQP). Upon receipt, OQP arranges for the external review through its contractor for the external peer review program. The contractor reviews the clinical record and all accompanying documentation, as well as any evidence regarding the relevant practice described in the literature, to determine whether appropriate and/or reasonable and necessary clinical service was provided and/or denied. A final written report, fully documenting the findings and recommendations of the reviewer(s), is provided to the VISN Director within 10 days of the receipt of the full documentation request.

d.) Rendering a written final decision to the patient, or the patient's representative, and the medical facility Director within 30 days after initial receipt of the clinical appeal.

e.) Ensuring that the Patient Advocate at the facility enters the clinical appeals into the national computerized Patient Complaint database where the appeal was originated. All details and decisions must be included in the final documentation before the case is closed.

4.) Office of Quality and Performance. The Office of Quality and Performance Director is responsible for administering VHA's external clinical appeals program using an outside vendor. OQP must ensure that all requests for external review are conducted in a timely and efficient manner.

5.) National Veteran Service and Advocacy Program, VHA Support Service Center. The National Veteran Service and Advocacy Program director, VHA Support Service Center, is responsible for providing support for the national computerized Patient Complaint database.

#### **4. REFERENCES:**

- A. VHA Directive [2006-057 [VHA] Clinical Appeals
- B. [TJC] Comprehensive Accreditation Manual
- C. Center Memorandum 00-134, Patient Safety Reporting Program (Potential/Actual Events)

**5. RESCISSION:** Center Memorandum 00-141 Patients Rights/Responsibilities/Clinical Appeals Process dated [July 25, 2006] is hereby rescinded.

6. ATTACHMENTS:

A. Code of Ethical Behavior

B. Sample Cascade for the Process Management of Clinical Appeals [within Medical Center]

[C. Sample Clinical Appeals Process to VISN 3 CMO]

*Philip C. Moschitta*

[PHILIP C. MOSCHITTA]

Director

Dist: A

Responsible Service: [Performance Improvement] (00PI)

**SUBJ: PATIENTS' RIGHTS/RESPONSIBILITIES/CLINICAL APPEALS PROCESS**

**1. PURPOSE AND SCOPE:** To provide policies and procedures establishing patient rights and responsibilities and to create a mechanism for both internal and external appeals. This mechanism is designed to establish responsibilities and procedures for handling patient issues and/or concerns when an impasse occurs between a patient (or the patient's representative) and the patient's healthcare provider pertaining to the following:

A. Provision of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.

B. Denial of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.

[]

**2. POLICY:**

A. It is the policy of the Medical Center to recognize the basic rights of patients as human beings. Freedoms of expression, decision and action will be guaranteed, as well as a concern for personal dignity; cultural, psychosocial, and spiritual values; and human relationships. Patients/residents/family/guardians shall participate in decisions regarding all aspects of care. Treatment programs shall maintain the fundamental human, civil, constitutional and statutory rights of the individual patient. It is policy of the Medical Center for the organization's code of ethical behavior and business practices to support patient rights (see Attachment A). It is the responsibility of the Medical Center Director and all employees to assure that these rights are preserved.

B. It is the policy of the Medical Center to remain responsive to patient concerns, complaints and questions about their medical care and the services provided. The Northport VAMC encourages patients to bring complaints to the attention of staff for immediate resolution.

C. It is the policy of the Medical Center to make the veteran's visit or stay as pleasant as possible. As part of our service to veterans and to the nation, we are committed to improving healthcare quality. Northport VAMC will train future healthcare professionals, conduct research, and support our country in times of national emergency. In all of these activities, employees will respect and support the veteran's rights as a patient.

D. In providing care, the Medical Center has the right to expect responsible behavior on the part of patients, their relatives and visitors. Patients and visitors are required to abide by VA regulations and Medical Center policies and procedures.

E. It is the policy of the Medical Center that staff members will be educated on patient rights,

and staff's role in supporting those rights.

F. It is the policy of the Northport VAMC that the patients (or patient's representative) have access to a fair and impartial review of disputes regarding clinical determinations or services that is not resolved at the point-of care level. *NOTE: This supports the vital concept that patients will be actively involved in all aspects of care that influence clinical outcomes, including decisions regarding referrals, transfers, discharge planning, and other factors which influence the clinical outcomes of care.*

### **3. RESPONSIBILITIES AND PROCEDURES:**

#### **A. Patient Rights and Responsibilities:**

1.) Health Administration Services (HAS) personnel will issue the Patient Handbook to all first time patients and all admissions to the hospital. The unit administration clerk will issue a copy of the Patient Handbook to all patients who are directly admitted to the patient care unit.

2.) For patients in psychiatric care the admitting physician is responsible for providing to and discussing with each voluntary patient, at the time of admission to Psychiatry, the written Notice of Status and Rights of Voluntary Patients. The physician must sign two (2) copies, giving one copy to the patient and the other for the patient's medical file. For patients who are incapable of understanding their rights, the procedure for involuntary psychiatric treatment/commitment will be followed. *NOTE:* The Patient Handbook is issued by the unit administration clerk to each patient admitted. In cases where the treatment team assesses that the patient is unable to understand his/her rights and responsibilities, the family or guardian (surrogate decision maker) will be issued these materials by the Social Worker.

3.) [The Unit clerk will provide Extended Care residents and their families with a copy of their rights and responsibilities specifically related to the Extended Care Program and the registered nurse will review the Resident Handbook with the resident.] Information will also be provided regarding external protective services. The resident will be informed of any changes in these rights or facility rules during his/her hospital stay. The physician shall assess whether the resident is capable of understanding his/her rights and responsibilities and enter this in the medical record. *NOTE:* For residents in Extended Care who are deemed incompetent, and/or are found by his/her physician to be medically incapable of understanding these rights and responsibilities, or who exhibit a communication barrier, the resident's guardian or next of kin, or other legally authorized responsible person is also permitted to exercise these rights on behalf of the resident. In the event that the resident has no next of kin or other legally authorized responsible person, the Chief of Staff will be appointed legal guardian and will accept knowledge of resident's rights. The Unit Social Worker will be available if needed to assist patients/families/guardians with their understanding of or concerns regarding the resident rights and resident's and family's responsibilities. Staff will ensure that the resident is aware of these rights and responsibilities at the level he or she is capable of

understanding. **NOTE:** Receipt of resident rights and responsibilities will be documented in the medical record verifying that these rights were explained and understood by the recipient and a copy given to him/her. The resident or his/her representative acknowledges, in writing, receipt of this information and any changes to it. In the event the family representative is not here in person to receive a copy of the rights and responsibilities, they will be sent by certified mail to their current address with return receipt requested. A follow-up call within seven days to the representative will verify that the family representative understands the rights and responsibilities. Documentation of follow-up call will be found in the medical record.

4.) Patients are responsible for following their treatment plan. This may include complying with instructions from doctors, nurses, and allied health personnel as they implement the coordinated plan of care. Patients are responsible for their actions. Employees will report abuse by patients upon other patients, visitors and staff to their immediate Supervisor, and complete a 2633.

B. Northport VAMC Clinical Appeals Process:

1.) Clinical Services – Responsibilities and Procedures:

a.) The Clinical Service where treatment was rendered to the patient is the first point of contact to attempt to resolve clinical disputes. Every effort will be made to resolve dispute as close to the point of care as possible.

b.) The Service Chief is responsible for patient concerns, answering questions, and resolving problems at the Service level. The Patient Advocate serves as liaison between patients and the institution, and seeks solutions to problems, perceived problems, concerns or unmet needs. Patients and families will be assisted in obtaining solutions to problems by having the Patient Advocate act on their behalf with any service or section, identifying those who need to be involved in the resolution, coordinating among services when necessary, and recommending alternative policies/procedures to improve service to patients. The Service Chief *will not* refer a patient to the Director's Office unless *all* potential resolutions have been pursued, and the Patient Advocate contacted.

c.) Upon receipt of a patient issue and/or concern, the Clinical Service Chief responsible for the episode of care will conduct a preliminary review in order to determine whether the patient can be maintained safely in the current environment of care. If it is determined that the patient cannot be safely maintained in the current environment of care, the Service Chief will arrange for immediate transfer of the patient to an appropriate setting.

d.) Clinical Service Chiefs will assure clinical disputes are handled through a fair and impartial review process. When this occurs, the Service Chief/Designee who initially reviews the case will invoke national evidence-based standards. When there is an

absence of a national evidence based standard for treatment, the local community based standards *will prevail*.

e.) Clinical Services will have procedures in place for written notification regarding provision/denial of clinical care. The Service Chief/Designee will provide written notification of the Service Chief's final determination to the patient or their representative within seven (7) calendar days after the receipt of the patient issue and/or concern. In addition, this notification will describe the Northport VAMC Clinical Appeals Process. The patient will be advised that in the event he/she is not satisfied with the determination, he/she may appeal the clinical decision, in writing to the Northport VAMC Director.

2.) VAMC Northport – Responsibilities and Procedures:

a.) The Performance Improvement Office acts on behalf of the VAMC Director to provide oversight of the VAMC Clinical Appeals Process [(Attachment B).]

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(1) Patient can be maintained safely in the current environment of care. If it is determined that the patient cannot be safely maintained in the current environment of care, the Performance Improvement Office will arrange for the immediate transfer of the patient.

(2) Clinical area of jurisdiction (point of care) where care was provided had an opportunity to formally address the issue. If the clinical area of jurisdiction has not attempted resolution, the request for review will be forwarded to the Patient Advocate for action.

(3) Dispute is appropriate for the VAMC Clinical Appeals Process. **NOTE:** *Issues that fall outside the scope of that process (i.e. administrative disputes, other complaints) will be referred to the appropriate office or location. This policy does not impact other appeals processes available to veterans, specifically the reconsideration process and appeals to the Veterans Benefits Administration.*

c.) Once a clinical dispute is accepted as an Internal Clinical Appeal, the Performance Improvement Office will request documentation and supporting arguments from both the clinical area where care was rendered and the patient, or patient's representative as appropriate. The Performance Improvement Office will either independently review the documentation, or convene an impartial VAMC Clinical Panel to review the documentation and make a recommendation.

d.) In order to expedite the Performance Improvement Office's review of the care, all paperwork (documentation and supporting documents) pertinent to the clinical review of the case will be forwarded within forty-eight (48) hours of request by the Performance Improvement Office. ***NOTE: Decisions rendered will be founded on national evidence-based standards. Where there is an absence of a national evidence-based standard for treatment, the local community standard prevails.***

e.) The Medical Center Director will assure clinical disputes are handled through a fair and impartial hearing. Clinical appeals will be reviewed and a decision provided to the patient within thirty (30) days after receipt of the appeal request.

f.) The Performance Improvement Office will render a written final decision to the patient or patient's representative and to the Clinical Service/Service Chief where the dispute originated, within thirty (30) days after the initial receipt of the Clinical Appeal. In addition, this notification will describe the VAMC Clinical Appeals Process. The patient will be advised that in the event he/she is not satisfied with the determinations, he/she may appeal the clinical decision to the Veterans Integrated Services Network 3 (VISN 3) Chief Medical Officer at the following address:

Chief, Medical Officer  
VISN 3  
130 West Kingsbridge Road  
B16  
Bronx, NY 10468

g.) The Performance Improvement Office will assure on a timely basis that the Facility Patient Advocate has entered the Clinical Appeals into the national computerized Patient Complaint database. All details and decisions must be included in the final documentation before the case is closed. The national computerized Patient Complaint database is to be used for documenting Clinical Appeals and producing quarterly reports for the Northport VAMC Director and the Network Chief Medical Officer, with tracking and trending of all issues.

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c.) When an independent external review is requested, the clinical record, the statement of appeal, and other relevant documentation and/or information produced by an internal review, must be forwarded to the Office of quality and Performance (OQP). Upon receipt, OQP arranges for the external review through its contractor for the external peer review program. The contractor reviews the clinical record and all accompanying documentation, as well as any evidence regarding the relevant practice described in the literature, to determine whether appropriate and/or reasonable and necessary clinical service was provided and/or denied. A final written report, fully documenting the findings and recommendations of the reviewer(s), is provided to the VISN Director within 10 days of the receipt of the full documentation request.

d.) Rendering a written final decision to the patient, or the patient's representative, and the medical facility Director within 30 days after initial receipt of the clinical appeal.

e.) Ensuring that the Patient Advocate at the facility enters the clinical appeals into the national computerized Patient Complaint database where the appeal was originated. All details and decisions must be included in the final documentation before the case is closed.

4.) Office of Quality and Performance. The Office of Quality and Performance Director is responsible for administering VHA's external clinical appeals program using an outside vendor. OQP must ensure that all requests for external review are conducted in a timely and efficient manner.

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- B. Sample Cascade for the Process Management of Clinical Appeals [within Medical Center]
- [C. Sample Clinical Appeals Process to VISN 3 CMO]

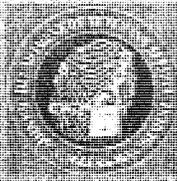
*Philip C. Moschitta*

[PHILIP C. MOSCHITTA]  
Director

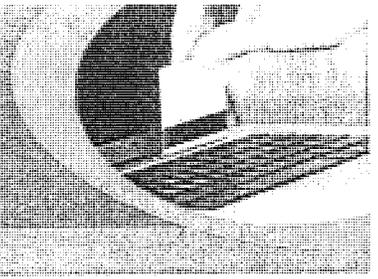
Dist: A  
Responsible Service: [Performance Improvement] (00PI)

## 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 fluorescent 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.



# Do's and Don'ts for PIV and Non-PIV Card Holders



Congratulations on getting your VA PIV/Non-PIV card! By caring for and using your card with integrity, you have the satisfaction of knowing that you are protecting the security, identity and privacy of not only yourself but of every single person at VA/VA as a whole, and the Veterans we serve.

Please follow these important guidelines for the proper care and use of your card.

## DO

- ✓ Keep your PIV or Non-PIV card in the VA-issued electromagnetically opaque card holder when you're not using it.
- ✓ Remember your personally selected 6 digit PIN.
- ✓ Use your PIV or Non-PIV card for physical access to buildings/facilities and logical access to computers/information systems as required.
- ✓ Treat your PIV or Non-PIV card with the same care you would give other identification credentials, such as your driver's license, credit card or social security card.
- ✓ Keep your PIV or Non-PIV card with you at all times and display it above the waist when not in use.
- ✓ Report a stolen or missing credential:
  - Within 24 hours or the next business day report it to your local badging office.
  - Coordinate with your PIV Sponsor to have PIV/Non-PIV card re-issued.

- ✓ Use your PIV or Non-PIV card to log on to the VA network.
- ✓ Make an appointment with your badging office six weeks ahead of the expiration date to ensure you get your credential renewed in time.
- ✓ Surrender your PIV or Non-PIV card when you resign, retire or end your affiliation with VA.

## DON'T

- ✗ Don't write down your PIN anywhere.
- ✗ Don't share your credential or PIN with anyone.
- ✗ Don't alter the credential in any way (do not scratch it, bend it, make holes in it or attach anything to it).
- ✗ Don't wear your PIV or Non-PIV card in an MRI room or near MPI or similar magnetic devices.
- ✗ Don't keep your PIV or Non-PIV card in anything other than the VA-issued electromagnetically opaque card holder.
- ✗ Don't leave your credential unattended.



## NATIONAL SECURITY BREACH VA NORTHPORT NY

Siobhan S. Bradley  
Attorney, Disclosure Unit  
U.S. Office of Special Counsel  
1730 M Street, N.W.  
Washington, D.C. 20036

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.

Joseph A Fasano  
100% Disabled Veteran  
115 Stonehurst Ln  
Dix Hills NY 11746-7930

C: 631-384-2769  
e-mail: [joesepe@msn.com](mailto:joesepe@msn.com)

## Mack, Edward

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**From:** Carrington, Cheryl L.  
**Sent:** Thursday, October 31, 2013 12:56 PM  
**To:** Mack, Edward  
**Subject:** RE:

Hi Dr. Mack,

So sorry that this is uncomfortable for you. As explained yesterday, it is normally the practice that the service chief issues the discipline. However, Dr. Limb was a witness in the AIB, thus it would not be appropriate for her to issue the discipline, nor is it appropriate for her to review the file if she was part of the investigation. Dr. Limb will never review this case file, only her own testimony. I asked Mr. Moschitta who is in Dr. Limb's chain of command, he informed me it was you and he was going to ask you to issue the discipline.

I understand that you were on vacation, I was vacation for 2 ½ weeks as well. Now that Mr. Moschitta has established this, and we are both back, you were subsequently sent a copy of the AIB report on Wednesday for your perusal. At the meeting, on Tuesday, I advised that you should read the AIB report. When you have read the report you will tell me what type of discipline you are proposing, I simply type it up for you that the employee will have proper due process in this action.

If you want to discuss your findings with your immediate sure that is permissible. Just please understand you are just the proposing official, you are NOT deciding the action. Whatever you decide to propose, please let me know; sorry I cannot make this decision for you, we only advise.

On Tuesday, you asked to speak with counsel regarding this, I informed you that Kate Tulloch is the attorney who I spoke with. Her number is (718) 630-2907, if you could not find it.

I understand that this may not be comfortable, but it is management's responsibility to issue corrective actions. Whatever you would like to do just let me know, I will prepare the proposal action for you. I just need to know exactly what you want to do, I'll try to make this as painless as possible.

Looking forward to hearing your final decision.

*Cheryl L. Carrington*

Labor Relations Specialist  
Human Resources Management Program  
Northport VAMC (05E)  
79 Middleville Road  
Northport, NY 11768  
(631) 261-4400 Ext. 2765  
(631) 754-7965 FAX  
[Cheryl.Carrington@va.gov](mailto:Cheryl.Carrington@va.gov)



## Mack, Edward

---

**From:** Mack, Edward  
**Sent:** Thursday, October 31, 2013 1:40 PM  
**To:** Carrington, Cheryl L.  
**Subject:** Re:

Is the 3 days suspension still active?

---

**From:** Carrington, Cheryl L.  
**Sent:** Thursday, October 31, 2013 12:55 PM Eastern Standard Time  
**To:** Mack, Edward  
**Subject:** RE:

Hi Dr. Mack,

So sorry that this is uncomfortable for you. As explained yesterday, it is normally the practice that the service chief issues the discipline. However, Dr. Limb was a witness in the AIB, thus it would not be appropriate for her to issue the discipline, nor is it appropriate for her to review the file if she was part of the investigation. Dr. Limb will never review this case file, only her own testimony. I asked Mr. Moschitta who is in Dr. Limb's chain of command, he informed me it was you and he was going to ask you to issue the discipline.

I understand that you were on vacation, I was vacation for 2 ½ weeks as well. Now that Mr. Moschitta has established this, and we are both back, you were subsequently sent a copy of the AIB report on Wednesday for your perusal. At the meeting, on Tuesday, I advised that you should read the AIB report. When you have read the report you will tell me what type of discipline you are proposing, I simply type it up for you that the employee will have proper due process in this action.

If you want to discuss your findings with your immediate sure that is permissible. Just please understand you are just the proposing official, you are NOT deciding the action. Whatever you decide to propose, please let me know; sorry I cannot make this decision for you, we only advise.

On Tuesday, you asked to speak with counsel regarding this, I informed you that Kate Tulloch is the attorney who I spoke with. Her number is (718) 630-2907, if you could not find it.

I understand that this may not be comfortable, but it is management's responsibility to issue corrective actions. Whatever you would like to do just let me know, I will prepare the proposal action for you. I just need to know exactly what you want to do, I'll try to make this as painless as possible.

Looking forward to hearing your final decision.

*Cheryl L. Carrington*

Labor Relations Specialist  
Human Resources Management Program  
Northport VAMC (05E)  
79 Middleville Road  
Northport, NY 11768  
(631) 261-4400 Ext. 2765  
(631) 754-7965 FAX  
[Cheryl.Carrington@va.gov](mailto:Cheryl.Carrington@va.gov)

## **Mack, Edward**

---

**From:** Carrington, Cheryl L.  
**Sent:** Thursday, October 31, 2013 2:34 PM  
**To:** Mack, Edward  
**Subject:** RE:

Active? It was never proposed, I am sorry Dr. Mack, I am not quite sure what you mean. You were clear and stated several times that you were uncomfortable issuing discipline of any sort without reading the case file at the meeting on Tuesday. I advised you to read the report, make your own determination. Did you read the AIB report? If so, what do you think the proposal should be? Just let me know what you decide that I can type up the action, if any, for you.

If you are asking for my professional opinion regarding if a suspension will be sustained in this case, honestly I do not know. This is a difficult case, and it is hard to determine the outcome. With all due respect, please let me know what you think, and we will take it from there.

I think we need another meeting, to discuss this; emails can be quite ambiguous. We really need to be on the same page here, I was under the impression that you wanted to read the case file to make a determination. I spoke with Juan Restrepo, the new Chief of ER/LR about this, he is willing to discuss this with you as well. When is your next availability? I am free tomorrow morning.

As of now, do you want me to inform the director that you are not ready to issue this discipline on Monday?

---

**From:** Mack, Edward  
**Sent:** Thursday, October 31, 2013 1:40 PM  
**To:** Carrington, Cheryl L.  
**Subject:** Re:

Is the 3 days suspension still active?

---

**From:** Carrington, Cheryl L.  
**Sent:** Thursday, October 31, 2013 12:55 PM Eastern Standard Time  
**To:** Mack, Edward  
**Subject:** RE:

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Looking forward to hearing your final decision.

*Cheryl L Carrington*

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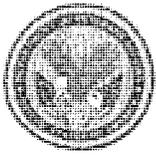
**From:** Mack, Edward  
**Sent:** Thursday, October 31, 2013 9:47 AM  
**To:** Carrington, Cheryl L.  
**Subject:** RE:

Cheryl, I got the board attachment yesterday from you. I just need some clarification because I came back from vacation on the 22<sup>nd</sup> of Oct and I was inform by OO that I have to sign the letter for Mr F to come back to work and the disciplinary letter. I was not involved in this case from the beginning As was discussed in the previous two days, you and OO inform me that the suspension letter was already written by HR and I need to sign it and hand this to Mr F when he returns because Dr Limb was a witness in the AIB and cannot sign the letter. She had not review the case file as of todote. As discussed in the previous two days If I disagree with the suspension I have to discussed this with OO is that correct?

---

**From:** Carrington, Cheryl L.  
**Sent:** Wednesday, October 30, 2013 8:50 AM  
**To:** Mack, Edward  
**Subject:**  
**Importance:** High

Dr. Mack,



---

**From:** Mack, Edward  
**Sent:** Thursday, October 31, 2013 9:47 AM  
**To:** Carrington, Cheryl L.  
**Subject:** RE:

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**From:** Carrington, Cheryl L.  
**Sent:** Wednesday, October 30, 2013 8:50 AM  
**To:** Mack, Edward  
**Subject:**  
**Importance:** High

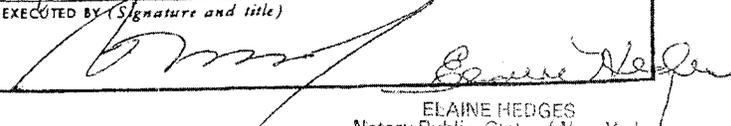
Dr. Mack,

As requested, attached is the AIB Report please review for your perusal.

*Cheryl L. Carrington*

Labor Relations Specialist  
Human Resources Management Program  
Northport VAMC (05E)  
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REPORT OF CONTACT		VA OFFICE	IDENTIFICATION NOS. (C, XC, SS, XSS, V, K, etc.)
NOTE: This form must be filled out in ink or on typewriter, as it becomes a permanent record in veterans' folders.			
LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN (Type or print) MACK EDWARD		DATE OF CONTACT	
ADDRESS OF VETERAN		TELEPHONE NO. OF VETERAN	
PERSON CONTACTED		TYPE OF CONTACT (Check) <input type="checkbox"/> PERSONAL <input type="checkbox"/> TELEPHONE	
ADDRESS OF PERSON CONTACTED		TELEPHONE NO. OF PERSON CONTACTED	
BRIEF STATEMENT OF INFORMATION REQUESTED AND GIVEN			
<p>This morning, NOV-1-2013, at 10:00 AM after morning report, the directors confronted me and brought up the issue of why Mr. Fattano NP's suspension was not signed. He raised his voice and stated 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. Fattano is found by the AIB to be abusive and downgrade <del>the</del> women and that I am delaying the process. He further stated that if I don't sign the letter <sup>my situation</sup> it will be escalated and he will have this signed by someone else! I tried to explain to him that I have not read the case file yet and I still am under of the charges. He again</p>			
DIVISION OR SECTION		EXECUTED BY (Signature and title)	
		 ELAINE HEDGES Notary Public, State of New York No. 0126828770 Qualified in Suffolk County Commission Expires October 31, 2014	

stated that he WANTS the letter signed by noon today,  
I tried to state that Mrs Corription states she had  
no letter prepared yet and his issue is he want to  
have this signed by NOON today I was extremely stress  
by this and went to talk to Dr Motion # (The chief of  
Surfing) I also tried to call my old VISN director (Mr  
Forsythe for advice) He had advised me before that he  
was concern with this process (i.e. the deciding official  
had already decided <sup>the disciplinary action</sup> and demand the proposing official  
to sign a predecided action with no due process) at

10:35 AM I went to the Director's office. In there  
was Cheryl Compton (the HR <sup>specialist</sup> ~~representative~~) Dray Merdock  
and my AA (~~Dray Merdock~~) 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 regardless of what the chapter  
are and the director again stated that the AIB and  
Regional Council recommend this disciplinary action. I left  
the room after <sup>I signed the</sup> my letter.



DEPARTMENT OF VETERANS AFFAIRS  
Medical Center  
79 Middleville Rd  
Northport, NY 11768

May 28, 2013

Mr. Joseph A. Fasano  
Nurse Practitioner  
Extended Care Service  
Northport VA Medical Center  
79 Middleville Road  
Northport, NY 11768-2290

Subject: Paid Non-Duty Status

At this time you are the subject of an investigation.

Please be advised that effective today, May 28, 2013, you will be placed in a non-duty status. During this period you will be carried in a pay status (Authorized Absence) without charge to leave. This status is subject to being terminated at the agency's discretion and you may be ordered to return to duty at any time.

You will need to remain available during your regular work hours. Please ensure that you provide me with a current phone number so that you can be reached during your work hours. In addition, you should anticipate receiving additional correspondence about this in the near future.

During the time of this investigation please refrain from contact with any member of the Community Living Center 4 (CLC4) clinical team or any member that supports this unit verbally, by telephone or by email. Furthermore, during this time period you may visit the VA Medical Center, Northport to meet with a union representative, attend to personal business such as banking, and based upon your Veteran's status, seek medical treatment. However, if it is necessary for you to visit the VA Medical Center or worksite, you must contact Police Service (24 hours) in advance so that arrangements can be made for an escort. The police may be contacted at (631) 261-4400 ext. 7151 to make escort arrangements.

If you have any questions, please do not hesitate to contact me at 631-261-4400 ext. 5075.

A handwritten signature in black ink, appearing to read "Younghee Limb".

Younghee Limb, MD  
Associate Chief of Staff  
Extended Care

---

Employee signature for receipt of letter

Date



Department of Veterans Affairs  
Health Eligibility Center  
2957 Clairmont Road  
Suite 200  
Atlanta GA 30329

PRSRT STD  
U.S. POSTAGE  
PAID  
ATLANTA GA  
PERMIT #1982

RETURN SERVICE REQUESTED



\*\*\*\*\*AUTO\*3-DIGIT 117 T77 P1 23242

JOSEPH ANTHONY FASANO  
115 STONE HURST LANE  
DIX HILLS NY 11746-7930



DEPARTMENT OF VETERANS AFFAIRS  
Chief Business Office  
Purchased Care  
Denver, CO 80246

March 1, 2013

As a Veteran enrolled in the VA health care system, you're probably familiar with many of the medical benefits VA can offer you. I'd like to make sure you know your options for care outside the VA in the event of an emergency.

First, the most important thing is for you to get the care you need if you're having a medical emergency. Call 911 or go to the nearest emergency room. You do not need pre-authorization from VA to seek emergency non-VA treatment.

VA defines an emergency as a condition that needs immediate medical attention or it could become hazardous to life or health.

If you do seek emergency treatment at a non-VA facility, it's important to contact the closest VA medical center within 72 hours. You, a family member, a friend or the non-VA hospital can make that contact. The VA facility will verify your eligibility for VA to pay for the care and advise you of claims filing procedures or deadlines. Please note, VA is not authorized to pay for all emergency care for Veterans; your individual eligibility will determine what VA is able to pay for.

Enclosed is a fact sheet that gives you more details on non-VA emergency care. Please take the time to review it, so you better understand your options should an emergency arise.

Thank you for your service to our country. It is our pleasure to serve you.

Sincerely,

A handwritten signature in cursive script that reads "Cynthia M. Kindred".

Cynthia M. Kindred  
Acting Deputy Chief Business Officer,  
Purchased Care



VA

# Non-VA Emergency Care Fact Sheet

At some time in your life, you may need emergency care. This document explains what VA might be able to do for you. When it is not possible for you to go to a VA Medical Center, you should go to the nearest hospital that has an emergency room. If you are in an ambulance, the paramedics will usually take you to the closest emergency room.

## What is an emergency?

A medical emergency is an injury or illness that is so severe that without immediate treatment, it threatens your life or health.

## How do I know my situation is an emergency?

Your situation is an emergency if you believe your life or health is in danger.

**If I believe my life or health is in danger, do I need to call the VA before I call for an ambulance or go to an emergency room?**

**No.** Call 911 or go to the nearest emergency room right away.

**When should I contact the VA regarding an emergency room visit?**

You, your family, friends or hospital staff should contact the nearest VA medical center as soon as possible, preferably within 72 hours of your emergency, so you are better aware of what services VA may or may not cover. Provide VA with information about your emergency and what services are being provided to you. Ask VA for guidance on what emergency charges may or may not be covered, so you can plan accordingly.

**If the doctor then wants to admit me to the hospital, must I obtain advance approval from the VA?**

- If the admission is an emergency—**NO**, although prompt notification of the VA is necessary.
- If the admission is not an emergency—**YES**

**If a VA bed is available and I can be safely transferred, do I have to move to the VA hospital?**

**YES**, if you want VA to continue to pay for your care. If you refuse to be transferred, VA will not pay for any further care.

**If I am admitted to the hospital as a result of an emergency, how much will VA pay?**

This depends on your VA eligibility. VA may pay all, some, or none of the charges. Some highlights are listed in the next column.

**For service-connected conditions, here are some of the criteria that must be met:**

1. Care or services were provided in a medical emergency, and
2. VA or another federal facility were not feasibly available, and
3. VA was notified within 72 hours of the admission.
4. Ask your local VA Medical Center's Non-VA (Fee) Care Office for further eligibility guidance.

**For non-service-connected conditions, here are some of the criteria that must be met:**

1. Veteran is enrolled in the VA Health Care System, and
2. Veteran has received health care services from VA within the previous 24 months, and
3. Veteran has no other health insurance coverage.
4. Ask your local VA Medical Center's Non-VA (Fee) Care Office for further eligibility guidance.

**How do I know if I have a service-connected condition?**

A service-connected condition refers to an illness or injury that was incurred in or aggravated by military service and has a rating assigned by the Veterans Benefits Administration.

**How long do I have to file a claim for reimbursement for emergency medical care?**

File your claim with the nearest VA Medical Center quickly because time limits usually apply. For non-service-connected care, the time limit is 90 days. Again, consult your local VA Medical Center for more information.

**Will VA pay for emergency care received outside the United States?**

VA will only pay for emergency care outside the U.S. if your emergency is related to a service-connected condition. For more information about care provided outside the U.S., contact the Foreign Medical Program (FMP) at (877) 345-8179, or go to the FMP website at: <http://www.va.gov/hac/forbeneficiaries/fmp>

For more information on non-VA emergency care, visit <http://www.nonvacare.va.gov>



**VA** | U.S. Department  
of Veterans Affairs

**DEPARTMENT OF VETERANS AFFAIRS  
VETERANS HEALTH ADMINISTRATION (VHA)  
810 Vermont Avenue N.W.  
Washington, DC 20420**

In Reply Refer To: NoPP

October 1, 2013

Dear Veteran:

The Veterans Health Administration (VHA) is providing an updated copy of the VHA Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are receiving this Notice because you have been identified by VHA as a Veteran enrolled for health care benefits as of July 1, 2013.

This Notice explains your patient privacy rights, identifies uses and disclosures of your protected health information, and includes other important privacy-related information.

If you have any questions about the VHA Notice of Privacy Practices, please contact the Health Resource Center (HRC) Call Center at 1-800-983-0936.

VHA thanks you for your service and looks forward to continuing to serve your health care needs.

Sincerely,

Stephanie H. Griffin, J.D.  
VHA Privacy Officer



Department of Veterans Affairs  
Veterans Health Administration  
**NOTICE OF PRIVACY PRACTICES**  
Effective Date **September 23, 2013**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) is required by law to maintain the privacy of your protected health information and to provide you with notice of its legal duties and privacy practices. VHA is also required to abide by the terms of this Notice and its privacy policies.

***How VHA May Use or Disclose Your Health Information without Your Authorization (See below for more information about these categories)***

- Treatment (e.g., giving information to VHA and other doctors and nurses caring for you)
- Payment (e.g., giving information to non-VHA facilities that provide care or services)
- Health Care Operations (e.g., giving information to individuals conducting Quality of Care reviews)
- Eligibility and Enrollment for VA Benefits (e.g., giving information to officials who decide benefits)
- Abuse Reporting (e.g., giving information about suspected abuse of elders or children to government agencies)
- Health or Safety Activities
- Public Health Activities (e.g., giving information about certain diseases to government agencies)
- Judicial or Administrative Proceedings (e.g., responding to court orders)
- Law Enforcement
- Health Care Oversight (e.g., giving information to the Office of Inspector General or a Congressional Committee)
- Cadaveric Organ, Eye, or Tissue Donation
- Coroner or Funeral Activities
- Services (e.g., giving information to contractors or business associates performing services for VHA)
- National Security Matters
- Workers' Compensation Cases (e.g., giving information to officials who decide payments for workplace injuries)
- Payment (e.g., giving information to non-VHA facilities that provide care or services)
- Correctional Facilities and/or Parole Officers
- When Required by Law
- Activities Related to Research (e.g., certain activities with only minimal or limited privacy or confidentiality risks)
- Planning VA research projects (e.g., investigator accesses, but does not disclose or record, individual health information to determine feasibility of opening a study)
- Military Activities (e.g., giving information to the Department of Defense (DoD))
- Academic Affiliates (e.g., giving information to assist in training medical students)
- State Prescription Drug Monitoring Program (SPDMP) reporting and query
- General Information Disclosures (e.g., giving out general information about you to your family and friends)
- Verbal disclosures to others while you are present
- Verbal Disclosures when you are not present (e.g., assisting Family Members or Designated Individuals Involved in your Care)

**Other Uses and Disclosures with Your Authorization.** We may use or disclose your health information for any purpose based on a signed, written authorization you provide us. Your signed written authorization is always required to disclose your psychotherapy notes if they exist. If we were to use or disclose your health information for marketing purposes we would require your signed written authorization. In all other cases, we will not use or make a disclosure of your health information without your signed, written authorization, unless the use or disclosure falls under one of the exceptions described in this Notice. When we receive your signed written authorization we will review the authorization to determine if it is valid, and then disclose your health information as requested by you in the authorization.





2) A Veteran is taken to a community hospital emergency room. Upon request from the emergency room, VHA discloses health information to the non-VHA hospital that needs the information to treat this Veteran.

3) A National Guard member seeks mental health care from VHA. VHA discloses this information to DoD by entering the information into a database that may be accessed by DoD providers at some future date.

**Payment.** We may use and disclose your health information for payment purposes or to receive reimbursement for care provided, including:

- Determining eligibility for health care services
- Paying for non-VHA care and services, including but not limited to, CHAMPVA and fee basis
- Coordinating benefits with other insurance payers
- Finding or verifying coverage under a health insurance plan or policy
- Allowing you to pay for your health care out of pocket so that your insurance is not billed
- Pre-certifying benefits
- Billing and collecting for health care services provided
- Providing personal information to consumer reporting agencies regarding delinquent debt owed to VHA

*Examples:*

1) A Veteran is seeking care at a VHA health care facility. VA uses the Veteran's health information to determine eligibility for health care services.

2) The VHA health care facility discloses a Veteran's health information to a private health insurance company to seek and receive payment for the care and services provided to the Veteran.

**Health Care Operations.** We may use or disclose your health information without your authorization to support the activities related to health care, including:

- Improving quality of care or services
- Conducting Veteran and beneficiary satisfaction surveys
- Reviewing competence or qualifications of health care professionals
- Providing information about treatment alternatives or other health-related benefits and services
- Conducting health care training programs
- Managing, budgeting and planning activities and reports
- Improving health care processes, reducing health care costs and assessing organizational performance
- Developing, maintaining and supporting computer systems
- Legal services
- Conducting accreditation activities
- Certifying, licensing, or credentialing of health care professionals
- Conducting audits and compliance programs, including fraud, waste and abuse investigations

*Examples:*

1) Medical Service, within a VHA health care facility, uses the health information of diabetic Veterans as part of a quality of care review process to determine if the care was provided in accordance with the established best clinical practices.

2) A VHA health care facility discloses a Veteran's health information to the Department of Justice (DOJ) attorneys assigned to VA for defense of VHA in litigation.

**Eligibility and Enrollment for Federal Benefits.** We may use or disclose your health information to other programs within VA or other Federal agencies, such as the Veterans Benefits Administration, Internal Revenue Service or Social Security Administration, to determine your eligibility for Federal benefits.

**Abuse Reporting.** We may use or disclose your health information without your authorization to report suspected child abuse, including child pornography; elder abuse or neglect; or domestic violence to appropriate Federal, State, local, or tribal authorities. This reporting is for the health and safety of the suspected victim.

**Health and Safety Activities.** We may use or disclose your health information without your authorization when necessary to prevent or lessen a serious threat to the health and safety of the public, yourself, or another person. Any disclosure would only be to someone able to help prevent or lessen the harm, such as a law enforcement agency or the person threatened. You will be notified in writing if any such disclosure has been made by a VHA health care facility.

**Public Health Activities.** We may disclose your health information without your authorization to public health and regulatory authorities, including the Food and Drug Administration (FDA) and Centers for Disease Control (CDC), for public health activities. Public health activities may include:

- Controlling and preventing disease, injury, or disability
- Reporting vital events such as births and deaths
- Reporting communicable diseases such as hepatitis, tuberculosis, sexually transmitted diseases & HIV
- Tracking FDA-regulated products
- Reporting adverse events and product defects or problems
- Enabling product recalls, repairs or replacements

**Judicial or Administrative Proceedings.** We may disclose your health information without your authorization for judicial or administrative proceedings, including:

- We receive an order of a court, such as a subpoena signed by a judge, or administrative tribunal, requiring the disclosure
- To defend VA in judicial and administrative proceedings

**Law Enforcement.** We may disclose your health information to law enforcement agencies for law enforcement purposes when applicable legal requirements are met. These law enforcement purposes may include:

- Responding to a court order
- Responding to a specific request when in pursuit of a focused civil or criminal law enforcement investigation
- Reporting crimes occurring at a VHA site
- Identifying or apprehending an individual who has admitted to participating in a violent crime
- Reporting a death where there is a suspicion that death has occurred as a result of a crime
- Reporting Fugitive Felons
- Routine reporting to law enforcement agencies, such as gunshot wounds
- Providing certain information to identify or locate a suspect, fugitive, material witness, or missing person

**Health Care Oversight.** We may disclose your health information to a governmental health care oversight agency (e.g., Inspector General; House Veterans Affairs Committee) for activities authorized by law, such as audits, investigations, and inspections. Health care oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and agencies that enforce civil rights laws.

**Cadaveric Organ, Eye, or Tissue Donation.** When you are an organ donor and death is imminent, we may use or disclose your relevant health information to an Organ Procurement Organization (OPO), or other entity designated by the OPO, for the purpose of determining suitability of your organs or tissues for organ donation. If you have not specified your donation preferences and can no longer do so, your family may make the determination regarding organ donation on your behalf.

**Coroner or Funeral Services.** Upon your death, we may disclose your health information to a funeral director for burial purposes, as authorized by law. We may also disclose your health information to a coroner or medical examiner for identification purposes, determining cause of death, or performing other duties authorized by law.

**Services.** We may provide your health information to individuals, companies and others who need to see your information to perform a function or service for or on behalf of VHA. An appropriately executed contract and business associate agreement must be in place securing your information.

**National Security Matters.** We may use and disclose your health information without your authorization to authorized Federal officials for the purpose of conducting national security and intelligence activities. These activities may include protective services for the President and others.

**Workers' Compensation.** We may use or disclose your health information without your authorization to comply with workers' compensation laws and other similar programs.

**Correctional Facilities.** We may disclose your health information without your authorization to a correctional facility if you are an inmate and disclosure is necessary to provide you with health care; to protect the health and safety of you or others; or for the safety of the facility.

**Required by Law.** We may use or disclose your health information for other purposes to the extent required or mandated by Federal law (e.g., to comply with the Americans with Disabilities Act; to comply with the Freedom of Information Act (FOIA); to comply with a Health Insurance Portability and Accountability Act (HIPAA) privacy or security rule complaint investigation or review by the Department of Health and Human Services).

**Activities Related to Research.** Before we may use health information for research, all research projects must go through a special VHA approval process. This process requires an Institutional Review Board (IRB) to evaluate the project and its use of health information based on, among other things, the level of risk to you and to your privacy. For many research projects, including any in which you are physically examined or provided care as part of the research, you will be asked to sign a consent form to participate in the project and a separate authorization form for use and possibly disclosure of your information. However, there are times when we may use your health information without an authorization, such as, when:

- A researcher is preparing a plan for a research project. For example, a researcher needs to examine patient medical records to identify patients with specific medical needs. The researcher must agree to use this information only to prepare a plan for a research study; the researcher may not use it to contact you or actually conduct the study. The researcher also must agree not to remove that information from the VHA health care facility. These activities are considered preparatory to research.
- The IRB approves a waiver of informed consent and a waiver of authorization to use or disclose health information for the research because privacy and confidentiality risks are minimal and other regulatory criteria are satisfied.
- A Limited Data Set containing only *indirectly* identifiable health information (such as dates, unique characteristics, unique numbers or zip codes) is used or disclosed, with a data use agreement (DUA) in place.

**Military Activities.** We may use or disclose your health information without your authorization if you are a member of the Armed Forces, for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, when applicable legal requirements are met. Members of the Armed Forces include Active Duty Service members and in some cases Reservist and National Guard members. An example of a military activity includes the disclosure of your health information to determine fitness for duty or deployment to your Base Commander.

**Academic Affiliates.** We may use or disclose your health information, without your authorization, to support our education and training program for students and residents to enhance the quality of care provided to you.

**State Prescription Drug Reporting Program (SPDMP).** We may use or disclose your health information, without your authorization, to a SPDMP in an effort to promote the sharing of prescription information to ensure appropriate medical care.

**General Information Disclosures.** We may disclose general information about you to your family and friends. These disclosures will be made only as necessary and on a need-to-know basis consistent with good medical and ethical practices, unless otherwise directed by you or your personal representative. General information is limited to:

- Verification of identity
- Your condition described in general terms (e.g., critical, stable, good, prognosis poor)
- Your location in a VHA health care facility (e.g., building, floor, or room number)

**Verbal Disclosures to Others While You Are Present.** When you are present, or otherwise available, we may disclose your health information to your next-of-kin, family or to other individuals that you identify. For example, your doctor may talk to your spouse about your condition while at your bedside. Before we make such a disclosure, we will ask you if you object. We will not make the disclosure if you object.

**Verbal Disclosures to Others When You Are Not Present.** When you are not present, or are unavailable, VHA health care providers may discuss your health care or payment for your health care with your next-of-kin, family, or others with a significant relationship to you without your authorization. This will only be done if it is determined that it is in your best interests. We will limit the disclosure to information that is directly relevant to the other person's involvement with your health care or payment for your health care.

Examples of this type of disclosure may include questions or discussions concerning your in-patient medical care, home-based care, medical supplies such as a wheelchair, and filled prescriptions.

**IMPORTANT NOTE:** *A copy of your medical records can be provided to family, next-of-kin, or other individuals involved in your care only if we have your signed, written authorization or if the individual is your authorized surrogate (the individual who is authorized to make health care decisions on your behalf if you can no longer do so) and the practitioner determines that the information is needed for the individual to make an informed decision regarding your treatment.*

### ***When We Offer You the Opportunity to Decline to the Use or Disclosure of Your Health Information***

**Patient Directories.** Unless you opt-out of the VHA medical center patient directory when being admitted to a VHA health care facility, we may list your general condition, religious affiliation and the location where you are receiving care. This information may be disclosed to people who ask for you by name. Your religious affiliation will only be disclosed to members of the clergy who ask for you by name. **If you do object to being listed in the Patient Directory, no information will be given out about you unless there is other legal authority. This means your family and friends will not be able to find what room you are in while you are in the hospital. It also means you will not be able to receive flowers or mail, including Federal benefits checks, while you are an inpatient in the hospital or nursing home. All flowers and mail will be returned to the sender.**

### ***When We Will Not Use or Disclose Your Health Information***

**Sale of Health Information.** We will not sell your health information. Receipt of a fee expressly permitted by law, such as Privacy Act copying fees or FOIA fees is not a sale of health information.

**Genetic Information Nondiscrimination Act (GINA).** We will not use genetic information to discriminate against you either through employment or to determine your eligibility for VA benefits.

### **Contact Information.**

You may contact your VHA health care facility's Privacy Officer if you have questions regarding the privacy of your health information or if you would like further explanation of this Notice. The VHA Privacy Office may be reached by mail at VHA Privacy Office, Office of Informatics and Analytics (10P2C1), 810 Vermont Avenue NW, Washington, DC 20420 or by telephone at 1-877-461-5038.

**NOTE:** *A large print version of this Notice is available upon request from the facility where you are receiving care.*

9

1 Q Okay.

2 A So, on the 28th of May when the -- when I had to give him

3 the letter, that's when he mentioned those and subsequently --

4 in subsequent complaints that he had, that's when he mentioned

5 it, that he had these disabilities. So, I knew it since all

6 this happened.

7 Q Okay.

8 A I should clarify that, yeah.

9 Q All right, okay. So you became aware of his disability or

10 became aware of PTSD, subsequent to -- well, May 28th and

11 subsequent to that, you learned more about it?

12 A Um-hum.

13 Q Okay. Well, since you have learned more about it, I have

14 more questions about the disability. Are you aware of whether

15 or not the condition affects his normal life functions in any

16 substantial way?

17 A No, I don't, because I have had no interaction with him

18 except for the two letters, since the 28th.

19 Q Okay, do you know whether or not it affects his ability to

20 perform his essential job duties?

21 A I did not feel there was any problem with his performance

22 as a Nurse Practitioner.

23 Q Okay, and do you know whether or not -- or if he, rather,

10

1 uses any kind of medication or assistive devices related to the

2 PTSD?

3 A No, I do not know.

4 Q Okay. All right. Let's move on now to the specific events

5 that we are -- okay.

6 Event 25. On May 28, 2013, the Associate Chief of Staff of

7 Extended Care, Younghee Limb (YL) placed the Complainant on a

8 paid non-duty status pending the outcome of an Administrative

9 Investigation Board (AIB).

10 What is your role in the authorization or convening of the

11 AIB, if any?

12 A I do not have a role in convening the AIB or putting

13 someone on a non-duty status. I was his point of contact for

14 the Medical Center and it was determined that I should be the

15 one, as his supervisor, to give him the letter.

16 Q Okay, so you -- I believe I heard you say in there, you

17 were his immediate supervisor?

18 A Correct.

19 Q Okay, so were you the person who recommended the AIB?

20 A No, I did not.

21 Q Do you know who recommended the AIB?

22 A I am not -- no, I do not know who recommended the AIB.

23 Q Okay. Do you know -- what is the -- do you know the reason

11

1 for the AIB?

2 A The reason? I am assuming the AIB was secondary to the

3 workplace violence complaint that was against Mr. Fasano.

4 Q Was there any -- you indicated that you sent some

5 correspondence to Mr. Fasano, as his supervisor. And I'm

6 looking at a couple of letters -- I just want to make sure that

7 I have all of them for the record. I see one that's signed by

8 you, dated May 28, 2013 and that -- it says the subject of that

9 is "Paid Non-Duty Status."

10 A Correct.

11 Q And it starts with, "At this time you are the subject of an

12 investigation" -- and I'm not going to read the complete letter,

13 but --

14 A Right.

15 Q -- just to make sure that we're talking about the same

16 letter is why I am reading a couple of sentences from the

17 letter. And it says, "Please be advised that effective May 28th

18 you will be placed in a non-duty status." That letter I have.

19 Then I have another one dated June 4, 2013, and it's signed

20 by you. And, briefly, it says in the first paragraph, "I read

21 with concern the issues shared via emails with the Honorable

22 Eric Shinseki, Secretary of the Department of Veterans Affairs,

23 after you were placed on paid, non-duty status, pending the

12

1 outcome of an ongoing investigation on Community Living Center

2 4."

3 And then another one, July 8th, signed -- it looks like

4 someone signed it on your behalf.

5 A Um-hum.

6 Q Um-hum, I can't read that, but it certainly looks like it

7 was penned or over your signature. It says in the first

8 paragraph, "Northport VA Medical Center's senior management team

9 and I continue to be genuinely concerned about you during this

10 investigative period" -- okay. So, "I'm aware of your expressed

11 concerns to the VA Secretary and others that this investigative

12 process is stressful for you. Please remember that the

13 investigative process is intended to protect your rights and

14 safety and the rights and safety of all parties concerned."

15 All right, Mr. -- one of Mr. Fasano's complaints is that he

16 has no information about the reason for this investigation. Was

17 there another letter or any other letters that went to him or

18 should have gone to him to explain the reason for the

19 investigation? Is that -- I mean, is that question clear?

20 A The question is clear. The process that takes place when a

21 workplace violence -- when I gave him the first letter on the

22 date -- the one that's dated the 28th, on the non-duty status --

23 paid non-duty status, at that point in time, the workplace

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J. Pasano

Evidence of that was that they received the worst performance measure rating from the Long Term Care Survey Institute two years consecutively.

The dynamics of it had to do with the toxic blend of the management situation and the clinical situation.

Q. So we will take those piece by piece. Let's talk about the management situation first. As a causal view, what do you think are the management challenges that presented this toxic environment?

A. I would have to say on different levels it would have to be probably a neophyte nurse manager that was very inexperienced.

As a matter of fact, I just want to submit this e-mail as evidence, and this will expand upon the explanation that I wanted to say to this.

I was purposely left off of this e-mail string; however, Dr. Yeh, who is the attending on CLC 3, we had a close working relationship for a couple of years when I

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J. Fasano

covered CLC 3 once a week. We actually became friends.

She was very upset that I was left off of this e-mail so she printed it out for me.

This is dated October 24, 2012. This e-mail -- I am going to submit it to you -- it was sent from Dr. Calandrino, the attending on CLC 4, to the other attendings on the CLCs, and the subject is Big Joe's duties.

I don't mind being referred to in that way, but there is two Joes that covered CLC 4, Dr. Joe Calandrino and Joe Fasano, nurse practitioner.

Why don't we refer to Dr. Calandrino as Little Joe? Everybody knows I'm big. I am 6'3, I am 240 pounds. It is pretty obvious, and it only reinforces the stereotype that I am this big monster and I am loud, I am ~~a cannon~~ <sup>Italian</sup>, I am expressive culturally, I have hearing loss from my service-connected conditions.

But Dr. Calandrino had let some frustrations boil over that had preceded my

Derogatory  
reference to  
my size and  
intimidating  
physical appearance  
and ethnic  
features.

**To:** Limb, Younghee J  
**Cc:** Mahmood, Sabahat; Yeh, Shing Shing  
**Subject:** Big Joe's duties.

Hi Younghee:

I think we are going to have to rethink Joe's duties, especially on CLC4. It is clear that his duties elsewhere prevent him from meeting his current obligations here on CLC4: he is often bogged down, too busy etc. in bldg 92. I wonder how often he is too busy on CLC4 to attend his duties elsewhere.

It might prove prudent to reduce his panels on all venues of care, so that some clarity of his commitments might emerge.

Joseph Calandrino, D.O., FAAFP, DABHPM  
Assistant Professor of Medicine and Family Medicine  
SUNY Stony Brook School of Medicine  
Medical Director, Palliative Care Services  
VAMC Northport  
79 Middleville Rd.  
Northport NY 11768  
Cell: 631-291-5123; Pager: 631-233-1029  
Office: 631-261-4400 X5528

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J. Fasano

He felt that lack of management experience negatively impacted the work environment.

So I am going to submit this here.

Dr. Calandrino in this e-mail will highlight that he felt that I was being stretched entirely too thin. I had way too many duties to cover to be 100 percent fully effective in any one of those capacities, because I was going to get stretched even more in my assignment. I was going to have to pick up an additional CLC to provide coverage.

CHAIRMAN HABERMAN: Let me read this.

The Board is in receipt of an e-mail that is dated October 24, 2012 from Dr. Calandrino regarding the assignment of Mr. Fasano.

*Board accepts e-mail*

The Board will accept this as Exhibit B.

(E-mail dated October 24, 2012 marked Exhibit B.)

MR. THOMESSEN: We would like to

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J. Fasano

So that was to that extent.

But, again, I had to really try to focus on trying to do my job in this dysfunctional environment and hopefully this would have brought some stability.

Q. Part B of the management discussion beyond Cathy Fasano would be the leadership of the medical portion of CLC 4, which would be the overall medical leadership of CLC 4 would be Dr. Calandrino.

A. Correct.

Q. He is just on the palliative side?

A. Here is the deal on how it was task organized. He is the attendant so he technically covers the whole unit, but my responsibility was for the whole unit, not palliative care.

Q. So you had rehab, respite, all that?

A. GEM, the whole thing. That was me.

I don't have it with me, because this police force restriction on me

*Evidence that A13 was informed of PTSD. Special accommodation denied  
Continued next page.*

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J. Fasano

that was imposed upon me exacerbates my  
service-connected posttraumatic stress  
disorder so I have not had access to documents  
and e-mails that I could submit today, because  
I can't come back to the campus.

I am getting paraded around to  
my friends, my DAV friends like some circus  
freak show so that is why I haven't been able  
to come back to access my e-mails.

To the medical end of it, the  
CLC 4 would get consults, and it was just --

MR. THOMSEN: Come on outside.

CHAIRMAN HABERMAN: We are off  
record now.

(Discussion off the record.)

A. I just want to make clear that  
these issues I was asked for help, I was the  
one that was asked because of my massive  
experience as a military officer. I was a top  
rated captain.

You don't lead a stick of men  
out the back of an aircraft at nighttime at  
1200 feet over a drop zone it is so dark you  
can't see your hand in front of your face

A13 informed  
of PTSD  
exacerbation.

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J. Fasano

Q. In psychology, there was an expression from Dr. Welsh in psychology regarding a patient's psychological needs, and her response was -- what is the phrase --

MS. ALBANESE: "Right now we are not in need of touchy feely."

Q. The words were touchy feely, and that was repeated by a couple of people.

A. I would say that these are matters of opinion and not fact. And I could say that it is easy to make me look like the big bad wolf. I am big. I can't change that. I am going to answer the question. I am loud. I have Italian expressive mannerisms.

People know that I am a veteran. It is also on here.

I'm answering the question.

People assume that I am dangerous because I was with Airborne, Special Forces. People know that I have posttraumatic stress disorder, because people tell you that people have looked in my chart.

I put in a ~~FOIA~~ request. I want to know from 1 September 2005 to the

AIB informed of discrimination by slanderous racist detractors using illegally obtained PH from my medical record + military service record screen.

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J. Fasano  
present how many times my chart has been  
inappropriately accessed.  
Q. Time out.  
A. Okay.  
Q. We are off on a tangent. I  
want my question answered. How is it that  
other people perceive that you perceive less  
value of their clinical or their professional  
preparation? Whether it is factual or not,  
that is their opinion. I want to know why  
they would perceive that?  
You could tell me "I have no  
idea," but just answer my question.  
MR. THOMESSEN: We are going to  
take a second to answer this.  
(A recess was taken.)  
Q. Back to my question.  
CHAIRMAN HABERMAN: Read the  
question back, please.  
(Record read.)  
CHAIRMAN HABERMAN: Off the  
record.  
(Discussion off the record.)  
A. Who specifically?

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J. Fasano

Q. Dr. Welsh.

A. I know there was an issue on CLC 1 that there was a patient who Dr. Welsh wrote in her chart, put me and Dr. Virmani, who at the time Dr. Virmani was the geri psychiatrist, and the patient said he wanted to buy a gun, he wanted to kill me and he wanted to kill Dr. Virmani.

My response might have been that right now this is not a time for touchy feely, when a man wants to buy a gun, he wants to kill me, he wants to kill Dr. Virmani. This is a safety and a violence issue, not a touchy feely issue, because I did not feel comfortable that there were enough things that were put in place to protect myself, Dr. Virmani or the other patients.

If it is just a matter of splitting hairs over terminology, I can't rationalize on how people want to reinforce a stereotyped threat of me based on their misperceptions of me.

Q. Same question regarding -- during an IDT meeting there was a discussion

*ATB informed of discrimination by detractors.*

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J. Fasano

A. I don't know about the same level of responsibility.

Q. I am talking about their job description; not a particular patient.

A. I don't know what their job description is.

Q. Okay. So you don't know that other people have the same level of responsibility --

A. That is not my response. I don't know what their job description is.

MR. THOMESSEN: That is your response.

THE WITNESS: What is that?

MR. THOMESSEN: What did you say, Paul?

Q. That you didn't know if they had the same level of responsibility?

A. Correct.

Q. Thank you.

A. I do have to say to the Board too that that I am looking down the barrel of this IAB in the absence of any wrongdoing, and I do have posttraumatic stress disorder. I am

*IAB refuses special accommodations request.*

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J. Fasano

also service-connected for migraine headaches  
so sometimes you do have to rephrase things a  
couple of times for me, and it actually does  
cause me to become dyslexic.

ATB denies special  
accommodation  
request.

Q. With your kind permission, I am  
going to revisit that later.

A. I just need to revisit  
something myself.

Regarding that patient that we  
were talking about over in IDT that Matt  
discussed, he wasn't my patient. That was Dr.  
Mahmood's patient so in retrospect, why is  
this being dumped in my lap?

I don't know where Dr. Mahmood  
was that day, and there was no coordination of  
care, because that is how IDT is running in my  
experience in the long-term care environment;  
it is basically a free-for-all. It wasn't  
organized.

The other thing is that my  
concerns, I felt that I was being devalued and  
disrespected by the other discipline's names,  
like Dr. Welsh, who is a psychologist, like  
Melanie Brodsky, who is a social work

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J. Fasano

She said to me, "I don't know why certain people" -- she didn't elaborate on who -- "might have issues with you, because you are just a really nice guy," and other people describe me as a big bear.

I am. I am a bear who has been defamed, declawed and hobbled because of my disabilities.

Even when I was the trigger puller, there is a difference between being mean and being tough. I was extremely tough. You can't believe the fact that I got the 220 percent service connected rating, and also the difference between being nice and being weak.

I am tough and I am nice, but I am definitely not mean. As a matter of fact, people will accuse me of being too nice at certain points.

Had I not valued other people in the process, I wouldn't speak to them, but who knows what the dynamic is? Maybe they don't like me to begin with. Maybe they don't like anything about me.

*Also informed of  
discrimination +  
abuse of me  
by others.*

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J. Fasano

Because of that, when I speak to them, everything that comes out of my mouth becomes offensive to them or dismissive, but I can't help that. I can't help that I am big. I can't help who I am in certain unmodifiable factors of myself.

AKB informed  
of discrimination

Q. I particularly appreciate the fact of what you just stated, your respect of others, and you painstakingly explained you were asked to cosign and asked them to cosign notes.

How do you feel when other people ask you to cosign their notes?

A. I will cosign them to the extent that if there is no, let's say, bizarre mischaracterizations in the note, and if I don't agree with the context of the note -- if I am not in agreement with it, I can't say that I am going to sign-off on something that I am not in agreement with, that the person disrespected me so much that they couldn't talk to me beforehand about it.

Q. I get it, I get it.

You stated before, a few minutes

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J. Fasano

They said "Joe, he doesn't look like right," blah blah blah. I was getting yelled at by everybody. ER didn't want to take him back. Medicine didn't want to take him back. Infectious disease basically saying I'm an idiot.

I diagnosed the Medical Center's first case of flu in 2012, because I valued that input, because they were respectful of me.

I am not saying deferential, but they were respectful of me in the way they interact with me.

However, when Matt Bessell would ask me a question or Dr. Welsh would ask me a question, they were like jerking my chain, that is how I felt, or smirking at me.

If they asked me to evaluate a patient or they are asking about a care plan with a patient, they implied that I am not doing a good job, and then I am trying to educate them to the biggest extent that I can given the time constraints that we have to work with patient care.

*AKB informed of discrimination.*

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J. Fasano

But they didn't do that to any other team member. They don't do that to the attending.

*A13 informed of discrimination.*

If they cast themselves as such professionals, why does it have to come to a ROC, a Report of Contact? They could have talked to me, they could have talked to my boss or they could have gone to my attending physician.

No. It is just easy to keep hitting Joe because he is the big bad wolf, because he is big, he is loud, he is service connected.

Q. Let's move on, okay?

A. Okay.

Q. During these interactions, in IDT meetings in particular, it has been characterized that some of the exchanges are -- not even exchanges, they are pretty doctrinaire based on the staff --

A. What is doctrinaire?

Q. In other words, like -- let me put it in a colloquial way. It has been characterized that in some of the IDT meetings

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J. Fasano

If you see Fasano, you better bet that I am going to do my best to deliver and give you an excellent package.

CHAIRMAN HABERMAN: Off the record.

(Discussion off the record.)

CHAIRMAN HABERMAN: We are back on.

Q. You have alluded many, many times during this conversation about having PTSD and how it has impacted on your interpersonal interactions and how -- your response to stress on certain levels. Have you ever considered your perception of your PTSD to have an impact on your role as far as how people respond and work with you?

*ATB mocks my disabilities.*

A. The thing is --

MR. THOMESSEN: Let's go outside.

(A recess was taken.)

A. Yes, I have posttraumatic stress disorder, which makes up 70 percent of my overall 220 percent disability rating, service-connected rating.

Also, 30 percent contributing

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J. Fasano

of that is migraine headaches as a result of  
service sacrifice to my country.

My post posttraumatic stress  
disorder, however, does not interfere with my  
work performance as evidenced by the fact that  
for the past several years I have had three  
consecutive outstanding performance  
evaluations in a row.

I will submit to the Board just  
a brief excerpt of accolades that I have  
received from patients.

This was dictated from a  
patient to Maryann Tierney, social worker, on  
February 13, 2013. This went to  
Mr. Moschitta, and I knew it was submitted. I  
got a signed copy of this from the social  
worker. But do you think anyone from  
administration acknowledged my role in saving  
this veteran's life? No.

MR. THOMESSEN: That's standard.

A. I do want to submit this letter  
that the veteran wrote and gave permission  
that he signed.

I also want to submit a letter

1 J. Fasano  
2 on Senator Charles Schumer's letterhead,  
3 because veterans contacted him, unsolicited,  
4 meaning I didn't tell them "Go contact your  
5 congressman about me," but they were so happy  
6 about that they could finally connect with a  
7 veteran, and the rapport that they developed  
8 to me, and I actually made a significant  
9 impact on their lives, that Charles Schumer  
10 sends me a letter because so many veterans  
11 were contacting him.

12 That administration never, ever  
13 told me about all these letters that they were  
14 receiving on my behalf that were positive.

15 Q. Are these the total?

16 A. No. These are a sample of many  
17 letters.

18 Q. These are the only ones you are  
19 going to submit?

20 A. Correct.

21 CHAIRMAN HABERMAN: We will take  
22 these as Exhibit D.

23 (Letters marked Exhibit D.)

24 A. To continue, my posttraumatic  
25 stress disorder gives me the better insight

*ARB informed of  
disabilities*

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J. Fasano  
into the veterans that I care for and their  
emotional well-being.

How I am viewed can't be  
answered by me, but I let them know I have  
posttraumatic stress disorder and it doesn't  
interfere with my work, as we have just  
discussed.

Their perception of me, my  
detractors, is discriminatory against me,  
because they assume against the Americans with  
Disabilities Act that I must be crazy, poorly  
adjusted, rigid and volatile, which I am none  
of, because that fits their prejudice against  
what a veteran with PTSD must behave as, them  
not being veterans.

Their personal prejudices have  
also tainted their professionalism.

If I could continue.

As a result of that, I am a  
100 percent service connected disabled  
American veteran as a result of selfless  
sacrifice in service to my country.

I served with honor and  
distinction in elite United States Army

AlB informed  
of discrimination  
of my disabilities.

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J. Fasano

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 treatment during my employment, I have made significant meaningful impact to patient care improving the quality of care and service to fellow veterans and positively influencing the overall care rendered to our nation's heros.

I am painfully reminded of my personal sacrifice every day having devoted my late teens and decade of my 20s to this nation. I am literally riddled from head to toe, inside and out and service connected to an extent of 100 percent; however, I gracefully persevere as the guidon bearer for my comrades that no longer can, with valor and courage of conviction, losing a popularity contest with great personal harm in the process.

Not all disabilities are glamorous. Not all disabilities are obvious. Not all disabilities are convenient. Not all disabilities have a heroic story. Not all

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J. Fasano  
disabilities are pleasant.

MR. THOMESSEN: Relax.

Q. Take a breath, Joe.

A. Not all disabilities can be  
turned off and tuned out.

MR. THOMESSEN: Let that picture  
slide by. Just take a breath.

THE WITNESS: I am just thinking  
about Len Taylor. My friend got killed on  
May 16th.

MR. THOMESSEN: He would want you  
to be strong.

A. Not all disabilities are  
convenient, not all disabilities have a heroic  
story, not all disabilities are pleasant, not  
all disabilities can be turned off and tuned  
out. The worst part of living with these  
disabilities is facing overwhelming ignorance  
and ignoble treatment in the form of daily  
workplace prejudice, including gossiping,  
rumor mongering and slander, having to endure  
a tirade of snide ridiculing and mocking me  
from everything to the way I speak, how I  
speak, my cultural mannerisms, my posture, my

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J. Fasano

gait and stance, et cetera, reinforcing the stereotype that I am virtually defenseless, like a bear that has been declawed, defanged and hobbled.

Only 18 percent of the VA Northport workforce are veterans sharing the same concerned disenchantment by a system that is only pro-veteran when it is convenient.

We have to speak for each other and support one another in hushed tones, in dark shadows, suffering in silence by a largely civilian workforce that is clueless 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 and guilt, particularly posttraumatic stress disorder.

Veteran employees are at a distinct disadvantage compared to their civilian counterpart since our VA and Department of Defense medical records and service records screens can be freely accessed by any employee with our entire Protected

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J. Fasano

Health Information on display for all to see.

Unfortunately, I have been the victim of this inappropriate 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, both with long sordid histories of this type of behavior at the VA, in the absence of any wrongdoing and without ever counseling me or asking me for my side of the story.

In the absence of any wrongdoing, the agency took a unilateral personnel action based solely on hearsay, false accusations and fake allegations labeling me a dangerous person.

I have not received any sort of statement of charges so I have no idea what I am facing or up against.

Preparing an adequate defense and response has been impossible since I have been restricted from the campus and access to any potential supportive witnesses, information e-mails, documents, et cetera.

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J. Fasano

This personnel action has harshly extended to me as a veteran and a patient. The severity of the police escort restriction is so severe that it prevents me from accessing my health and benefits that I am entitled to by law as a 100 percent service connected disabled veteran, since it exacerbates my PTSD.

This is very humiliating for me to be paraded around like a criminal without any 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 a sacred trust desecrated by the abusive and disparate treatment that I am receiving as a 100 percent service connected disabled American veteran.

I don't know what kind of course correction can get the VA Northport's moral obligatory bearings back on track again.

I consider this action retaliation for the current EEO cases that I have, as well as whistle blower retaliation

1 J. Fasano  
2 according to the Office of Special Counsel's  
3 Prohibited Personnel Practices, having informed  
4 the director of serious patient safety issues  
5 in long-term care, whose reporting and  
6 documentation was being suppressed by Dr. Limb,  
7 to the extent that she would scream and  
8 threaten me and others for filing incident  
9 report forms creating a culture and climate of  
10 fear of reprisals versus doing the right thing.

11 It's no small wonder that the  
12 CLCs have received the absolute worst possible  
13 ratings by Long Term Care Institute Survey for  
14 nearly three consecutive years without any  
15 sense of course correction.

16 It was this mess and broken  
17 environment that I was forced to conduct  
18 business on a daily basis fighting a Sisyphean  
19 task; eventually being crushed by the boulder  
20 of retaliation to force a submissive  
21 capitulation.

22 MR. THOMESSEN: Enter that in.

23 CHAIRMAN HABERMAN: This is a  
24 statement that was just read by Mr. Fasano. We  
25 are going to enter it in as Exhibit E.

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J. Fasano  
(Mr. Fasano statement marked  
Exhibit E.)

Q. Joe, if I may, I would like to  
continue on the discussion about your PTSD and  
your service connection.

To your reference, you said it  
has never gotten in the way of doing your role  
here, but you have alluded to in the memos that  
I received from the Workplace Violence  
Committee -- the ones that were submitted to  
Rich through NFFE -- that certain actions taken  
by some of the other members of the IDT and  
some of the other disciplines have focused on  
that; that their actions have served to trigger  
your PTSD, or as analogous to a -- to  
exacerbate it.

Has there been a time in your  
employment here where you have had to look at  
that situation and say "This is a challenge for  
me in my role"; that your PTSD is a challenge  
for you in your role, that you are controlling  
it, et cetera, but that it is a challenge; that  
because of certain situations they bring that  
out? It is alluded to in your statement also,

*ATB marks my  
PTSD. Aggressive  
+ insensitive  
discriminatory  
humiliating line of  
questioning  
beyond scope of  
purpose of  
ATB since  
my disabilities  
are not  
on trial!*

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J. Fasano  
and it has been alluded to multiple times in  
your statements here.

But would you characterize it  
that way, that this is a challenge for you?

(Discussion off the record.)

A. Yes. It is a disability so it  
is a daily challenge every single day in all  
aspects of my life.

As far as interfering with my  
life, no, and it doesn't interfere with my  
capacity to work.

However, because of this  
current situation that I am unfairly being  
treated like an animal with this police  
escort, it exacerbates my PTSD.

The facility, though, refuses  
to make a special accommodation for me. They  
unfairly extended a personnel action, which  
disrupts my ability to access my care as a  
veteran, and during this time frame it is so  
bad for me to come here, I have to now do  
phone consultations with VAP, okay?

They won't even pay for a fee  
basis psychiatrist. I have to pay privately

ARB informed of  
denial of  
special accommodations  
request

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J. Fasano

during this time for me.

I filed complaints with the patient advocate that I consider this patient abuse of me, because that personnel action got extended to me as the veteran.

I also make sure that I seek assistance privately, because I don't trust the privacy of my records here because they get freely accessed and people talk, and people talk, and then it gets twisted into a prejudicial way that they want to use against me.

But it is a daily challenge. It is not glamorous. It is not obvious.

But people think that if you have PTSD, you just snap and go off the deep end, but that doesn't happen, because you have to look at how someone is consistent.

An analogy would be the exacerbation of flu-like symptoms. They range anywhere from mild to very severe, and that is what happens to me.

As an example -- I am not pulling out a firearm. I am not dangerous.

1 J. Fasano

2 MR. THOMSEN: Apparently you  
3 are because of the police escort.

4 THE WITNESS: True.

5 A. And I have been mocked and  
6 phoned -- I have been mocked and sniggered at  
7 my entire employment. People call me a  
8 phoney. People say I am a fake veteran. Dr.  
9 Tia (ph.) kept calling me a fake veteran and  
10 falsely said I had never served.

11 So I want to just show you -- I  
12 keep this every day, I keep this heavy burden  
13 on me.

14 This is the Special Operations  
15 Forces Medical Handbook. This is the  
16 June 2001 edition.

17 Recognize that person right  
18 there? Captain Joseph Fasano.

19 So I would not be listed in  
20 this book, I would not be listed as a  
21 contributing author or part of this team -- I  
22 am also in the June 2008 editions -- if I was  
23 a fake or a phoney.

24 What I am saying is this is the  
25 burden I have to carry every day as a reminder

1 J. Fasano

2 to me.

3 CHAIRMAN HABERMAN: Thank you.

4 Mr. Fasano has submitted for the  
5 observation of the Board the Special Operations  
6 Forces Medical Handbook from the United States  
7 Special Forces Command, of which he is listed  
8 as a contributing author.

9 Q. Continue about these  
10 challenges. This is not something that you  
11 have had to -- this given situation since the  
12 end of May notwithstanding, it is not  
13 something that is something that has come up  
14 for you that you would say, you know -- to  
15 rephrase what you are saying, this has not  
16 gotten in the way of your functionality; this  
17 is a matter of something that you deal with,  
18 even though you said the symptoms wax and wane  
19 from being non-existence to severe, but you  
20 had that always under control and able to --  
21 it doesn't get in the way of your functioning,  
22 is what you are saying?

23 A. No, but I could prove that  
24 because of the fact that I had outstanding  
25 performance evaluations, and despite what some

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J. Fasano

detractors might say, the overall majority is positive about me.

Q. When you get a proficiency as a registered nurse here, the proficiency is based on your performance, your collegiality, scientific inquiry and educational development. Those were the four parameters.

A. Right.

Q. Any behavioral issues are not addressed, or any interpersonal, except for literally collaboration for the actual patient care. They are not addressing your proficiency.

A. But they would be addressing a counseling statement, and I have never, ever, in my entire employment at the VA, ever had a counseling statement that I had a behavior problem.

Q. You said that, and I am letting you know I appreciate your outstanding proficiencies, but the matter before -- that we are looking here now, the question of workplace violence and patient abuse, the patient abuse notwithstanding, the other

1 J. Fasano  
2 matters are not addressed. They are addressed  
3 in a counseling which you said you have never  
4 had.

5 A. Correct.

6 Q. Just making sure you are clear  
7 on that. I appreciate your four outstanding  
8 proficiencies. That's wonderful. Those are  
9 your clinical ability, which is --

10 MR. THOMSEN: Can we --

11 CHAIRMAN HABERMAN: Off line,  
12 please.

13 (Discussion off the record.)

14 Q. With the understanding that  
15 collegiality has to do with the total totality  
16 of your collegiality, understanding that,  
17 things that come off the norm as far as  
18 interpersonal, those are addressed; not under  
19 proficiency. Those are addressed under  
20 counseling. You said you have never gotten  
21 one, and I appreciate that.

22 A. I would also like to further  
23 state that I have never received a verbal,  
24 informal, written counseling, an admonishment,  
25 a suspension or a reprimand in my entire

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J. Fasano  
employment or any in my entire professional  
career.  
Q. Got it.  
Barbara?  
BY MS. ALBANESE:  
Q. I would like you to ask you a  
question. You have described yourself many  
times as being big and loud and can appear to  
be somewhat intimidating. What have you done  
with that personal knowledge to check how you  
present to other people?  
A. I can't change my size, but I  
try to remain seated at all times.  
Again, you could say what have  
other people done in their daily lives and my  
detractors for things about them that may not  
be unpleasant -- or that may be unpleasant?  
As far as --  
BY MR. WINTCH:  
Q. That is true, but we are  
talking about you.  
A. Right. But there is an  
interaction here. A communication is a  
two-way street so there is a communication

AIB mocks  
my disabilities.  
line of  
inappropriate +  
insensitive  
interrogation  
beyond scope +  
purview of this  
AIB.  
Interrogators lose  
all objectivity  
attacking my  
disabilities.

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J. Fasano

interaction.

I mean, the people who say that, if you had listened to my thing about my disabilities, people say I am very stiff. They make fun of me on how I walk, and they even mentioned it to my union president, but they don't know that I broke my back like two times on a jump and I am in horrible pain. I am service connected from neck to back for a service connection. I have to stand a certain way.

But, but, it comes across that I am arrogant.

BY MS. ALBANESE:

Q. Joe, Joe, again, just asking what do you do to moderate your presentation --

A. I try to remain seated as much as I can.

Q. Your verbal --

A. The verbal, I do try to tone it down. I do try.

Again, I am not always successful of it, but I don't yell.

*ATB attacking my disabilities. I cannot shriek - God made me big!*

1 J. Fasano

2 Q. Is your presentation because of  
3 hearing and that is a piece of it, or is it  
4 that it is just your voice?

5 A. I mean, it could be --

6 MR. THOMESSEN: Let's go outside  
7 for a second.

8 CHAIRMAN HABERMAN: We are  
9 offline.

10 (Discussion off the record.)

11 A. So we talked about that.

12 I mean, part of my  
13 service-connected conditions do affect the way  
14 I speak, how I speak, the volume at which I  
15 speak, but you are faulting me the same way  
16 you would be faulting, it sounds, someone that  
17 would be -- let's say, I was in a wheelchair,  
18 paralyzed. That is like saying to that person  
19 "Have you done anything to try to walk?"

20 Certain things are very  
21 difficult, and no one would think to say  
22 something that offensive to that individual.

23 Let's see. I have  
24 post-traumatic stress disorder, migraines, and  
25 I had a stroke when I was in the army as a

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J. Fasano

result of the dangerous things that I did.

So if people want to say to me "Joe, you are a little loud," I will tone it down, but that is like saying to anybody that has any obvious disability -- and to me it is very insulting and offensive to say to them if they have to modify their disability in any sense.

To me it comes across that someone -- that the same type of this demand that is being placed on me needs to be placed on everybody that has a disability or whatever disabling condition that they have.

Q. What I was just --

A. I am not yelling at you, by the way.

Q. Thank you. I am glad you clarified that. That is the piece I am saying, is that you do, you know, and sometimes --

A. It is not sometimes, Ms. Albanese. It is constant. You have to prioritize what it is you are going to work on.

I should not have to defend my disabilities to the ATB.

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J. Fasano

For instance, when I am in severe pain in the winter, it is bad. I am focused in on that because I have to get through the day.

People say "Why don't you take medication for it?"

Because I don't have to, number one.

Number two, I can't because I am service-connected for a gut condition. Because of all the stuff I was on because of my service-connected conditions, ruined my stomach.

So if I walk a certain way, or -- someone recommended to me "Joe, take off your white lab coat." I wear a 52 extra long lab coat, and then it is stuffed with all my medical equipment so I am going to look like this big white Michelin man, so that could be imposing.

You could laugh because I laugh at it.

Then I get very stiff and kind of walk like Frankenstein if I am in a lot of

*Paul Haberman  
starts laughing at  
my disabilities.*

1 J. Fasano  
2 severe pain because of my knees, because of my  
3 ankles, because of my feet.

4 I sometimes will try to take  
5 off my lab coat so I don't look as stiff, but  
6 I can't help it.

7 Sometimes I can get really --  
8 people have complained they thought I was too  
9 stiff. They said "Look at the way he walks  
10 around. He is so arrogant."

11 The fact that -- do I have to  
12 go around with a band around saying "I got  
13 this disability and it could cause me to  
14 present this, this and this way"?

15 BY MR. WINTCH:

16 Q. Not at all, but you did mention  
17 earlier that the VA has not accommodated your  
18 disabilities. Those were your words just a  
19 few moments ago. Have you ever asked for an  
20 accommodation?

21 A. I have. I remember even  
22 with -- just even basic things like my work  
23 station with Laverne Glover, and I gave up,  
24 because I wasn't the things like the special  
25 qwerty keyboard or the special mouse and the

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J. Fasano

ergonomic work environment. The only thing I ever got for that as an ergonomic mouse pad, which made it hurt even worse.

As far as speaking to people, like supervisors, I have informed them "Listen. I have this going on in the background, and I do try to work with it, but you have to work with me here."

As far as putting in an official special accommodation, this paper here that I submitted as evidence earlier, I did submit that to Human Resources.

BY CHAIRMAN HABERMAN:

Q. You say you have hearing difficulties too which is part of your raised volume. Have you asked for a prosthetic?

*AtB mocks my disabilities*

A. No, but that is just like saying to someone who has any other disability have they asked for that, because that could be --

Q. Well, you alluded to the fact that if someone can't walk how do you try walking, well no, but if the person can't walk --

*Paul Haberman is blaming me the victim for my disabilities.*

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J. Fasano

MR. THOMESSEN: Can we go off the record?

CHAIRMAN HABERMAN: Sure.  
(Discussion off the record.)

CHAIRMAN HABERMAN: We are back on the record.

Q. Let's return to the question, Barbara's question about people's perception. You said "I can't help what they think."

What if what they think gets in the way -- not your disabilities, talking about your interpersonal skills -- what if they think that gets in the way of communication?

A. But, so, here is the deal. Let's just say someone has a visual deficit.

Q. We are not talking deficits. I am talking about your presentation.

A. But that is a presentation. They wouldn't think to only communicate them by writing something down.

If I have a coworker that I know can't see, I am not going to write them my notes. I am going to have to find a way on my responsibilities to communicate with them.

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J. Fasano

Communication is two ways at a minimum, it is not one way.

Just because a few people may have issues with me doesn't mean that now I have to become a chameleon or a hand puppet to just please and satisfy them, because I don't know what their prejudices are.

Q. Let me go to a different line of questioning. How do you feel about profanity in the workplace?

A. Well, do you mean profanity or vulgarity?

Q. Profanity. I am asking the question. You either go off-line --

MR. THOMSEN: Off-line. I can't say it off-line. You told me not to say it.

I am going to go off-line.

CHAIRMAN HABERMAN: We are off-line.

(Discussion off the record.)

CHAIRMAN HABERMAN: We are back on-line.

Q. I am alluding to the seven

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P R O C E E D I N G S

CHAIRMAN HABERMAN: Good morning.

This is Friday, the 28th of June, 2013.

This is a continuation of testimony from Joseph Fasano.

Present are all the board members and Rich Thomesen, the president of NFFE.

Good morning, Mr. Fasano. I just want to remind you your affirmation stands.

MR. FASANO: Mm-hmm.

Whereupon,

JOSEPH FASANO,

after having been previously duly affirmed, was examined and testified as follows:

EXAMINATION BY MR. WINTCH:

Q. I just had a question. Being the privacy officer, we saw some of the things we submitted through Rich that had to do with people accessing your medical record or doing criminal background checks on people on CLC 4. Could you just talk about that a little bit, maybe who you suspect to have been going into your record unauthorized and other people, if you could give us the names of people who did criminal background checks, and your

*ARB informed of illegal access of my VA medical records*

J. Fasano

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2 thoughts?

3 A. Well, Steve, you and I, and also me and  
4 Linda McGinty, over the past few years have been in  
5 contact, both verbal and e-mail, about my concerns  
6 and about my protected health information.

7 Q. Yes.

8 A. I know that the last time you and I had  
9 a telephone conversation you said that the director  
10 had said something to the effect that there were like  
11 a flood of requests coming in. Now, you have to  
12 understand that a lot of us veteran employees are  
13 very concerned and have very real concerns about  
14 people going into our medical record. And I  
15 expressed my misgivings to you a long time ago  
16 regarding the fact there is nothing that bars an  
17 employee from going into my record. Yes, that  
18 restrictive warning pops up, but all you have to do  
19 is ignore it. There's no way for me to know who's  
20 been accessing my record.

21 I had suggested that a really good  
22 deterrent would be that every time that someone  
23 accesses my medical record, I should get an instant  
24 message. That would be an awesome deterrent. So  
25 this way I know exactly who went into my chart, when,

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J. Fasano

whether they -- in real time data, and whether or not they had the authority or it was appropriate for them to access my medical records.

So I can tell you it's a very real concern because there are so few of us veterans -- veteran employees here at the VA Northport -- we're an extreme minority -- that we have to look out for each other, and so we talk. And that is what is talked about a lot, that our medical records and medical information is inappropriately used against us. And it puts us at a distinct disadvantage to our civilian counterparts because their protected health information is very difficult to access, where my mine is literally a fingertip away. You could go through my DOD records through the remote portal. It's very simple to do. It's called the remote accessing feature in there.

AFB advised of privacy breaches.

So to that extent, I know when I did request a couple years ago, you would only give me like a six-month time hack (sic) instead of the entire time block that I requested. It's my right as a veteran and a patient to know who's always been accessing my records, but for whatever reason a restriction was put on me. So that's why I had to

J. Fasano

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2 FOIA, even though I don't technically have to, in  
3 order to -- my rights keep getting trampled on at the  
4 facility.

5 It's very uncanny that four or five  
6 people, during that little time frame that you would  
7 release that information, went into my chart. There  
8 was no business for them to go into my chart. So it  
9 lends itself to -- it doesn't pass the sniff test.

10 During the short window of time, half a  
11 dozen employees have accessed my medical record, not  
12 once, not twice, not three times, but multiple times,  
13 and they had no business entering it. Who else has  
14 been snooping about my records, and what did they  
15 tell other people what they found in my medical  
16 record? How does that information then get  
17 transferred out in the rumor mill?

18 I would have to say I'm still a little  
19 upset. I know your perception is different from  
20 mine, but I'm a veteran. I'm the disabled person.  
21 And some comments that came from you guys yesterday  
22 was still very insulting and hurtful to me. You're  
23 blaming the victim. I'm being blamed for my  
24 disability. I have to elaborate on how other people  
25 just know about my disability, people that I never

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J. Fasano

even told about my disability, because not all disabilities are obvious. I'm not in a wheelchair and so people can't say well, he must be disabled or crippled.

ATB advised of privacy breaches.

I'm very concerned, as a veteran, an employee, that this has occurred because now people have labeled me -- because people target me and say I'm crazy and that I must be crazy and I must be dangerous because I had -- the different units I was in in the military. They can access my records screen. So they have this assumption that they put these things together, that then I must be dangerous. That was an unfair application of an interpretation of a policy and a personnel action that negatively affected my status as veteran and a patient, that bars me from accessing my rights and entitlements by law.

To that extent, I know that Maryann Tierney, the social worker -- because she openly would talk about it, that she would -- and I submitted I think a workplace violence memo on this -- she would do background checks on patients just out of interest or -- I'm not even sure, but in her capacity as unit social worker.

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J. Fasano

MR. WINTCH: These are criminal  
background checks?

A. Correct.

Q. Thank you.

A. And she did a lot of what you call  
"snooping and pooping around." In health care -- it  
doesn't matter if it's veteran or civilian, we have  
to deliver impartial care to anybody. It doesn't  
matter -- you could be a very bad person or Mother  
Theresa or somewhere in between. You have to give  
them the same access to the same level of quality  
care. That's it. Whatever else, it's superfluous.

Q. My follow-up question then to you --  
because I just want to stay with my train of thought,  
too. Do you think then that -- because looking up  
someone's criminal background, as you know, anyone  
can do. It's public knowledge. It's not a privacy  
violation by any means. She could do it at her home  
and she could --

A. You can't do it at your home, and I'll  
tell you why --

Q. You can because -- you can absolutely.

A. You could bring patient information home  
with their social security number?

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J. Fasano

CHAIRMAN HABERMAN: No, no. You can do a criminal background check.

Q. You can do a criminal background check.

A. On a veteran.

Q. On anyone.

The question is -- because that's not a privacy violation.

A. Okay.

Q. Do you feel, then, that that impacted the care that she gave those patients? Because you could do a criminal background check and still give impartial and excellent care.

A. I have to disagree on the criminal background check. Yes, outside of the VA, you could do a criminal background check on your neighbor and that's not illegal; however, you cannot use patient identifiable information that you have access to. You can't bring that home. You can't. First of all, you can't do that. Second of all, your home computer does not have the same fire walls and safeguards built into the system that we have here at the VA. So that makes that computer vulnerable. So it makes that data vulnerable.

Believe me, years ago when there was all

ATB advised  
of privacy  
breaches.

1 J. Fasano  
2 those big data breaches, I was one of the millions of  
3 veterans that kept getting letters about, you know,  
4 my PHI could have been compromised.  
5 CHAIRMAN HABERMAN: The laptop was lost  
6 in Virginia.  
7 A. Right. I got a whole bunch of those  
8 letters, too.  
9 So now, to get to the question for --  
10 because I remember -- I remember one example  
11 distinctly. I don't remember the person's name. I  
12 believe the last name started with the letter C, but  
13 Maryann said something to the effect, "Oh, my God,  
14 he's 6 foot 6. He's over 300 pounds. He's a Level 3  
15 sex offender and he raped, I think she said a  
16 7-year-old. And then she was worried about him  
17 coming to the unit. How are we going to handle him?  
18 He doesn't belong here. And he wound up dying out of  
19 the unit anyhow. He never made it to the palliative  
20 care unit. Now, I wasn't responsible for the PC  
21 side of the house, but I had mixed feelings on that.  
22 I said, "My gosh, if that can happen to one person,  
23 that can happen to anybody." And I said, "That could  
24 very well happen to me."  
25 Q. What could happen?

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J. Fasano

A. That someone can just access my data and information. It's literally fingertips away.

Q. Thank you.

So I guess my question was -- and you can just say "yes" or "no" or whatever.

A. Okay.

Q. Did her looking up that information, knowing that information affect the patient care that she gave? Was anyone's care compromised?

A. I would say yes because there was a perceived delay in having these patients that were deemed -- what's the proper term -- for lack of a better term, not as good as, let's say, someone else that didn't have the same type of criminal background or whatever.

You have to understand, you could pull the workload, Steve, and you could see on a 10-to-12-beds palliative care unit capacity, look to see for the past eight months what the census has been. It's been less than 50 percent. The vacancy rate is 75 percent. The occupancy rate is probably 25 percent. But let me put that in real terms for you. Two of those patients on palliative care, Both of them, two of them had been there for two years.

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J. Fasano

So you can't count them into the mix. It still was a big question mark on how someone who is very healthy can be maintained on palliative care unit for two years. He eventually got discharged because he wanted to just live with his brother on the outside. One of those patients is still on the unit. He's been there for, like, two years.

So when you really look at the true numbers, how is it that a 10-to-12-bed palliative care capacity unit is not full? It should be full all the time. The census should be high.

Q. And you would attribute that to people doing criminal background checks?

MR. THOMESSEN: Could we talk outside a minute?

THE WITNESS: Yeah, sure.

(Recess.)

CHAIRMAN HABERMAN: Go ahead.

A. So I believe that she would otherwise not have access to the veteran demographic data, including name, full social security number, date of birth, address, to perform a sophisticated or more specific detailed background check or just even a Google search and access to prior notes whether they

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J. Fasano  
were VA or private.  
That phrase, that should have never been included as part of the conversation. It should just be, "We have a veteran in the community who's eligible to access their entitlements. We have an empty bed. Let's put them in it." That's it. That's how it should go.  
MS. ALBANESE: What phrase?  
THE WITNESS: About --  
CHAIRMAN HABERMAN: The sex offender thing?  
A. Sex offender, criminal, whatever it has to be.  
BY MR. WINTCH:  
Q. Just so you are aware, because it sounds like you may not be aware.  
A. Okay.  
Q. It's well within the purview of a social worker to do those background checks on any patient who comes up here, especially considering that we have the day care. And to protect the children at the day care or children who come to the camp here, it is well within the purview of a social worker to do those background checks. I have spoken to John

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J. Fasano

Sperandeo about this on more than one occasion.

Just to follow up on the accessing the record, which, of course, we do take veterans, especially veteran employees' privacy very seriously. We do our best to safeguard it, and I do appreciate each time someone comes and wishes to get access to the list of people who do the records.

I just wanted to add also that Mr. Moschitta really has never made a comment about the barrage of requests. I don't really let him know requests that come in. It's not something that I need to report to him about. If he asked, I would tell him. We get a steady stream of requests, but it's never this big wave that comes in. We tend to get them, just FYI, after I do a new employee orientation session, because Linda and I mention it, and you can do that.

However, would you please tell me who has access to your record according to your knowledge or who you have suspected accessed your record?

A. For the time frame that you released it a couple of years ago, it's not germane to this particular investigation.

Q. Okay.

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J. Fasano

A. However, you did tell me on the phone, Steve, that you were getting an increase or a spike in these requests and that there was -- and I asked you well, is there a policy on that? Do I have to put in a FOIA? And you said no.

*ATB privacy  
batches.*

So then you told me to send you an e-mail. I sent you an e-mail, and I flagged it "read and delivered." You got it delivered, but you never read it.

Q. But I did print out the list. And I even printed out a new one to bring to you. And I know that Linda McGinty recently gave you a list as well.

A. Not recently.

Q. Would you mind looking over that and telling me if there's any names of co-workers that should not have been in your record?

MR. THOMSEN: Off the record for a minute.

(Discussion held off the record.)

CHAIRMAN HABERMAN: I have the transcript and I know specifically. The discussion was about people accessing veteran records and your concern about people accessing your employee veteran

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J. Fasano

records, because you're an employee here and they're readily accessible.

The purview of this committee, well known to you, is for the period we're discussing, that we're charged to look at. We are looking at that time frame.

MR. THOMESSEN: That's not the question. That's not what I understand the question to be.

Obviously then you need to rephrase the question.

CHAIRMAN HABERMAN: It wasn't my question. There was an assertion by Mr. Fasano. I never asked the question. Mr. Fasano said it three times, that he is concerned, as are other veterans, that as employees their veteran records are being accessed by people who don't have a means --

MR. THOMESSEN: His concern was that -- you're saying that within this peer review of --

CHAIRMAN HABERMAN: That is that time frame.

MR. THOMESSEN: Asked and answered. Asked and answered. That's done.

The other issues will be addressed --

CHAIRMAN HABERMAN: Exactly. He's 100

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J. Fasano

percent right. Thank you.

Go ahead.

BY MR. WINTCH:

Q. Are there any names of co-workers on that list from the time period you were on CLC 4 that shouldn't be on that list, shouldn't have accessed your records?

A. This does not cover the entire time frame at CLC 4, but --

Q. You told us yesterday you started on CLC 4 in the middle of August sometime, and that's from August 1st until the present day.

A. Anybody could have accessed my medical records going back to September 2005. It doesn't matter. And now we work together.

MR. THOMSEN: Could we go off the record?

CHAIRMAN HABERMAN: Yes.

(Discussion held off the record.)

CHAIRMAN HABERMAN: Before you go out, if it's not specific, then why bring it up? Why is it a concern to be brought up thrice at this committee if now we go -- and go to the effort to find out exactly what the real data is and to

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J. Fasano

reassure you and to show you what we have, and now  
it's not a concern, but why was it brought to this  
committee?

THE WITNESS: It is a concern. Let's  
go.

CHAIRMAN HABERMAN: Take a break.  
Thank you.

(Recess.)

CHAIRMAN HABERMAN: Finish your  
thoughts.

BY MR. WINTCH:

Q. So that record is provided to you as a  
courtesy to cover the period of time that is being  
investigated, and I'm sure, as you know, the privacy  
or information security officer can go in and check  
who has accessed people's records as a spot check any  
time that we wish in order to do our jobs.

Were there any names on there that  
accessed --

A. Right. But this isn't a courtesy. This  
is my right. I'm 100 service connected. It's not a  
courtesy. It's my right. It's my right.

Q. I'm aware of that.

A. It's my right.

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J. Fasano

Q. Since Rich was saying you hadn't specifically requested that copy, it's being provided to you as a courtesy.

A. Okay.

I requested the records as a greater scope of privacy breaches that have occurred at the VA on my medical records. However, what I was handed today is significantly limited in scope outside of the time frames that I've requested, stating September 1, 2005 to the present.

Q. I've never received a September 1, 2005 to the present request.

A. We'll resubmit that then.

Fear of others knowing my disabilities, without me telling them directly, has caused me substantial personal harm, professional harm and emotional harm. And my continuous requests over the past couple of years to the Privacy Office have been denied. My verbal requests and my written requests.

Q. Your one written request -- and it has not been denied.

A. So for me as a veteran, these repeated denials for this information gives the appearance that the organization is hiding something. It's not

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J. Fasano  
a transparent practice. A sending of requests during  
the time period that covers my EEO complaints, I  
consider this action retaliation for two EEO  
complaints that I have currently against the  
facility.

AIB privacy  
breaches.

MR. THOMESSEN: Who do you have them  
against?

THE WITNESS: Dr. Tank and Joanne  
Anderson.

A. According to this list, there are --  
we've identified up to twelve individuals that I have  
no idea why they've accessed my medical record for  
the time frame August 1, 2012 through June 7, 2013.  
I will name them.

Barbara Inskip, June 26, 2013.  
Regina Divico, November 2, 2012.

CHAIRPERSON HABERMAN: Are you going to  
read them all?

THE WITNESS: Yes.

CHAIRMAN HABERMAN: No. You're going  
to submit the list. You will not read them for the  
transcript.

MR. THOMESSEN: Why?

THE WITNESS: Why?

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J. Fasano

MR. THOMESSEN: There's only twelve people.

CHAIRMAN HABERMAN: Oh, I thought he was going to read the whole thing.

THE WITNESS: No.

MR. THOMESSEN: No, just the twelve names.

CHAIRMAN HABERMAN: Fine.

A. Luesender Carter, May 21, 2013, twice.  
Eleanor Hobbs, June 11, 2013.

And what's disturbing is that on some of these dates I haven't even been to campus. I can't come to campus. It was very clear yesterday that having a cop with me -- unjustified -- exacerbates my PTSD.

Eleanor Hobbs, June 11, 2013.

Cathy Washburn, June 11, 2013.

Marie Irwin, three times on June 12, 2013.

Angel Thomas, once, June 12, 2013.

Gino Nardelli, police officer, May 24, 2013.

Porshe Leshore, November 20th.

Porshe Leshore, twice, October 3, 2012.

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J. Fasano

Let me back up. Gino Nardelli, police officer, May 24, 2013.

Porshe Leshore, November 20, 2012.

Porshe Leshore October 3, twice, 2012.

Porshe Leshore, September 13, 2012.

Porshe Leshore, September 10, 2012.

Porshe Leshore, August 15, 2012, three times, three times.

Marcia Bowens, June 18, 2013, twice.

Paola Valencia, October 17, 2012, three times.

Q. Thank you. We take those accusations very seriously, and I will look into those names. Maybe afterwards we can step out and you can give me a copy.

A. Sure.

MR. THOMESSEN: You gave him the copy.

MR. WINTCH: I need the copy of the names he wants me to investigate.

CHAIRMAN HABERMAN: And we'll give a copy, before we leave, to the reporter so she can put them in. Then you can have it back.

THE WITNESS: I need to mention the other people?

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J. Fasano

MR. THOMSEN: Yes, absolutely.

A. For the prior time frames, the very limited time frame that I was released in the past, I don't have that information with me, but I do know by memory. I recall.

Scott Diaz, Cathy Washburn, Florence Ford, Vanessa Brown.

And you and I spoke about this on a couple of occasions in the past, and I don't know where the follow-up fell through.

Q. I'll go -- and again, I'll collect those names afterwards from you, so I have my complete list. Thank you, Joe.

BY CHAIRMAN HABERMAN:

Q. All right. I have several questions, Joe.

There was a concern about the discussion of firearms on the unit, recreation use of firearms. I'm not going to give you an open-ended question because it can be quite arduous to go through this, but did anyone -- did Maryann Tierney or Dr. Calandrino, having that discussion that you alluded to about firearms or recreational firearms in your workplace violence submission, did they -- I have to

*HRB privacy breaches.*

## AIB BRADY VIOLATIONS VA NORTHPORT NY

Siobhan S. Bradley  
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Washington, D.C. 20036  
10/29/2013

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. Copies of the transcript are available upon review.

## AIB DISCRIMINATION/ADA VIOLATIONS

Siobhan S. Bradley  
Attorney, Disclosure Unit  
U.S. Office of Special Counsel  
1730 M Street, N.W.  
Washington, D.C. 20036  
10/29/2013

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. Copies of the transcript are available upon request.

## RESPONSE TO ASSAULTIVE AND DISTURBANCE SITUATIONS

1. The Occupational Safety and Health Administration (OSHA) has recommended that each individual VA medical center develop and implement a written Violence Prevention Program (Assault Prevention Plan) that identifies risk factors for violent behavior, emphasizes prevention techniques using forethought, assessment, and preparation), early intervention, and minimizes exposure of employees to violent behavior. The training of all facility employees, including VA police officers, volunteers, and staff, in the prevention and management of violent behavior is a principle element of the Violent Behavior Prevention Program.
2. General Definitions:
  - a. Criminal Assault – When a person unlawfully and intentionally causes bodily harm to another person, or places another person in fear of imminent bodily harm.
  - b. Patient Abuse – Unkindness, rudeness, verbally inappropriate comments, rough treatment, responding to a patient's disturbed or violent behavior with violence. Patient abuse must be reported to the employee's supervisor.
  - c. Physical Assault – Intentionally touching someone without his or her permission or making an imminent threat to do so. This includes physical altercations between beneficiaries, patients, visitors, or staff.
3. Warning signs of potential physical assault:
  - a. Verbally Aggressive – Unwanted yelling, cursing, "talking ugly", telling others that they are not wanted, threats, sexual comments, or racial insults.
  - b. Physically Aggressive – Unwanted pulling/grabbing hair, pushing, shoving, kicking, throwing things, hitting, swinging, spitting, biting, pinching, shoving, scratching, tripping, grabbing, or touching another's body parts. Threatening with a weapon (knife, gun, bomb, etc.) or with something that could cause seriously injury (pool cue, baseball bat, golf club, etc.)
  - c. Property Destruction – Breaking, defacing, or damaging the property of another, intentionally tripping over objects or furniture, setting fires, dropping burning ashes, stuffing or clogging toilets or sinks, defecating anywhere other than in a toilet, urinating anywhere other than in a toilet, urinal, or shower.
4. In situations where patient violence exceeds the ability of the patient care staff to control the situation or the threat of serious injury and property destruction exists, police officers should be called to restore order and should do so in an expeditious manner.

3. The senior or responsible patient care staff member at a scene should always clearly signal to the police when to intervene. Members of the treatment team should remain available to assist the police to pursue appropriate courses of restraint or attempts at voluntary submission. When control of the patient has been established, the police officer must clearly indicate the return of patient responsibility to the patient care staff and the termination of their involvement.
6. The availability of trained and effective police officers does not abrogate or lessen the fact that direct patient care personnel have foremost responsibility for the handling of disturbed or disorderly patients, and when necessary for their restraint. It is recognized that no employee should be needlessly subjected to excessive physical abuse or serious bodily harm. However, police are not to be used as a disciplinary force responding to minor disturbances that are within the capability of the patient care staff to manage. The police should be called in all cases of severe patient violence, whether in progress or pending.
7. It is considered appropriate to use police officers to assist in escorting violence-prone patients between wards and clinics or other internal or external facilities when the attending physician believes such precautions are necessary.
8. Ordinarily, assaultive behavior by an individual that results in the injury of another, or in the destruction of property, constitutes a criminal offense. However, most emotionally disturbed patients or applicants for medical care who become assaultive and inflict injury or damage require special understanding and compassion. Courts of law recognize this need through "mitigating circumstances." The assessment of these factors has become a responsibility of the medical staff, police, and management officials.
9. Generally, it is understood that the arrest and punishment of an assaultive person whose illness has significantly heightened emotions and impaired self-control is unjustified. For more serious misbehavior or irresponsiveness to administrative action, police officers may issue a U.S. District Court Violation Notice.
10. How police officers handle patients or others in various stages of violence is the same as for patient care personnel. That is, to continue attempts to calm the disturbed person and to use only the minimum force required to stop injurious action. Officers continue to have a responsibility to the patient even while involved in an altercation with that patient. Physical assault, or verbal abuse never justifies a similar response from a police officer.
11. Responses to emergency calls for assistance:
  - a. Must be prompt, but not reckless!
  - b. May pose an image that is frightening to some patients.
  - c. Hasty or excited motions at the scene can seriously worsen the situation.

## 12. Conduct at the scene

### a. Police officers must have self-control to include:

- (1) Maintaining an outward appearance of calm in voice, movement, and facial expression;
- (2) If in a treatment setting must waiting or seek instructions from the person with medical responsibility; and
- (3) Contributing to order and organization through calm communication with staff personnel and direction to bystanders to leave the area.

### b. Approaching a disturbed patient or applicant:

- (1) If the situation permits, wait for your backup
  - (2) Only in cases of severe violence should the officers approach the assaultive patient simultaneously;
  - (3) Open communication with the patient through eye contact and calm speech
  - (4) Approach slowly and from the side, not head-on as in direct confrontation.
  - (5) While nearing the disturbed person use terms of courtesy, help, and respect. Be reassuring.
  - (6) Be alert for indications that the patient is hesitant to combine the violent action or aggressiveness. Respond accordingly with a friendly gesture (a smile or handshake) or withdrawal.
- c. Use of physical restraint:
- (1) If the assault continues, begin measures to physically restrain the assaultive person.
  - (2) Minimum force to gain control should be used. The person should be taken off their feet with the objective of applying restraints.
  - (3) The most common injury at the "take down" action results from the person's head striking an object or the floor. Extreme care should be taken to avoid this type of injury.
  - (4) Defensive parties to deflect blows and various immobilizing holds should be used. However, an officer should not strike an offensive hand blow (either open hand or closed fist) or a kick with the legs, except in clear and obvious life-threatening situation.
- d. Use of Chemical (OC) Oleoresin Capsicum Agent Projector or PR-24:

An assaultive patient in the course of violent motion or action may be subjected to PR-24 side handle baton techniques or chemical irritant spray. Officers should always employ the least amount of force necessary to stop the violent behavior.

13. Post-incident police assistance: Following the restraint of an assaultive patient, the medical staff person in charge will determine whether continued police presence or escort of the patient is needed. It is appropriate that police escort violent-prone patients, or that they stand by when the attending physician or other patient care personnel believe such precaution is necessary.

## 14. Communications:

### a. Two essential communication needs should be anticipated and provided for. These are:

- (1) Reliable equipment and procedures in which on-duty police officers may be contacted at any time from wards and treatment areas. Two basic technical systems in use at VA medical centers are described below:

(a) Radio-telephone circuit: police officers are provided portable two-way radios. This facilitates instant communication and direction during emergencies. Telephones will be promptly answered and requests for service will be broadcast by radio or phone patch to police officers.

(b) The duress alarm: In conjunction with the radio-telephone circuit, the VA medical centers will make use of duress alarm buttons in areas where disturbances may be anticipated. The duress alarm buttons are connected to annunciators located in the dispatch (insert appropriate information) area. Both visual and low audio signals are given at these annunciators when a duress alarm button is depressed. The annunciators indicate the source of the alarm. An immediate response to each alarm is required.

(c) A standard of audible signals at incident scenes:

- (1) The noise and commotion at the scene of an assault or disturbance may be distracting. It is essential that responsible patient care or administrative staff member promptly and clearly notify police officers responding to the call exactly what is expected of the police (unless obvious violent assault is taking place). For example, a doctor, nurse, or hospital official is in contact with the offender and aggressiveness has stopped, the police should be clearly signaled to "stand down". If staff efforts to control the disturbed individual have been exhausted, the police may be signaled to "take charge". This means for the police to immobilize and restrain the police may be person until the medical staff can regain control of the situation.

(2) Some situations are essentially threatening or disruptive, such as a belligerent person in the admissions area or waiting room. This person's prolonged belligerence, refusal to accept instructions, or intimidation of the staff can be upsetting to other patients and may warrant transfer to a private officer or the police operations area. "Take away" action is required whenever a person's behavior is infringing upon the staff's ability to serve others, is actually disturbing other

personnel, and the staff memorandum to the staff posted in the station. The person should also engage the medical equipment of the hospital for emergency use.

(1) The proposed proposal of all prearranged available requests are:

(1) To provide the responsible staff member at the scene to make a situational decision and to transfer authority.

(2) To facilitate communications and preclude any misunderstanding by police.

(3) To make clearly state what police action is desired by direct care personnel.

Department of Veterans Affairs      Operational Group      VHA OFFICE 115V-0018-053  
Attn: Mr. John Williams      07-01-2010  
Washington, DC 20340

#### PATIENT RECORD FILES

December 1, 2010

1. **PHYSICIAN:** This Veterans Health Administration (VHA) Directive outlines policy and guidance for the proper use of Patient Record Files (PRF) to enhance safety for patients, employees, and visitors.

#### 2. BACKGROUND

a. VHA is committed to a safety program that is systems based and focused on prevention, not on punishment or retribution. Preventative methods that target root causes are favored.

b. A PRF alert, VHA employees to patients whose behavior, medical status, or characteristics may pose an immediate threat either to that patient's safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter. PRF enhance both the right of all patients to receive confidential, safe, and appropriate health care, as well as the right of all patients to receive environment. PRF permit employees to develop strategies to most effectively challenge patients who, in an effort to receive VHA health care.

c. PRF was originally developed for the specific health care to patients who are identified as posing an initial moment of imminent danger. These PRF's are to be used very judiciously and approved either by appropriate local or VHA authorities.

d. The effectiveness of PRF is paradoxically based upon the degree to which their appearance on the computer screen is so unusual that it captures the attention of the user. Inappropriate use of any PRF reduces the effectiveness of all PRFs. Frequent training of busy clinic clerks, emergency department triage nurses, pharmacy technicians, and other typical PRF users is necessary to ensure appropriate use, and to maintain alertness to any PRF.

e. For ethical reasons, it is inappropriate to use a PRF in the absence of a clear risk to safety. Labeling them as difficult, problematic for two reasons. First, a PRF stigmatizes patients, compromises privacy because it reveals private patient information to anyone who opens the patient's chart, regardless of whether that person has the need to know that would normally justify revealing such information. Accordingly, a PRF must only be used for a compelling safety reason which satisfies the ethical component.

1. The use of PRF to label a patient as difficult or problematic is inappropriate. These are PRF are not an appropriate tool with which to identify, label, or stigmatize patients. The use of PRF to label a patient as difficult or problematic is inappropriate. These are PRF are not an appropriate tool with which to identify, label, or stigmatize patients. The use of PRF to label a patient as difficult or problematic is inappropriate. These are PRF are not an appropriate tool with which to identify, label, or stigmatize patients.

VHA VHA DIRECTIVE 115V-0018-053

patients, or is physically intimidating to the staff, patients, or visitors. In other words disrupting the normal operation of the hospital (disorderly conduct).

(c) The principal purposes of all prearranged audible signals are:

(1) To enable the responsible staff member at the scene to make a situational decision and to transfer authority;

(2) To facilitate communications and preclude any misunderstanding by police;

(3) To make clearly state what police action is desired by direct care personnel.

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

Corrected Copy  
02/03/2011

VHA DIRECTIVE 2010-053

December 3, 2010

PATIENT RECORD FLAGS

1. PURPOSE: This Veterans Health Administration (VHA) Directive outlines policy and guidance for the proper use of Patient Record Flags (PRF) to enhance safety for patients, employees, and visitors.

2. BACKGROUND

a. VHA is committed to a safety program that is systems based and focused on prevention, not on punishment or retribution. Preventative methods that target root causes are favored.

b. A PRF alert, VHA employees to patients whose behavior, medical status, or characteristics may pose an immediate threat either to that patient's safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter. PRF enhance both the right of all patients to receive confidential, safe, and appropriate health care, as well as the right of VHA employees to work in a safe environment. PRF permit employees to develop strategies to address the most behaviorally-challenging patients who, in an effort to receive VHA health care, are at risk of being injured or causing injury to others.

c. PRF was originally developed for the specific health care to patients who are identified as posing an initial risk to the safety of other patients, employees, or the public. The use of PRF is expanded to address a limited number of additional initial moments of a patient encounter. These PRF's are to be used very judiciously, and approved either by appropriate local or VHA authorities.

d. The effectiveness of PRF is paradoxically based upon the degree to which their appearance on the computer screen is so unusual that it captures the attention of the user. Inappropriate use of any PRF reduces the effectiveness of all PRF's. Frequent training of busi-ness users is necessary to ensure appropriate use, and to maintain alertness to any PRF.

e. For ethical reasons, it is inappropriate to use a PRF in the absence of a clear risk to safety. The use of PRF can be ethically problematic for two reasons. First, a PRF stigmatizes patients, labeling them as difficult, whether for clinical or behavioral reasons. Second, a PRF compromises privacy because it reveals private patient information to anyone who opens the patient's chart, regardless of whether that person has the need to know that would normally justify revealing such information. Accordingly, a PRF must only be used for a compelling safety reason which outweighs these ethical concerns.

f. The use of PRF is limited to addressing immediate clinical safety issues. However, PRF are not an appropriate tool with which to alert employees to every potential safety issue. For example, a patient's human immunodeficiency virus status is not an immediate threat to the safety of other patients, employees, or the public.

THIS VHA DIRECTIVE EXPIRES DECEMBER 31, 2015

(3) Establishing a plan to transition previous Vista, CHRIS, Local Class III, Advisories, and any other behavioral alerts or warnings system in use to VHA's nationally released PRF software. *NOTE: As of September 23, 2003, only PRF computerized databases as described in Attachment B are approved for use in the identification of patients who are at significant risk for violence.*

(4) Ensuring that each Category I PRF assigned to a patient is reviewed at least every 2 years; however, reviews may be appropriate anytime a patient's violence risk factors change significantly; the patient requests a review; or for other appropriate reasons.

(5) Training appropriate staff in determining when a PRF is to be entered, how PRFs are entered, and how PRF and PRF-related documents are to be maintained and reviewed.

(6) Evaluating the facility process to ensure that PRF is assigned appropriately.

(7) Ensuring that each PRF in a patient's record is accompanied by a TLU Progress Note. The TLU titles utilized must be:

- (a) PRF Category I, or
- (b) PRF Category II.

d. Clinical Executives: Chief of Staff (COS) and Nurse Executive. The COS and Nurse Executive are responsible for:

(1) Instituting procedures to ensure that the utilization of PRF and the associated processes for recommending PRF are clinical, ethically appropriate, supported by adequate resources, and used in accordance with this Directive.

(2) Ensuring that patients are notified that a PRF has been placed in their health record and that they are informed of its contents.

(3) Establishing a DBC or a Disruptive Behavior Board (DBB).

(a) The DBC or DBB is responsible for:

1. Coordinating, when possible and appropriate, with the clinicians responsible for the patient's medical care, and recommending amendments to the treatment plan that may address factors that may reduce the patient's risk of violence.

2. Implementing the standards in Attachments A and B.

3. Collecting and analyzing incidents of patient disruptive, threatening, or violent behavior.

4. Assessing the risk of violence in individual patients.

3. Informing patients they have a right to request amendment to the contents of a PRF, and providing the information for contacting the facility privacy officer in the event the patient wants to pursue an amendment.

6. Identifying system problems.

7. Identifying training needs relating to the prevention and management of disruptive behavior.

8. Recommending to the COS other actions related to the problem of patient violence.

(b) The DBC or DBB must be comprised of:

1. A senior clinician chair that has knowledge of, and experience in, assessment of violence;

2. A representative of the Prevention Management of Disruptive Behavior Program in the facility (see subpart 51);

3. VA Police;

4. Health Information Management Service and/or Privacy Officer (ad hoc);

5. Patient Safety and/or Risk Management official;

6. Regional Counsel (ad hoc);

7. Patient Advocate;

8. Other members as needed, with special attention to representatives of facility areas that are at high risk for violence (e.g., emergency department, nursing home, inpatient psychiatry, and community-based outpatient clinics);

9. Representative of the Union Safety Committee; and

10. Clerical and administrative support staff to accomplish the required tasks.

(c) The DBC or DBB, whose primary focus is upon reducing the risk of patient violence toward employees and others, will offer technical advice to other PRF software users as appropriate.

(4) Identifying a Suicide Prevention Coordinator who will be responsible for orienting, maintaining, and deactivating Category II Suicide PRFs in accordance with VHA policy regarding the use of PRFs to identify patients at high risk for suicide.



VHA DIRECTIVE 2010-053  
December 3, 2010

VHA DIRECTIVE 2010-053  
December 3, 2010

7. RESCISSIONS: VHA Directive 2003-448, dated August 28, 2003 is rescinded. This Directive expires on December 31, 2015.

Robert A. Petzel, MD  
Under Secretary for Health

Attachments

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 12/8/2010

#### ATTACHMENT A

#### STANDARDS FOR CATEGORY I AND CATEGORY II PATIENT RECORD FLAGS

1. **BACKGROUND:** A diverse group of patients present with certain behavioral or clinical risk factors that place special demands upon the health care system. It is both a privilege and a challenge for the Department of Veterans Affairs (VA) health care employees and facilities to offer safe and appropriate care to all patients. The safety of patients and the safety of staff who treat them can be enhanced when carefully designed Patient Record Flags (PRF) immediately alert care providers to the presence of risk factors *that must be made known in the initial moments of a patient encounter.*
  - a. Because some of the most challenging patients may be nonacute, and because a patient's electronic health record is increasingly available to other facilities, it is essential that conventions for creating, supporting, and maintaining computerized advisories be made uniform throughout VA's health care system.
    - b. PRFs should never be used to punish or to discriminate against patients; nor should they be constructed merely for staff convenience. The effectiveness of PRF's depends upon limiting their use to those unusual risks that threaten the safe delivery of health care. Threats to the effective use of PRFs are their misuse and overuse.
      - c. Providing an environment that is safe for patients, visitors, and employees is a critical factor in health care. The safety of patients and staff, as well as the effectiveness of care and patients' right to privacy and dignity, need not be compromised by threats of violence or other clinical safety risk factors. Risks associated with a history of violence or other risk factors can be limited when those risks are recognized and reported. Risks need to be addressed by an interdisciplinary group under senior clinical leadership and documented, when appropriate, in the patient's treatment plan. They must also be communicated in a standardized manner to those most at risk in an encounter with a "flagged" patient.
  2. **PROCEDURES:** Each facility must demonstrate its readiness to use PRF in a manner which is consistent with the standards and protocols outlined in this Directive.
    - a. As part of the patient health record, all PRFs are entered under the authority of the Chief of Staff (COS) or designee at each facility. *NOTE: PRF must be recorded the same confidentiality and security as any other part of the health record.*
    - b. The COS, or designee, at each facility is responsible for identifying those employees authorized to initiate, enter, and access PRF. The COS, or designee, must ensure that only those employees with a demonstrated need to know are permitted access to PRF menu options.
    - c. Access to viewing PRF's is recommended for employees who are likely to be the first to encounter a "flagged" patient, prior to or at the time of the patient's visit. Access includes viewing the type of PRF and the narrative associated with it. Those who access a PRF are

responsible for communicating the PRF advisory to doctors, nurses, and others who have a need to know. The following are examples of medical center staff who have direct patient contact needing to view, or be made aware of PRF:

- (1) Emergency room clerks and receptionists;
- (2) Administrative Officer of the Day;
- (3) Pharmacists and pharmacy technicians;
- (4) VA police officers;
- (5) Enrollment clerks;
- (6) Social Work staff;
- (7) Triage and telephone care staff;
- (8) Ward and clinic clerks;
- (9) Insurance and billing staff;
- (10) Receptionists;
- (11) Travel clerks;
- (12) Laboratory clerks and technicians;
- (13) All medical staff;
- (14) Patient advocates;
- (15) All Nursing staff;
- (16) Decedent Affairs Clerk;
- (17) Scheduling staff;
- (18) Fee clerks; and
- (19) Release of Information Clerks.

d. PRF software is in place. Although facilities may respond appropriately to PRF transmitted from other facilities, only facilities that employ the criteria in this Directive may enter new Category I PRFs.

e. A Text Integration Utility (TIU) Progress Note must be entered at the same time as the entry of any PRF. This note must provide general guidance to PRF users, and should include a brief summary of the rationale for the existence of the specific PRF. The progress note, however, is not the same narrative as the PRF itself.

f. A process exists for the review of each flag for risk of violent behavior at least every 2 years. A review may be appropriate when: the risk factors change significantly; a patient with a PRF requests a review; or for other appropriate reasons as determined by the facility that established the flag. A reminder for an upcoming review must be generated 60 days prior to the 2-year anniversary date of each PRF.

g. PRFs serve only to preserve and enhance the safety and appropriateness of patient care.

h. PRFs alert staff to a potential risk only; they are advisories. At each patient encounter, the examining physician or other clinician remains responsible for making appropriate clinical decisions.

i. Each facility must have clearly written definitions and entry criteria that are consistent with this VHA Directive) for all Category I and Category II PRFs.

j. PRF should be entered, only by employees who have been trained in the technical aspects of entry, with the appropriate criteria, and in the conventions for security, format, and terminology.

k. PRF must be free of redundant language, slang/verbiage or inflammatory jargon, and must provide sufficient information or guidance for action. PRF narratives must be written in language sufficiently specific as to inform readers of the nature of the risk and recommended actions to reduce that risk. The PRF narrative should also avoid alluding to site-specific persons, acronyms, abbreviations, processes, buildings, or other descriptors unique to the originating site that would have no meaning for other sites where the Veteran may appear.

l. In order for PRFs to be effective, they must be used only when necessary. PRFs should be deactivated when their usefulness has passed. Oversight of the importance of a PRF. Each facility must exercise great care in establishing optional Category II PRFs. Only when there is a compelling immediate clinical safety issue should additional PRF types be utilized. PRF is not to be used for staff convenience, or to address administrative or law enforcement concerns. Category II PRF types must adhere to the standards as spelled out in this attachment.

m. Patients may request an amendment to the presence or content of a PRF advisory through the facility privacy officer.

n. The Deputy Under Secretary for Health for Operations and Management (DUM) provides oversight to the Veterans Integrated Service Networks (VISN) to ensure that PRFs are appropriately implemented by the facilities.

o. All VHA staff must respond appropriately to the appearance of PRF.

f. All VISNs must establish processes for the origination and appropriate use of Category I PRFs.

(1) All facilities are required to implement and respond to Category I PRFs, regardless of which facility originated the flag.

(2) All facilities must participate in utilization of PRF, regardless of the originating facility for any individual advisory or type of PRF advisory. Only the nationally developed PRF is to be utilized.

g. The responsibility for ensuring the quality, timeliness, routine review, and documentation in support of a PRF advisory belongs to the originating facility.

(1) The advisory itself will reference the authorizing facility and the COS or designee who can provide additional information about a specific PRF advisory. A facility that, in the course of providing care to a patient who was "flagged" by another facility, discovers new information that could influence the status of that advisory should not amend the original advisory, but instead should contact the originating facility with the new information.

(2) The responsibility for ownership and maintenance of PRF needs to be transferred when it appears that a flagged patient has relocated to a new facility. The originating facility should make available to the new facility, copies of all documents and records in support of the advisory.

i. PRF Training.

(1) Training must provide instruction on how to utilize PRF software on the assignment, continuation, inactivation, and review of flags.

(2) Training content must address:

- (a) Various types of PRF.
- (b) Appropriate responses.
- (c) PRF confidentiality, and
- (d) Compliance with Public Law 105-220 Section 508 (see subpars. 5h and 5i).

#### ATTACHMENT B

##### CATEGORY I PATIENT RECORD FLAGS (PRF): SPECIAL REQUIREMENTS

a. Category I Violent and Disruptive Behavior are currently the only implemented *types* of Category I PRFs that are designed to appear in all Department of Veterans Affairs (VA) facilities where a Veteran is registered to receive care. All Category I PRFs require a Text Integrated Utility (TIU) Progress Note in the Computerized Patient Record System (CPRS).

b. Category I Violent and Disruptive Behavior PRF describe patient risk factors that may pose an immediate threat to the safety of other patients, visitors, or employees. Category I Violent and Disruptive Behavior PRF also recommend specific behavioral limit settings or treatment-planning actions designed to reduce violence risk.

c. Health care workers experience one of the highest rates of nonfatal injuries from workplace assault of any occupation in the United States (U.S.). Health care is one of only two industries that have merited special attention from the U.S. Occupational Safety and Health Administration (OSHA) (see subpars. 5a and 5b). When compared to employees of other health care systems, Veterans Health Administration (VHA) employees are two and a half times more likely to suffer injuries in violent incidents involving patients (United States Postal Commission, 2000; Hodgson et al. 2004). In recognition, VHA has initiated a broad-based program of violence prevention, including performance monitors through the Office of the Deputy Under Secretary for Operations and Management. Efforts have included the redesign of the basic course for all employees, "Prevention and Management of Disruptive Behaviors," and the development of new courses for geriatrics and other disciplines.

d. The Joint Commission recently made patient violence and its prevention, a focus of the Environment of Care Standards (see subpar. 5c).

e. VA's Office of Inspector General (OIG) in its report "Evaluation of VHA's Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients" (6H-A28-035, dated March 25, 1996) recommended that facilities communicate among themselves so that staff are aware of high risk patients regardless of where in VHA's system they may seek health care (see subpar. 5b).

f. For PRF to assist in the prevention of adverse events when high risk patients travel between facilities, all facilities must follow uniform processes as described in current VHA policy on inter-facility transfer. This would include noting any existing Patient Record Flag. The effectiveness of PRF's depends upon limiting their use to those unusual clinical risks that immediately threaten health care safety, and quality in the initial moments of a patient encounter.

g. The safety of patients and employees, the effectiveness of care, and the patient's right to privacy need not be compromised by threats of violence. Risk of violence can be mitigated by reporting, assessing, documenting, communicating, and developing treatment plans that specifically make violence reduction a treatment objective.



Static Risk Factors: (Include additional detail for each item checked)

- ..... Male Gender (10X risk for females)
- ..... Veteran's history of violence in and outside of health care facilities.
- ..... Consider frequency and recency of violence, and severity of injury to victims, if any.
- ..... Additional Comments:
- ..... Veteran's self-report of arrests and convictions for violent crimes.  
(Criminal background investigation data may be available in selected cases; if VA Police conclude that there is probable cause for obtaining and sharing this information on a need-to-know basis.)
- ..... Additional Comments:
- ..... Documented credible threats toward VA employees or patients.
- ..... Additional Comments:
- ..... Prior supervision/treatment plan failures, (e.g., probation, mandated Drug and Alcohol treatment).
- ..... Additional Comments:
- ..... Presence of serious psychiatric disorder, especially psychosis, or paranoia.
- ..... Additional Comments:
- ..... Head injury with Loss of Consciousness by history.
- ..... Additional Comments:
- ..... Dynamic Risk Factors: (Include additional detail for each item checked)
- ..... Recent incidents of disruptions, threats, or violence in or out of health care settings.
- ..... Additional Comments:
- ..... Recent (past 6 mos) abuse of Central Nervous System (CNS) stimulants, including Cocaine and Methamphetamines.
- ..... Additional Comments:
- ..... Recent abuse of ETOH or other CNS disinhibitors.
- ..... Additional Comments:

- ..... Presence of situational stressors and destabilizing events, such as recent incarceration, death of loved ones, financial problems, estrangement from his or her family, homelessness, onset of acute medical problems, and other destabilizing events.
- ..... Additional Comments:
- ..... Chronic pain or narcotics seeking behavior.
- ..... Additional Comments:
- ..... Documented impulsivity (e.g., financial, sexual, or other decision making).
- ..... Additional Comments:
- ..... Veteran's claims of weapons in his possession, especially new acquisition or relocation of firearms.
- ..... Additional Comments:
- ..... Risk Mitigation Factors: (Include additional detail for each item checked)
- ..... Numerous visits to Medical Center without incidents.
- ..... Additional Comments:
- ..... Positive recommendation of Veteran's health care providers.
- ..... Additional Comments:
- ..... Documentation of successful participation in substance abuse recovery program with a significant (60 days or more) period of sobriety.
- ..... Additional Comments:
- ..... Documented resolution of destabilizing events or factors.
- ..... Additional Comments:
- ..... Patient's acknowledgement of his previous disruptive behavior with plans for preventing recurrence.
- ..... Additional Comments:
- ..... Changes in patient's health status or mobility that would mitigate any threat the patient previously posed.
- ..... Additional Comments:
- ..... SETTING RISK FACTORS
- ..... Staffing issues (please describe):
- ..... Training deficits (please describe):
- ..... Supervisory issues (please describe):

ATTACHMENT D

NEW SERVICE REQUESTS  
CATEGORY I PATIENT RECORD FLAG (PRF)

1. BACKGROUND

Patient Record Flags were initially mandated by the Veterans Health Administration (VHA) Under Secretary for Health at the urging of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) solely as a tool for reducing the risk of imminent violence associated with 'high risk' patients. On August 28, 2003, Directive 2003-048, National Patient Record Flags, was issued in conjunction with a release of revised Veterans Information System and Technology Architecture (VISA) Computerized Patient Record System (CPRS) software. By alerting VHA employees to a significant *immediate* risk of violence, this software enables health care providers and other VA employees who may encounter a high-risk patient to take measures to offer the patient safe and appropriate health care regardless of where, in the VHA system, the patient appears and regardless of where the PRF originated. While initially intended to address the problem of high-risk-for-violence patients only, the PRF software was recognized as offering potential additional uses. It is expected that New Service Requests (NSR) for additional types of Category I PRF may be proposed. This packet is intended to assist those who are considering the proposal of NSR for Category I PRF types.

2. PROCESS

- a. Applicants should thoroughly familiarize themselves with the VHA Patient Record Flag policy prior to completing the attached application. The policy addresses the specific use of Category I PRF for preventing violence, but also includes many standards that will be used to measure the appropriateness of any future Category I PRF uses. These standards have been reviewed in depth and approved by the VA OIG, the VA Center on Ethics, and others that continue to monitor the use of Category I PRF. Applicants can also find more information about the intent and proper use of PRFs on the PRF Web site: <http://www.vista.med.va.gov/vista/PRF/default.htm>. **NOTE:** This is an internal VA Web site not available to the public.
- b. Category I PRF are, by definition, disseminated throughout all VHA facilities where the patient is registered. Category II PRF, in contrast, are entered locally and appear only locally at the originating facility. The present packet relates to Category I (national) PRF only. However, Directive 2003-048 is clear that even 'local' (Category II) PRF should be used judiciously and, as with Category I PRF, only for alerting users to immediate threats to the clinical care and safety of patients or staff. The more PRFs of any type to which receptionists, clerks, and other VA employees must attend in the initial moments of an encounter with a patient, the less patient any PRF alert will be. More is not better when it comes to PRF.
- c. The responsibility for PRFs is assigned to the Office of Mental Health (116) under Patient Care Services (11). The Deputy Chief Patient Care Services, Officer for Mental Health Services (116) has authorized the formation of a PRF Advisory Review Board to review NSRs for new

Category I PRFs. The PRF Advisory Review Board considers the NSR and other input required (textual or verbal presentation) and makes recommendation(s) back to the PRF Program Office (116A) to approve or disapprove with comments. The PRF Program Office (116A) then responds in the NSR with recommendation(s).

d. The PRF Program Office (116A) forwards the decision to the Chief Officer of Patient Care Services (11) for any other action that may be required.

e. Current membership of the PRF Advisory Group includes:

(1) The Deputy Under Secretary for Health for Operations and Management (10N).

(2) Patient Care Service, VA Central Office (11).

(3) Health Information Management (HIM) Program Office, VHA Office of Health Information (19).

(4) VA Office of Information and Technology (OIT) (005), PRF Project Manager.

(5) Field Subject Matter Experts, at least two at any given time.

(6) Office of the General Counsel, VA Central Office (02).

(7) National Center for Ethics, VA Central Office (10E).

(8) VHA Occupation Health Program (136A).

f. At the discretion of the chair, Deputy Chief Patient Care Services Officer for Mental Health (116), other subject matter experts may be called upon to evaluate specific NSRs.

### 3. APPLICATION

a. An online NSR application is available at: <http://vishia.meds.va.gov/ansr/> and is accessed by pressing the New Request button.

b. When filling out the form it is important to identify the unique issues of a PRF.

(1) Describe the clinical safety issue to be addressed. Note that the use of PRFs is restricted to the communication of information of a clinical safety nature that must be available in the initial moments of a patient encounter. As PRFs are effective only to the extent that they are unusual stimuli in the user's visual field, Category I PRF are to be used only for immediate clinical safety purposes, and only when there are no viable alternatives. Describe all possible alternatives to a PRF that you explored to meet your safety goals and objectives.

(2) Other factors might include any additional factors that make this request a high clinical safety priority that must be available in the initial moments of a patient encounter. Provide all

relevant VHA references, (e.g., Congressional Mandate, Directive, Secretary's Performance Measure, studies). Note factors both inclusive and exclusive that would justify entry of a PRF of this proposed type into the health record of a given patient, and also the factors that would be used to determine that the PRF would be no longer necessary. Describe the frequency with which a PRF of this type would be reviewed and by whom. Note on what basis this frequency of review is proposed. Also note that the PRF must be accompanied by a CPKS progress note.

DEPARTMENT OF VETERANS AFFAIRS  
NORTHPORT, New York 11768

CENTER MEMORANDUM 00-104  
December 22, 2010

SUBJ: PREVENTION OF WORKPLACE VIOLENCE

1. PURPOSE: [The Northport VA is committed to promoting a culture of civility and safety for veterans, visitors and staff where professional, courteous, respectful and collegial behavior is valued and practiced by all employees. This policy is intended to: support the efforts of the Northport VA to provide a safe and healthful workplace and an optimal healthcare environment; to describe and support the ongoing implementation of the Workplace Violence Prevention Program; identify and support policies and/or procedures designed to minimize or eliminate the risk for violent and/or threatening behavior (e.g., verbal or physical aggression); identify and support policies and procedures designed to minimize the severity of injuries resulting from violent behavior; identify and support efforts at the Northport VA to prevent and address disruptive and/or intimidating behaviors and the escalation of aggressive behaviors to potential violence; assure that employees exposed to disruptive, intimidating and/or violent behavior are provided appropriate medical care and counseling as needed.]

2. BACKGROUND: [It is well known that most workplace violence assaults occur in healthcare than in any other. VHA has developed and implemented programs to prevent violence and reduce risks associated with providing healthcare. These programs include the Prevention and Management of Disruptive Behavior (PMDB) focused on the enhancement of employee knowledge and skills with respect to identification of predisposing and precipitating factors associated with risks and intervention strategies to reduce such risks. VHA mandated the establishment of Disruptive Behavior Committees and Patient Record Flag procedures to help oversee the management of disruptive and potentially violent patients. VHA has also implemented programs designed to promote a culture of civility and safety, such as the Civility, Respect and Engagement in the Workplace (CREW) initiative, alternate dispute resolution and customer service programs, in part to reduce the risks for disruptive and violent behavior.]

[Disruptive and/or intimidating behavior can escalate to violent and/or threatening behavior by patients, beneficiaries, visitors, volunteers, and/or employees in the workplace or in the healthcare environment. Behavior that is aggressive, threatening and/or violent is a potential occupational health hazard in healthcare settings and at the Northport VAMC and other locations where facility employees are required to perform their duties.] Workplace violence is preventable and most acts of violence in the workplace have warning signs (verbal and non-verbal). Prevention of violence in the workplace greatly enhances services provided by allowing staff to safely interact with patients, beneficiaries, visitors, volunteers, and other employees. Additionally, preventive measures reduce costs associated with work-related injuries.

The Northport VA Medical Center is required by Federal law (Public Law 91-596 and Executive Order 12196) to provide a place of employment free from recognized hazards that may cause death or serious injury. The Occupational Safety and Health Administration (OSHA) has cited Federal facilities for failing to protect its workers from violent behavior in accordance

with Executive Order 12196, "Occupational Safety and Health Programs for Federal Employees," paragraph 1-201a.

[Clinical and administrative staff at the Northport VAMC are actively involved in numerous initiatives that are directly related to promoting a civil and respectful environment and/or to the prevention of and response to [disruptive, intimidating, violent and/or threatening behavior. The Workplace Violence Prevention Program has identified these important initiatives and related procedures/policies in section "g" of this center memorandum.]

3. POLICY: [In order to maintain a safe, professional and civil workplace and an optimal environment for patient care], violent and/or threatening behavior will not be tolerated at this facility. Persons (patients, beneficiaries, volunteers, visitors, employees) committing or threatening acts of violence will be reported to the appropriate authorities as identified in Medical Center Policies referenced in this document and prosecuted to the fullest extent of the law. Behavior that is intended to intimidate and/or provoke others is also unacceptable and will be responded to as outlined in this Center Memorandum and/or described in the Center Memorandum referenced in this document. [VHA expects VA medical center leaders and managers to communicate expectations to clinicians and other staff that disruptive, inappropriate, intimidating and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans.] Appropriate disciplinary action will be instituted against employees that are verbally or physically aggressive.

4. RESPONSIBILITIES:

A. Medical Center Director is responsible to:

- 1.) Assure that patients, visitors, employees and volunteers are provided a safe and healthful environment for treatment or for work;
- 2.) Ensure that systems are in place to notify appropriate law enforcement agencies and/or Risk Management staff as needed when a VA patient, beneficiary, volunteer, visitor, or employee is assaulted or is the subject of a serious threat as a result of direct or indirect employment-related involvement with the workplace.

B. Chief Psychology Service/Chairperson, Disturbed [Disruptive] Behavior Committees will serve as the facility Workplace Violence Prevention Program Coordinator and is responsible to:

- 1.) Coordinate the facility Workplace Violence Prevention Program;
- 2.) Assure that all employees and volunteers are provided training in [The Prevention and Management of Disruptive Behavior (PMDB)] [in accordance with paragraph 6];
- 3.) Serve as Chairperson [Employee/Employee Workplace Violence Review Team];
- 4.) Review the facility's Workplace Violence Prevention Program annually to assure that

the Program is current and addresses the facility's needs;

- 5.) Review data and information relevant to all incidents of workplace violence including ASISTS cases;
- 6.) Conduct incident investigations and/or studies of the possible patterns and trends of such incidents, if deemed appropriate, and to identify corrective actions and make appropriate recommendations to preclude incidents of violence at the facility;
- 7.) Provide the Medical Center Environment of Care Committee and Clinical Executive Board with periodic reports concerning program effectiveness to ensure the coordination of activities that are directly related to the prevention of [disruptive, intimidating, violent and/or threatening behavior;
- 8.) Provide consultative support to the Medical Center to assist in resolving identified problems;
- 9.) [ ] Coordinate [consultation] by the Disturbed/Disruptive Behavior Committee, the use of Behavioral Patient Record Flags (BPRFs) and the Special Intervention Program ("3-D Program") to develop, review and/or recommend [ ] clinical intervention plans for those patients who present unresolved safety concerns at the facility.

C. Chief, VA Police is responsible to:

- 1.) Assure that incidents involving significant threats and/or violence at the facility, in the surrounding neighborhood, or at off-site work areas are reported and addressed as part of the facility's Workplace Violence Prevention Program;
- 2.) Develop recommendations and implement corrective action(s) intended to preclude recurrence of violence at the facility (in collaboration with the Disturbed [Disruptive] Behavior Committee);
- 3.) Assist in the presentation of training to prevent and/or respond to violent behavior throughout the facility; and
- 4.) Assist and support the WVP Program coordinator and the [Disturbed/Disruptive Behavior Committee] [ ] to implement an effective Workplace Violence Prevention Program throughout the facility.

D. Medical Center Safety Officer is responsible to:

- 1.) Review reported incidents of violence involving visitors, employees or volunteers [ ] as part of the facility's Workplace Violence Prevention Program;
- 2.) Provide support for the development and implementation of corrective action(s) intended to preclude recurrence of violent behavior incidents involving employees (in

collaboration with the Disturbed [Disruptive] Behavior Committee);

- 3.) Provide support for the presentation of training to prevent and/or respond to violent behavior for employees and volunteers;
  - 4.) Assist and support the WVP Program coordinator and the [Disturbed/Disruptive Behavior Committee] [ ] to implement an effective Workplace Violence Prevention Program throughout the facility, including but not limited to guidance concerning environmental factors related to the prevention of workplace violence.
- E. Service Chiefs/Supervisors are responsible to:
- 1.) Enforce VA safety rules, regulations, and standards, including those concerning violent behavior;
  - 2.) Ensure that all incidents involving either potential violence, significant threat of violence and/or actual violence are reported to the appropriate personnel;
  - 3.) Investigate incidents of violence in the workplace involving a supervisee and document the results of the investigation on the ASISTS Electronic Form, VA Form 2162.
  - 4.) Assure that employees under their supervision receive prompt and appropriate medical attention in the event of injury;
  - 5.) Instruct employees and volunteers under their supervision in safe [and respectful] work practices as related to the prevention of workplace violence and correct employees or volunteers that do not follow safe [and respectful] work practices;
  - 6.) Assure that employees or volunteers who are verbally or physically assaulted, who witness violent behavior in the workplace, or who have demonstrated warning signs associated with potential violent behavior are provided counseling and professional support, as appropriate;
  - 7.) Initiate disciplinary action, as appropriate, against employees or volunteers who assault beneficiaries, volunteers, visitors, or other employees; and
  - 8.) Assure that all employees or volunteers assigned to them complete appropriate training to prevent and/or respond to [disruptive, intimidating, threatening and/or] violent behavior.
  - 9.) Assure that employees report all patient incidents, using VA Form 10-2633, where a beneficiary is involved in an incident that has harmed or has the potential of causing harm as outlined in CMI 00-134 Patient Safety Reporting Program.

F. Employees and Volunteers are responsible to: [All employees and volunteers are expected to conduct themselves in a manner that promotes a courteous, professional, and safe environment with civility and respect for all employees, Veterans, visitors, and volunteers.]

- 1.) Follow safe work practices (those that minimize the potential for violent behavior);
- 2.) Recognize unsafe conditions and immediately take corrective action to eliminate those unsafe conditions under the control of the employee;
- 3.) Report unsafe conditions to supervisory personnel, including situations in which they have witnessed a significant threat expressed verbally or behaviorally directed at themselves or others at the facility;
- 4.) Report work-related injuries to supervisory personnel;
- 5.) [Complete training required of employees or of volunteers related to the Prevention and Management of Disruptive Behavior] [ ]
- 6.) Report all instances where a beneficiary is involved in an incident that has harmed or has the potential of causing harm using VA Form IO-2633 as outlined in CM 00-134, Patient Safety Reporting Program (Potential/Actual Events);
- 7.) Reports all instances where employees, volunteers or visitors are involved in an incident that has harmed or has the potential of causing harm as outlined in CM 05-03.

G. Medical Center Environment of Care Committee is responsible to:

- 1.) Provide assistance and support for the facility violence prevention program;
- 2.) Assist in the development and revision of policies, programs, and procedures related to the prevention of disruptive, intimidating, threatening and/or violent behavior [ ] ;
- 3.) Assist in the identification of trends and in the development of strategies to reduce or eliminate risks associated with [disruptive, intimidating, threatening and/or violent behavior] behavior at the facility; and
- 4.) Promote violent behavior prevention throughout the facility.

H. The Disturbed [Disruptive] Behavior Committee is responsible to:

- 1.) Assist the Violent Behavior Prevention Program Coordinator to develop and implement an effective violent behavior prevention program and serve as the focal point for facility-wide violent behavior prevention initiatives.
- 2.) Provide consultation, technical support and assistance for the facility violent behavior prevention program;

- 3.) Provide education and/or training concerning the prevention of workplace violence;
- 4.) [Provide consultation] and develop, [support, and/or] implement programmatic initiatives designed to prevent and address [disruptive and intimidating behavior and] workplace violence incidents, including but not limited to: the review of all incidents of disruptive, intimidating and/or aggressive violent behavior; tracking/trending of such incidents; the Employee-to-Employee Workplace Violence Prevention Program; the use of Behavioral Patient Record Flags (PRFs) and] the Special Intervention Program; Performance Improvement Projects; [support of the Prevention and Management of Disruptive Behavior (PMDH) national program]; [ ] and evaluate the effectiveness of related policies, programs and procedures

5.) Ensure that the diverse programs and functions that address issues relevant to the prevention of workplace violence throughout the facility work in a complimentary fashion and effectively address prevention goals.

I. [Learning Systems] [ ]

1.) Assist the Violent Behavior Prevention Program Coordinator in the development and implementation of training to prevent and/or respond to violent behavior, [including the Prevention and Management of Disruptive Behavior (PMDH) national program].

2.) Provide education and/or training in the prevention of and/or response to violent behavior.

## 5. IDENTIFICATION OF POTENTIAL SOURCES OF VIOLENT BEHAVIOR:

A. Assessment: Assessment of potential sources of threatening and/or violent behavior is conducted on an ongoing basis by the Disturbed [Disruptive] Behavior Committee, the P.I. Manager, [the Patient Safety Officer], the Chief Police, the Facility Environment of Care Committee and the Safety Officer, the Employee Assistance Program and appropriate clinical Services. Ongoing assessment activities address the potential for threatening and/or violent behavior among patients, employees, volunteers, and visitors. Incidents of significant threat and/or violence, particularly those that represent a trend or pattern of incidents, will be reviewed by the Disturbed [Disruptive] Behavior Committee and the Committee will determine if further investigation and/or follow-up is required. Follow-up activities may include, but are not limited to recommendations for corrective actions and/or Committee intervention. [ ]

Assessment activities will be reviewed on an ongoing basis and formally summarized and reported on an annual basis. The annual report will include an evaluation of the clinical activities of the Disturbed [Disruptive] Behavior Committee as well as summaries of the following efforts described more fully below: Work-site Analysis; Workplace Security Analysis; and Hazard Prevention and Control as related to the Prevention of Workplace Violence (e.g. engineering controls and workplace adaptation). The annual report will be

submitted by the Chairperson, Disturbed [Disruptive] Behavior Committee to both the Medical Center Environment of Care Committee and the Clinical Executive Board.

1.) Worksite Analysis:

a.) A worksite analysis involves a step-by-step, common sense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop. [A worksite analysis approach is included in safety-related reviews of the environment of care conducted on an ongoing basis, such as the reviews of the safety of the residential and inpatient units.] [Vulnerability to workplace violence [is part of the review] and the focus of the assessment will be guided by recommendations provided by [VHA and] OSHA [ ] guidelines.]

On-site worksite analyses will be scheduled when indication of need has been established by [VHA Policy, the Disturbed [Disruptive] Behavior Committee, the Patient Safety Officer, the Medical Center Safety Officer, the Chief, VA Police] and/or the Medical Center Environment of Care Committee.

Results of the worksite analysis will be reviewed by [the involved staff/Services and reported according to VHA Policy]. [The Disturbed [Disruptive] Behavior Committee and the Medical Center Environment of Care Committee will track identified issues and implementation of any corrective actions.

2.) Workplace Security Analysis:

a.) The Chief Police shall periodically inspect the workplace to identify hazards, conditions, operations, and situations that could lead to violence. The periodic inspection will include, as necessary, the following: analysis of incidents; the identification of high risk locations and/or situations; the effectiveness of existing security measures; and a determination if risk factors have been reduced or eliminated and/or appropriate action initiated

3.) Hazard Prevention and Control:

a.) If hazards related to the potential for violence are identified through the systematic process noted within this document, a corrective action needs to be developed. The corrective action may involve the design and implementation of measures through engineering controls or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important part of preventing future incidents. Examples of controls may include measures designed to address building access, office or ward access, office or ward configuration, and neighborhood safeguards.

4.) Considerations for Engineering Controls and Workplace Adaption:

Engineering controls, for example, may remove the hazard from the workplace or may create a barrier between the worker and the hazard. The selection of any measure, of course, should be based upon the hazards identified in the worksite and workplace security analyses of each facility.

B. Annual Assessment Update:

The Disturbed [Disruptive] Behavior Committee, in conjunction with the interservice/interprogram efforts described throughout this document, will perform a formal update assessment of the [actual and] potential sources of violent behavior and this will be included in the annual report of the Disturbed [Disruptive] Behavior Committee. Recommendations concerning corrective actions, as appropriate, will be developed and/or tracked by the Disturbed [Disruptive] Behavior Committee on an ongoing basis and will be included in the annual report which will be submitted to the Environment of Care Committee and Clinical Executive Board for review.

6. TRAINING:

A. Employees:

1.) General Training:

[All new employees receive training in the Prevention and Management of Disruptive Behavior (PMDB)], including information about the general violent behavior prevention and intervention awareness training and specific issues related to healthcare settings. Training specifically includes: the prevalence and vulnerabilities with respect to aggressive, threatening and/or violent behavior in healthcare settings; predisposing and precipitating factors for potential violence; behaviors of potential concern and high risk situations; nonverbal and verbal intervention; limit setting; and clinical factors to be aware of regarding risk for disruptive and/or violence behavior is specific clinical situations (geriatrics, mental health, etc...). Education is also provided concerning the Employee-to-Employee Workplace Violence Prevention Program, the use of Behavioral Patient Record Flags, and clinical and security/police resources available at Northport. Annual online training is provided to all staff and this provides a review of the training material provided to all new employees.]

2.) [ ] [Area/Service Specific Training – The Disturbed/Disruptive Behavior Committee and Workplace Violence Review Team provides consultation and onsite training on an as needed basis as part of the ongoing procedures under the Workplace Violence Prevention Program.]

7. MEDICAL CARE AND COUNSELING:

A. Emergency Medical Care:

Any employee that is injured on the job will be provided medical care as outlined in CM 05-23 Health Services-Employees.

**B. Counseling:**

The Nottport VA Medical Center has made provision for counseling services to employees or volunteers who have [experienced disruptive behavior and/or have] been verbally, or physically assaulted, harassed or that witness violent behavior. These services are defined within CM 05-25 Employee Assistance Program, CM 05-03 Employee/Employee Incidents of Workplace Violence, and under [CM 001-108 Disaster Mental Health Plan] [ ]. Counseling will be confidential, free of charge, and the employee allotted authorized absence to attend sessions. The Employee Assistance Program Coordinator can be reached at extension 7066. Employees who are the subject of serious threats will be encouraged to inform their supervisor and the VA Police immediately and to contact the Chairperson of the Disturbed/Disruptive Behavior Committee).

**C. Patients:**

Patient-related incidents are reported and addressed as outlined in CM 00-134 Patient Safety Reporting Program (Potential/Actual Events and as outlined in the Policies/Procedures referenced in the Center Memorandum. [Clinical staff will provide intervention as needed. The Disturbed/Disruptive Behavior Committee reviews all disruptive, threatening and/or violent incidents involving patients and will initiate a Behavioral Patient Record Flag and special precautions as clinically needed.]

**8. DISCIPLINARY ACTIONS:**

Disciplinary action associated with violent behavior will be addressed as outlined in CM 05-04 Disciplinary and Adverse Actions Title 5 and Title 38 Employees.

**9. RELATED PROCEDURES/POLICIES:**

- A. CM 11-133: Disturbed/Disruptive Behavior Committee
- B. CM 00-134: Patient Safety Reporting Program
- C. CM 05-03: Employee/Employee Incidents of Workplace Violence
- D. CM 05-23: Employee Assistance Program
- E. [CM 001-126: Safety Management Program Plan] [ ]
- F. CM 11-116: Crisis Intervention Team for the Management of Disturbed Behavior
- G. CM 11-149: Special Intervention Program
- H. CM 001-108: [Disaster Mental Health Plan] [ ]
- I. CM 07B-3: Hostage Situation
- J. [\*CM 07B-01 Security Management Plan]
- K. CM 00-123: New Employee Orientation
- L. CM 05-21: Management of Work Related Injuries
- M. CM 05-23: Health Services-Employees
- N. CM 05-04: Disciplinary and Adverse Actions Title 5 and Title 38 Employees

**O. 116A-#4: Psychiatry Service Policy: Crisis Prevention Clinical Pathways Program**

**10. REFERENCES:**

- A. Under Secretary for Health's Information Letter: IL 10-2010-002, Dated January 13, 2010: Intimidating and Disruptive Behaviors that Undermine A Culture Of Patient Safety.
- B. The Joint Commission Comprehensive Accreditation Manual for Hospitals
- C. The Joint Commission Sentinel Event Alert Issue 40, July 9, 2008: Behaviors that Undermine a Culture of Safety
- D. Dealing with Workplace Violence: A Guide for Agency Planners. United States Office of Personnel Management, Office of Workforce Relations. Document # OWR-037, October 1997.
- E. VHA Under Secretary For Health's Information Letter: Violent Behavior Prevention Program, IL 10-97-006 dated February 3, 1997
- F. U.S. Department of Labor, Occupational Safety and Health Administration: Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA 3148, 1996.
- G. [VA/AFGE Master Agreement, 1997] [ ]
- H. [VA/NFFE Labor/Management Master Agreement, Part B, 1997]

**11. RESCISSION:**

Center Memorandum 00-104, Prevention of Workplace Violence, dated [August 4, 2006]

**12. ATTACHMENT:** A. Policy & Procedure Guide for the Prevention of Workplace Violence: The Provision of Services in the Community

*Philip C. Moschitta*

PHILIP C. MOSCHITTA  
Director

Distribution: C  
Responsible Service: Psychology (116B)

2.) Complete training [in the Prevention and Management of Disruptive Behavior (PMDDB), including the annual online training for Workplace Violence Awareness, Disruptive Behavior and Prevention, [ ]]

#### 4. PROCEDURES:

Employees who provide services in the community, as well as their supervisors, must follow the policies and procedures outlined in CM 00-104 (Prevention of Workplace Violence) as well as those outlined in this Attachment

##### A. ASSESSMENT:

Employees must continuously evaluate the community-based work setting (i.e., clinic, community agency, community residence, or private home) to determine if services can be provided without significant risk of violence. Factors employees need to evaluate include: general location of the residence or other setting; known history of violence and/or threatening behavior on the part of the patient or others residing or visiting the work setting; current behavioral and/or environmental indications of potential risk; general safety related concerns, such as lighting, time of the day, degree of isolation, and potential means of escape if behavior becomes threatening or violent; the presence of weapons in the residence or setting; and any other circumstances that may be related to an increased risk for threatening and/or violent behavior.

##### B. INTERVENTION:

1.) If in the employee's clinical judgment a significant and immediate risk for violence exists and that such risk cannot be effectively reduced with clinical intervention on their part, then the following steps need to be initiated:

- a.) Employee should take action to remove himself/herself from the immediately threatening situation in a manner that is not expected to trigger violence;
- b.) The local Police Department needs to be called as soon as possible through use of the emergency 911 number;
- c.) The appropriate supervisor and/or clinical team need to be informed as soon as possible;
- d.) The supervisor/Service Chief will insure that the VA Police, the P.I. Manager, the EAP Director, the Medical Center Director, and other Services as appropriate are informed of the situation as soon as possible;
- e.) Intervention should include follow-up consultation with [the] interdisciplinary team.
- f.) VA employee will complete an incident report involving a veteran or beneficiary.

### ATTACHMENT A SUB: POLICY AND PROCEDURE GUIDE FOR THE PREVENTION OF WORKPLACE VIOLENCE; THE PROVISION OF SERVICES IN THE COMMUNITY

#### I. PURPOSE:

To establish policy and procedure to assure that the risk for workplace violence is minimized to the degree possible for employees who provide services in the community.

#### 2. POLICY:

Violent and/or threatening behavior directed towards employees who provide services in the community is not acceptable. Specific procedures are necessary to ensure that the risk for workplace violence is reduced as much as feasible for employees who provide services in the community. The policies and procedures described in this Attachment supplement those outlined in CM 00-104 (Prevention of Workplace Violence) and all relevant procedures need to be followed. Services provided in the community currently include the following Program/Clinic areas: Community Residential Care Program (CRCP); [ ]; Mental Health Intensive Case Management Program (MHICM); Home Based Primary Care (HBPC); [ ]; Homeless Services Programs; Employee Assistance Program (EAP); [ ]; [Community Based Outpatient Clinics, such as Plainview, Patchogue and Westhampton CBOCs]; [ ]; and [ ]; Satellite Clinic locations. This Policy will also apply to any newly established Program or Clinic that provides community-based services.

#### 3. RESPONSIBILITY:

A. Supervisors are responsible to:

- 1.) Ensure that employees under their supervision who regularly provide services in the community receive appropriate training in the Prevention and Management of Disruptive Behavior (PMDDB), including the annual online training for Workplace Violence Awareness, Disruptive Behavior and Prevention, [ ] and follow the guidelines outlined in this Attachment;
- 2.) Identify and address any issue that may pose a significant risk for workplace violence for their employees who provide services in the community.

B. Employees providing services in the community are responsible to:

- 1.) Follow safe work practices that minimize the risk for violent behavior, including those practices described in this Attachment;

2.) If in the employee's clinical judgment a significant but not immediate risk for violence exists and the level of risk cannot be effectively reduced by their intervention alone, then the following steps should be initiated:

- a.) Employee should take action to remove himself/herself from the situation in a professional and courteous manner, ensuring that the action does not expose the patient, the employee or others to an adverse outcome that is avoidable through appropriate intervention;
  - b.) The supervisor needs to be notified immediately and take action to ensure that the needs of both the patient and the employee are effectively addressed;
  - c.) In such situations, future services should not be provided by employees working alone unless the identified risk for violence has been determined by the provider of services to have been effectively reduced and the appropriate supervisor agrees with this assessment. Furthermore, if the opinion of the involved staff and/or the appropriate supervisor is that the presence of a second staff member does not sufficiently and effectively reduce the potential for violence in the situation so identified, then services can only be provided if the clinicians are accompanied by the local Police and with the approval of the appropriate supervisor.
- 3.) Information indicating the existence of a significant risk for threatening and/or violent behavior must be reported to the employee's supervisor and to the appropriate clinical team even if the employee believes no special precautions are warranted.

#### C. EVALUATION:

The potential for violence towards staff providing services in the community will be monitored and periodically assessed as part of the Workplace Violence Prevention Program as outlined in GM 00-104. This will specifically include review of significant incidents of threat, potential violence and/or violence involving community providers. Review of such incidents will include a determination if an incident or pattern of incidents warrants a change in established policies/procedures or other intervention.

#### 5. PREVENTION RELATED POLICIES/PRACTICES:

In order to reduce the potential for violence, threats of violence, and the serious injuries that might be sustained by employees or others when such incidents occur, the following related procedures are established for employees who provide services in the community but not at a clinic location:

- A. Employees will be provided cellular phones and will be responsible for carrying them while engaging in the delivery of community-based services;
- B. Employees providing services must inform their supervisors of their expected schedule and significant changes to this schedule to facilitate communication and to assist in

identifying and responding to potential emergency situations involving the provider:

- C. Employees are not permitted to transport veterans or family members in their personal vehicles. As per Regional Counsel employees are not permitted to transport family members/significant others in a GSA vehicle.
- D. Clinicians need to evaluate on an ongoing basis the potential for violence while providing services and ensure that patient-specific identified risks are documented and addressed as part of the patient's treatment plan.  
[E. Clinicians are encouraged to review relevant clinical information prior to a community-based visit, including clinical information most likely related to safety such as the Veteran's and/or family members behavioral history. When needed, clinicians should discuss the need for additional precautions with their supervisor prior to the visit. If either the veteran or the community setting is new to the clinician, then a telephone screen is recommended to in part assess potential safety issues as well, as to educate the veteran/caregiver to the purpose of the visit.]  
[F. Employees providing these community based services are strongly advised to:
  - 1.) Carry only the necessary identification and money
  - 2.) Leave valuables in the office or at home
  - 3.) Avoid wearing jewelry that might make them the target of violence or be used to strangle them if assaulted
  - 4.) Not carry items that may be used against them as a weapon
  - 5.) Request a second staff member accompany them when concern exists for their safety
  - 6.) Telephone the patient/caregiver prior to arriving at the location to verify the visit/appointment
  - 7.) Ensure that they are meeting the patient or caregiver at a safe location and/or ask the patient/caregiver to meet you at the entrance
  - 8.) Park their vehicles in well-lit and visible areas
  - 9.) Not leave valuables or supplies in a parked car unless placed in the trunk prior to leaving the VA facility
  - 10.) Be aware of changes in the residential/community setting that might indicate a change in level of risk in or around the setting.
  - 11.) Take precautions to ensure safety with respect to use of vehicles in the community.

SUBJ: DISTURBED/DISRUPTIVE BEHAVIOR COMMITTEE (DBC)

1. **PURPOSE AND SCOPE:** To establish [and maintain] an inter-disciplinary Disturbed/Disruptive [Behavior Committee (DBC)] as a subcommittee of the Clinical Executive Board. [It is well known that more workplace violence assaults occur in healthcare than in any other work setting. VHA has responded to this fact and developed and implemented programs to prevent violence and reduce risks associated with providing healthcare. This includes the VHA mandate to establish and maintain Disruptive Behavior Committees to help oversee the prevention and management of disruptive and potentially violent patients. More generally, VHA and the Northport VA is committed to promoting a culture of civility and safety for veterans, visitors and staff where professional, courteous, respectful and collegial behavior is valued and practiced by all employees. The VHA and the Northport VA expects medical center leaders and managers to communicate expectations to clinicians and other staff that disruptive, inappropriate, intimidating and unwell behavior can compromise our mission to provide high quality health care service to Veterans.]

2. **DEFINITION:** Disturbed Behavior is defined as violent or otherwise dangerous human behavior that poses the risk of harm to self or others. Disruptive Behavior is unacceptable behavior as defined in CM 11-200 Patient Received Flags and the Management of Disturbed/Disruptive Behavior.

[Disruptive behavior is broadly conceptualized as any behavior that interferes with communication, team performance or safe patient care. In addition to verbal abuse or harassment, examples of Disruptive Behavior include but are not limited to: behavior that bullies, humiliates, disrespects, degrades, intimidates, and/or provokes others; exclusionary behavior such as intentionally not including others in meetings or in making decisions that they should be part of or not communicating information to other staff who need access to that information to carry out their responsibilities; and verbal (or e-mail) interactions that a reasonable person would find offensive and/or abusive]

3. **POLICY:** The Disturbed/Disruptive Behavior Committee will serve as the inter-disciplinary body that reviews data on all disturbed/disruptive behavior at the Medical Center, [identifies] problems and trends in disturbed/disruptive behavior and [formulates] and [recommends] policies and procedures to effectively manage disturbed/disruptive behavior, including the identification of any need for staff training in the management of disturbed behavior. The Committee works collaboratively with the P.I. Department, Environment of Care Committee, Safety Department and Clinical services to ensure effective communication and a coordinated approach to the prevention and management of disturbed/disruptive behavior. The DBC coordinates and implements [the program for Behavioral Patient Record Flags.] Northport's Special Intervention Program (S-IP) and assumes primary responsibility for the development, implementation and oversight of the Medical Center's Workplace Violence Prevention Program. The prevention and management of disruptive behavior is a fundamental aspect of workplace violence prevention. [The DBC also

to include keeping doors locked and windows closed, check gas gauge as needed, and planning the trip route in advance.

12.) [Require that animals/pets in the home or community setting be caged or secured in a separate room/area prior to the employee entering the home/community setting.]

13.) [Maintain vigilance with respect to: the potential presence of an intoxicated Veteran, family member or visitor and any disruptive and/or dangerous behavior; maintain alertness to surroundings and any changes in the environment that may pose a risk or alter level of safety; attending to an intuitive sense of safety, trust, instincts, and if needed initiate action including leaving the location and/or calling for assistance; and not directly intervening (physically) if a domestic fight occurs. If the environment becomes threatening in some manner, the employee should leave the location and call for assistance and consult with their supervisor.]

6. **RESPONSE/POST-INCIDENT RESPONSE:**

A. Incidents involving threats, potential violence and/or violence that involve employees while providing services in the community will be responded to as outlined in CM 00-104. When appropriate, active communication with local law enforcement agencies will be initiated.

B. Support for the affected employee(s) will be provided as outlined in CM 00-104.

7. **TRAINING:**

A. The information in this Attachment will be reviewed with all staff that regularly provide services in the community.

B. For these employees, this information should also be reviewed as part of the annual requirement for the Prevention of Workplace Violence training that is part of the annual [online] safety training required for all employees.

integrates the Employee-to-Employee Workplace Violence Prevention Program as outlined in Center Memorandum 05-03: Employee-to-Employee Incidents of Workplace Violence into the overall Medical Center's Workplace Violence Prevention Program.]

**4. GENERAL:**

- A. Membership
  - Chief, Psychology Service (Chairperson)
  - P.I. Representative
  - Chief, VA Police (or designee)
  - [ACOS for Mental Health] | | (or designee) \*
  - Chief, Social Work Service (or designee)
  - SAFE Department representative
  - Associate Chief Nurse Psychiatry (or designee)
  - | |
  - EAP Coordinator
  - Clinical Nurse Specialist
  - [Nurse Manager/CLC]
  - [Prevention and Management of Disruptive Behavior (PMDB) Trainer]
  - [Psychologist/CLC]
  - [SARIT? Program Director]
  - Nursing Representative, Outpatient MH
  - NFFE Representative Local 387
  - AFGE Representative Local 1843
  - AFGE Representative Local 387

Representatives of other Medical Center Services may be invited to attend meetings on an ad hoc

basis when necessary. \*Ex-officio member

- B. Chief, Psychology Services Chairs the Committee and is responsible for coordinating the [Behavioral] Patient Record Flag Program, the Special Intervention Program and the Workplace Violence Prevention Program.
- C. The DBC will meet monthly or at the call of the Chairperson.
- D. | | The DBC submits an annual report to the CEB for review and approval, and reports information concerning employee-to-employee complaints regarding disruptive and/or workplace violence behaviors to the Environment of Care Committee as part of the Workplace Violence Prevention Program]

**5. PROCEDURES:** The DBC will:

- A. Review committee activities on an ongoing basis and formally report to the CEB annually.
- B. Review reports of crises submitted by the appropriate interdisciplinary treatment team and/or the crisis intervention team as reported by either the Associate Chief Nurse Psychiatry (or designee) or Chief, Psychiatry (or designee).
- C. Review summaries of Incident Reports (VA Form 10-2633) and multiple incident reports involving disturbed behavior provided by P.I., as needed.
- D. Review summaries of police reports involving disturbed/disruptive behavior provided by VA Police representatives.
- E. Discuss data presented by Committee members relating to disturbed/disruptive behavior and its prevention and management. | |
- F. Sponsor problem focused studies to obtain data concerning specific disturbed/disruptive behavior problems to facilitate improved management of such problems and ultimately a reduction in the frequency and/or severity of such incidents.
- G. Identify and present findings of trends and/or problems of disturbed/disruptive behavior to Medical Center management for review [as needed]
- H. Formulate and propose policies, plans and measures to improve management of disturbed/disruptive behavior for approval and implementation by Medical Center management.
- I. Identify needs for staff training and promote implementation of training programs relevant to the prevention and/or response to incidents of disturbed/disruptive behavior [such as the national Prevention and Management of Disruptive Behavior (PMDB) Program].

J. Committee will, when needed, [provide consultation] [ ] to assist in the resolution of identified problems involving patients/staff.

K. Committee will develop, implement, and oversee the Medical Center's Program to reduce the risk of violence in the workplace. This will be accomplished through close collaboration with the Medical Center's SAFE and [Learning Systems] [ ] Departments. The Program will include, at a minimum, educational/training of all employees during orientation; annual [online] training to enhance the competency of employees with respect to the prevention of workplace violence; implementation of the Employee-to-Employee Workplace Violence Prevention Program as outlined in Center Memorandum 05-03 Employee-to-Employee Incidents of Workplace Violence; service specific refresher training by qualified trainers as determined by the needs of individual services [in consultation with the DBC] [ ]; consultation by the DBC concerning the prevention of and response to violent behavior; and the ongoing identification of patients at risk for such behavior and the development of interventions to reduce such risks.

L. The Committee will actively facilitate communication across clinical and administration services concerning the prevention and response to disturbed/disruptive behavior and workplace violence. Towards that end, the Committee will provide quarterly reports to the Environment of Care Committee [concerning information, data and analysis related to employee-to-employee complaints of disruptive, threatening and/or violent behavior] [ ]. Chairperson, Disturbed /Disruptive Behavior Committee, [is] [ ] a member of the Environment of Care (EOC) Committee to further this process.

M. The Disturbed /Disruptive Behavior Committee is a resource to clinical and administrative service areas concerning disturbed and/or disruptive behavior. The Disturbed /Disruptive Behavior Committee also actively encourages communication between clinical and support services critical to prevention of and response to disturbed and/or disruptive behavior and workplace violence. This facilitation of communication includes, but is not limited to, encouraging early involvement of Employee Assistance Program for affected employees; clinical review of problematic situations by the Crisis Prevention Committee; collaboration with [Learning Systems] [ ] to ensure the training of new employees and the annual training of all employees adequately addresses issues related to disturbed and/or disruptive behavior and the prevention of workplace violence; the early involvement of the VA Police whenever needed; and the integral involvement of the SAFE Dept. and the Environment of Care Committee, as needed.

N. Chairperson of the DBC also serves as the Facility Fugitive/Escort Program (FFP) Coordinator. The DBC is primarily involved with the review of clinical issues and appropriate intervention for veterans identified by the FFP, with specific attention to the prevention of situations with the potential of disturbed/disruptive behaviors.

## 6. REFERENCES:

A. [ ] [Center memorandum 11-200j, Patient Record Flags and the Management of Patients at

Risk for Violent, Threatening, Abusive or Disruptive Behavior]

B. [ ] [Under Secretary for Health's Information Letter, IL 10-2010-002, Dated January 13, 2010: Intimidating And Disruptive Behaviors That Undermine A Culture Of Patient Safety ]

C. [VHA Directive 2003-048, National Patient Record Flags, August 28,2003]

D. Center Memorandum 00-104 Prevention of Workplace Violence

E. The Joint Commission Comprehensive Accreditation Manual for Hospitals.

F. The Joint Commission Sentinel Event Alert Issue 40, July 9, 2008: Behaviors that Undermine a Culture of Safety.

G. Center Memorandum 05-03 Employee-to-Employee Incidents of Workplace Violence]

7. RESCISSION: Center Memorandum 11-133 dated [October 1, 2007]

*Philip C. Moschetti*

[PHILIP C. MOSCHETTA]

Director

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Responsible Service: Psychology (116B)

associated with the Veterans behavior and/or potential behavior remain at an unacceptable level).

C. Unacceptable behavior includes, but is not limited to the following:

- 1.) A history of violence against patients or staff
  - 2.) Documented acts of repeated violence against others
  - 3.) Credible verbal threats of harm against specific individual patients, staff, or VA property
  - 4.) Possession of weapons or objects used as weapons in a health care facility
  - 5.) A history of suicidal or parasuicidal behavior within health care facilities (and a clinical determination by the DBC with the input of the facility Suicide Prevention Coordinator that a National Behavioral PRF is needed to augment or replace an existing level II Suicide Prevention Flag)
  - 6.) A history of repeated nuisance and disruptive or larcenous behavior that disrupts the environment of care. Examples include but are not limited to: repetitive use of abusive profane or obscene language to employees, visitors, volunteers, or other patients; and the possession, selling (prescription and/or illicit drugs) and/or the use of intoxicating beverages, narcotics, hallucinogenic, or mood altering drugs not prescribed by his/her health care providers while on the property of the Northport VA or at one of our community clinic locations
  - 7.) A history of sexual harassment towards patients or staff
- D. The violent, threatening and/or disruptive patient behaviors noted above from Sections "a" through "g" will result in a Category I [National Behavioral] PRF (mandated areas for the PRF Program nationally) if an alert is warranted in response to the behavior. A Category I [National Behavioral] alert/flag once established is viewable nationally and is maintained by the facility that originates it. The facility that establishes the alert/flag can transfer "ownership" to another VA facility when the other facility becomes the primary treatment location for the veteran. Individual facilities, such as the Northport VA, may elect to establish Category II alerts/flags if the need for such meets the national standards established for the PRF Program. Category II alerts are not shared across facilities and remain local to the originating facility. Communication regarding the transfer of facility ownership for the Category I [National Behavioral] alert/flag should be handled by either the Chair of the DBC and/or the Office supporting the establishment of the flag should be provided to the new facility that assumes ownership.

### 3. RESPONSIBILITY:

A. In line with VHA Directive 2003-048, the composition of the Disturbed/Disruptive

DEPARTMENT OF VETERANS AFFAIRS  
NORTHPORT, New York 11768  
CENTER MEMORANDUM 11-200  
December 22, 2010

SUBJ: PATIENT RECORD FLAGS AND THE MANAGEMENT OF PATIENTS AT RISK FOR VIOLENT, THREATENING, ABUSIVE, OR DISRUPTIVE BEHAVIOR

1. **PURPOSE:** This Policy will define the use of [National Behavioral] Patient Record Flags (PRFs) to assist in identifying and managing patients at risk for violent, abusive, or disruptive behavior. The goal is to promote a [Civil, respectful and] safe environment for staff, patients, volunteers and visitors and to implement VHA Directive 2003-048 to ensure consistency in the use of [National Behavioral] PRFs across the VISN and other VHA facilities.

2. **POLICY:** [The VHA and the Northport VA are committed to promoting a culture of civility and safety for Veterans, visitors and staff where professional, courteous, respectful and collegial behavior is valued and practiced by all employees. The VHA and the Northport VA expects medical center leaders and managers to communicate expectations to clinicians and other staff that disruptive, inappropriate, intimidating and uncivil behavior can compromise our mission to provide high quality health care service to Veterans.]

A. [In order to promote and provide a safe, respectful and healthy workplace and optimal healthcare environment,] it is the policy of the DVA Medical Center at Northport that Veterans receiving care adhere to acceptable standards of conduct as prescribed by the Department of Veterans Affairs regulations and local policies concerning Patient's Rights and Responsibilities. The safety of our veteran patients, their families, visitors, volunteers, and our employees is a priority. Potentially dangerous, abusive, or disruptive behavior is to be prevented whenever possible.

B. A key aspect of our approach for the management of repetitively disruptive, threatening or violent prone veterans is to identify them in advance to both administrative and clinical staff through an alert/flag system in the Computerized Patient Record System (CPRS). The [National Behavioral] PRF procedures defined in VHA Directive 2003-048 "National Patient Record Flags" will be followed to alert staff to a patient flag. The goal of the use of the [National Behavioral] PRF system is to establish a safe and effective way of providing care to veterans who have by their behavior and related predisposing risk factors for such behavior created a significant safety concern at Northport or at one of our community clinic locations. Conditions for providing care (Health Care Agreements as per CM 11-149 "Special Intervention Program") may also be established for patients who repetitively exhibit unacceptable behavior at the Northport VA or at our community clinic locations. If the unacceptable behavior persists or is severe in nature, a patient may ultimately be barred from receiving services at the Northport VA and at our community clinic locations except for emergency care. [Barring a Veteran from receiving services is a last resort and considered only when clinical intervention, the National Behavioral PRF procedures and related restrictions are not able to effectively address safety-related concerns and safety risks

Behavior Committee (DBC), which reports to the Chief of Staff, will include:

- 1.) A senior clinician as Chair, who has the knowledge of and experience with the assessment of violence.
- 2.) A representative of the Prevention and Management of Disruptive Behavior Program in the facility
- 3.) A VA Police representative
- 4.) The Performance Improvement Representative/Patient Safety
- 5.) A patient, advocate or patient representative
- 6.) A representative from HIMS, IRM or CPRS as needed
- 7.) Other clinicians from high risk areas
- 8.) Regional Counsel (ad hoc)
- 9.) Clerical/administrative support
- 10.) Employee Union representatives

B. The responsibilities of the DBC are outlined in detail in Center Memorandum 11-133 and will also include the following functions as outlined in VHA Directive 2003-048:

- 1.) Coordinating the treatment plan with appropriate clinicians responsible for the patient's medical care
- 2.) Implementing the Standards for the PRF Directive as outlined in Attachment A ("Standards For Patient Record Flags") of the VHA Directive 2003-048
- 3.) Collecting and analyzing incidents of patient disruptive, threatening, or violent behavior
- 4.) Assessing the risk of violence in individual patients
- 5.) Identifying system problems
- 6.) Identifying training needs relating to the prevention and management of disruptive behavior
- 7.) Recommending to the COS other actions related to the problem of patient violence

C. All staff are responsible for reporting concerns regarding unacceptable patient behaviors to their supervisors. Employees may also contact a member of the DBC for information or clarification regarding the application of the [National Behavioral] PRF system and potential applicability to any patient behavior of concern to them. A patient or patient behavior of concern should be referred to the DBC for consideration for initiation of a [National Behavioral] PRF. Whenever possible, the referral process should include the clinician(s) responsible for the care of the patient.

D. The DBC reviews the written referral and any supportive documentation concerning the patient/patient behavior of concern. The DBC determines if the threat of violent, abusive or

disruptive behavior is serious enough to warrant a computer flag/alert. If a [National Behavioral] PRF is to be activated, the DBC will also determine the scope and content of the progress note that must accompany the placement of [the] [ ] PRF. Conditions for providing care (Health Care Agreements) will be established when warranted. The DBC will utilize the opinion of direct care providers, evaluations by mental health practitioners, medical record review, and information concerning the unacceptable behavior and the patient's history of similar behavior in making this determination. A letter will be mailed to the Veteran patient and noted in the patient's computerized medical record when the opportunity to meet directly with the Veteran is not available and/or appropriate. [Notification of the patient with respect to a National Behavioral PRF may be postponed if it is determined that notification may result in an unacceptable increase in the risk of violent behavior to either a specific staff member or another individual or to staff or others in general.]

E. The DBC will ensure that a PRF is entered into CPRS

F. When conditions for providing care (Health Care Agreements) are established, review and concurrence by the COS is required.

G. Patients will be provided an opportunity for input in the process of developing conditions for providing care/Health Care Agreements if and only if such involvement does not place employees, patients or others at an increase risk for violent, threatening and/or abusive behavior.

H. The DBC will review all requests to bar a patient from the facility, and will make a recommendation to the COS. The COS will make the final recommendation to the Director of the Northport VA concerning any request to bar a Veteran from the facility. Patients have the right to due process in this matter.

I. The DBC [ ] work[s] with [Learning Systems] [ ] to ensure that training concerning the [National Behavioral] PRF system is provided to all clinical staff and administrative/clinical staff with direct patient contact. Training concerning [National Behavioral] PRFs will be, whenever possible, integrated within ongoing [online] training for the Workplace Violence [Awareness, Disruptive Behavior and Prevention] [ ] and the Prevention and Management of Disruptive Behavior [(PMDB)] training provided to all new employees).

4. **PROCEDURE:** The following procedures will be used in addressing concerns with patients who pose repetitive threats of violent, abusive or disruptive behavior.

A. The clinician, clinical team or clinical supervisor will complete a brief form [or provide a brief clinical summary] requesting the initiation of a [National Behavioral] PRF and forward it to the DBC. Whenever possible, this information should be sent via e-mail to the DBC. If the referral is from an administrative staff member/supervisor, the DBC will contact the appropriate clinician/clinical team or clinical supervisor to obtain the necessary information to evaluate the request.

B. A copy of the request will be forwarded to members of the DBC for discussion and

- review. The DBC will meet on an emergency basis if needed to respond to an urgent request.
- C. If the DBC decides that a flag/alert is warranted in the patient's record, the patient will be notified as part of their ongoing clinical care when possible. If this is not possible, the patient will be sent a letter notifying him/her of this fact and the reasons for this decision. Any specific requirements of the patient will be noted in the letter to the patient and will also be noted in the progress note written to accompany the flag/alert. The progress note will also include the reasons for the PRF and any specific guidance and/or recommendations concerning managing the patient and the behavior of concern. [As noted above, notification of the patient may be postponed if it is determined that notification may result in an increase in the risk of violent behavior.]
- D. The DBC will enter the [National Behavioral] PRF and the required progress note.
- E. If the DBC determines that a more comprehensive plan for managing the patient's behavior and care is needed, a process to establish conditions for providing care (Health Care Agreement or HCA) will be initiated as per Center Memorandum 11-149 "Special Intervention Program". The [National Behavioral] PRF system will be utilized to alert staff regarding the implementation of a HCA.
- F. The VA Police representative is an integral member of the DBC. The Chief, VA Police will ensure that all VA Police Officers are aware of the existence of a [National Behavioral] PRF and the responsibilities or Police actions needed in support of PRF's entered for specific patients.
- G. All patients with [National Behavioral] PRF's [ ] will be reviewed by the DBC at least every two years. If review of the patient's behavior indicates that a [National Behavioral] PRF is no longer indicated, it will be removed or amended as clinically appropriate. If a HCA is involved, approval of the COS or his/her designee will be obtained. As a general guideline, if a patient's behavior adheres to acceptable standards for a period of two years, the DBC will consider removing the PRF. A patient's providers can request that the DBC consider modifying a PRF at any time they believe a change in the patient's behavior or condition warrants such a change.
- H. A [National Behavioral] PRF can never be used to punish or discriminate against patients; nor should they be implemented merely for staff convenience. The effectiveness of the [National Behavioral] PRF's depends upon limiting their use to those unusual risks that threaten the safety of health care. Threats to the effective use of PRF's are their misuse and their overuse. The facility may utilize a Category II PRF for other optional areas, but only when there is a compelling safety or quality of care issue.
- I. Patients may request an amendment to the presence or content of a [National Behavioral] PRF advisory through the facility privacy officer.
- J. Staff must respond appropriately to the appearance of PRF's. Training must be provided to all clinical staff, as well as to those administrative/clinical staff

members that have direct patient contact.

- K. [The Coordinator for the Employee Assistance Program (EAP) is a member of the Disturbed/Disruptive Behavior Committee and participates in the review of situations involving disruptive and/or violent behavior. The EAP Coordinator provides input in the process utilized to consider implementing a National Behavioral Patient Record Flag. This input includes, but is not limited to, an advocacy role for employees with respect to providing a safe, civil and respectful work environment for employees.]

5. REFERENCES:

- A. VHA Directive 3003-048, National Patient Record Flags August 28, 2003  
 B. Center Memorandum 11-133, Disturbed/[Disruptive] Behavior Committee [ ]  
 C. Center Memorandum 11-149, Special Intervention Program. [ ]  
 D. Center Memorandum 00-104 Prevention of Workplace Violence  
 E. Under Secretary for Health's Information Letter: IL 10-2010-002, Dated January 13, 2010: Intimidating And/Disruptive Behaviors That Undermine A Culture Of Patient Safety.  
 F. The Joint Commission Comprehensive Accreditation Manual for Hospitals.  
 G. The Joint Commission Sentinel Event Alert Issue 40, July 9, 2008: Behaviors that Undermine a Culture of Safety]

6. REVISION: [CAM 11-200 dated [ ] [August 29, 2007]

*Philip C. Moschetti*

PHILIP C. MOSCHITTA  
 Director

Distribution C  
 Responsible Service: Psychology (116B)

DEPARTMENT OF VETERANS AFFAIRS  
NORTHPORT, New York 11768

SUBJ: SPECIAL INTERVENTION PROGRAM - Computerized Warnings and Health  
Care Agreements for [Disruptive, Difficult, and Potentially Dangerous Patients] | | (SD)  
December 22, 2010

1. **PURPOSE:** The Medical Center maintains a [Special Intervention Program] | | designed to ensure a safe and effective treatment environment for patients with a history of [disruptive, difficult, and potentially] dangerous | | behavior. [More generally, the Northport VA is committed to promoting a culture of civility and safety for veterans, visitors and staff. This VA to provide a safe and healthful workplace and an optimal healthcare environment, and minimize the risk of disruptive, difficult, and/or dangerous/violent behavior from patients with a known significant risk for disruptive, difficult, and/or dangerous/violent behavior.]

2. **POLICY:** | | It is well known that more workplace violence assaults occur in healthcare than in any other work setting. VHA and the Northport VA have developed and implemented programs to prevent violence and reduce risks associated with providing healthcare. The Northport VA is determined to prevent disruptive, difficult, and potentially dangerous behavior whenever possible and to provide coordinated and effective care to reduce the risk of such behavior. For veterans with significant history of such behavior, provision of medical services in an orderly and safe manner may depend upon staff taking reasonable safety precautions. [A key aspect of our approach for the management of repetitively disruptive clinical staff through an alert/flag system is to identify them in advance to both administrative and medical staff through an alert/flag system in the Computerized Patient Record System (CPRS). The National Behavioral PRF procedures defined in VHA Directive 2003-048 "National Patient Behavioral PRF" will be followed to alert staff to a patient flag. The goal of the use of the National Behavioral PRF system is to establish a safe and effective way of providing care to Veterans who have been identified as disruptive, difficult, and/or dangerous/violent behavior.]

[Patients who present with disruptive, threatening and/or violent behavior across medical center settings may require a comprehensive and integrated plan to address their difficult, disruptive, and/or dangerous behavior. Under such circumstances, the development of a Health Care Agreement may be necessary to provide a coordinated, consistent and effective approach to managing the highly disruptive and/or dangerous behavior. A National Behavioral Patient Record Flag (PRF) is entered to advise staff that a Health Care Agreement on an identified Veteran has been developed and implemented to address the documented risk of disruptive behavior with a potentially dangerous patient. While a Patient Record Flag may be entered as part of the PRF clinical note attached to the National Behavioral PRF, the Health Care Agreement is to be used to guide health care activities and to establish conditions for providing care. The [National Behavioral] PRF warning appears when staff access the

Program (EAP) is a member of the Disturbed/Disruptive Behavior Committee and participates in the review of situations involving disruptive and/or violent behavior. The EAP Coordinator provides input in the process utilized to consider implementing a Health Care Agreement and/or National Behavioral Patient Record Flag. This input includes, but is not limited to, an advocacy role for employees with respect to providing a safe, civil and respectful work environment for employees)

5. **RESPONSIBILITIES:**

A. Establishing and Maintaining Electronic Precautionary Warnings:

1.) Documentation of the need for [National Behavioral] Patient Record Flags and Health Care Agreements is the responsibility of the Disturbed/Disruptive Behavior Committee. The usual mechanism for determining need is a trend in incident reporting documents used by the Disturbed/Disruptive Behavior Committee for monitoring incidents of dangerous behavior. However, any reliable source of data, including referrals from health care providers, police reports, hospital summaries, etc., may be used.

2.) It is the responsibility of the DBC to enter or amend [National Behavioral] Patient Record Flags and Health Care Agreements.

3.) Urgent cases (i.e., a situation in which a computerized warning and health care agreement is needed quickly) can be referred to the Disturbed/Disruptive Behavior Committee and the CURT will meet on an emergency basis.

4.) Reviews of [National Behavioral] PRF's and Health Care Agreements are conducted as needed by the Disturbed/Disruptive Behavior Committee. The review may be referred to the Coordinated Care Review Team for consultation, amendment or discontinuation of the PRF and/or HCA. Such action will depend upon the nature of the original reasons for the warning/agreement, the medical, psychological and social status of the Veteran since the warning was instituted, and the assessed risk for dangerous behavior, if any.

5.) Changes in the Health Care Agreement are subject to the approval of the Chief of Staff or his/her designee.

6.) Computerized patient information should be handled in accordance with patient privacy regulations.

7.) A Veteran wishing to review, appeal/amend or remove a [National Behavioral] Patient Record Flag or Health Care Agreement in the patient record may do so through the facility privacy officer.

8.) [National Behavioral] Patient Record Flags/Health Care Agreements will be reviewed as outlined in CM 11-200, Patient Record Flags and the Management of Patients at Risk for

**Violent, Threatening, Abusive, or Disruptive Behavior.**

**B. Response to Warnings:**

- 1.) It is the responsibility of staff who access a Patient Record Flag to give top priority to communicating the existence of a [National Behavioral] PRT/Health Care Agreement to the clinical staff in the area.
- 2.) It is the responsibility of the clinician to access and implement the Health Care Agreement, via the Patient Record Flag Clinical note.
- 3.) Health Care providers requesting consults and/or referring patients with Health Care Agreements to other services must make this information available to the consultant/service.
- 4.) When VA police officer(s) are summoned, they will respond promptly. It is also their responsibility to assure that a Uniform Offense Report is prepared for criminal incidents involving designated Veterans and [information shared regarding the incident]with [ ], [the Chairperson of the] Disturbed/Disruptive Behavior Committee.
- 5.) Clinicians will provide appropriate medical care for emergency conditions for any Veteran.
- 6.) Clinicians, police officer(s), and staff responding to a situation involving a patient with a Health Care Agreement will cooperate in developing and implementing an appropriate response consistent with the conditions and procedures outlined in the patient's Health Care Agreement. Professional clinical judgment may take precedence over any specific advisory described in the Health Care Agreement. The senior clinician involved is responsible for the final plan to manage the Veteran's medical care.

**5. REFERENCES:**

- A. [Center Memorandum 11-133, Disturbed/Disruptive Behavior Committee]
- B. [Center memorandum 11-200, Patient Record Flags and the Management of Patients at Risk for Violent, Threatening, Abusive or Disruptive Behavior]
- C. [Under Secretary for Health's Information Letter: IL 10-2010-002, Dated January 13, 2010: Intimidating And Disruptive Behaviors That Undermine A Culture Of Patient Safety.]
- D. VHA Directive 2003-048, National Patient Record Flags, August 28,2003
- E. Center Memorandum 00-104 Prevention of Workplace Violence

F. [The Joint Commission Comprehensive Accreditation Manual for Hospitals.]

G. [The Joint Commission Sentinel Event Alert Issue 40, July 9, 2008 Behaviors that Undermine a Culture of Safety.]

H. Federal Privacy Act of 1974, 5 U.S.C. 522a, dated May 3, 1989

6. **RESCUSSION:** Center Memorandum 11-149 dated [August 29, 2007]

*Philip C. Moschitta*

[PHILIP C. MOSCHITTA]

Director

Distribution: C

Responsible Service: Psychology (116B)

# Memorandum

Department of  
Veterans Affairs

Page 2

Subj: New Federal Regulations Prohibit the Practice of Banning Disruptive, Threatening, and Violent Patients from Veterans Health Administration (VHA) Care

Date: FEB 20 2010  
From: Deputy Under Secretary for Health for Operations and Management (10N)  
Subj: New Federal Regulations Prohibit the Practice of Banning Disruptive Threatening, and Violent Patients from Veterans Health Administration (VHA) Care  
To: Network Directors (10N1-23)  
Chief Medical Officers  
Facility Directors (00)  
Chiefs of Staff

4. Network and facility directors and chiefs of staff must be aware that the administrative procedure of banning disruptive patients is no longer permitted. Network and facility directors must ensure that Disruptive Behavior Committees (DBC), functioning under the authority of chiefs of staff, are aware of this change in regulations and have specific plans for offering a return to safe VHA care to any Veteran who has previously been banned from care, no later than the date of the next scheduled review. DBC's must address in-house management of disruptive and potentially disruptive patients and may determine and recommend one of several approaches and requirements for specific patients.

5. These actions may include, but are not limited to:

- a. Increased availability of VA Police escorts may be required, including one-on-one coverage from the time of arrival on VHA property.
  - b. Care may be restricted to medical centers and not be available at Community Based Outpatient Clinics.
  - c. DBCs may restrict provider choice.
6. For further information, please contact Lynn Van Male, PhD, Director, Behavioral Threat Management Program at [lynn.vanmale@va.gov](mailto:lynn.vanmale@va.gov), or (503) 228-8262, ext. 33048. Monthly Threat Management VANTS calls are scheduled every third Thursday of each month at 12:00 EST, at 1(800)767-1750, Access 42968.



William Schoenhard, FACHE

1. On November 16, 2010, CFR 38, Part 17, 106 was published in the Federal Register, effective on December 16, 2010, prohibiting the practice of banning 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."
2. The restrictions on care may include, but are not limited to:
  - a. Specifying the hours and locations in which non-emergent Veteran/patient care will be provided;
  - b. Specifying the health care provider, and related personnel, who will be involved with the Veteran/patient's care;
  - c. Requiring VA Police escort;
  - d. Authorizing VA providers to terminate an encounter immediately if certain behaviors occur;
3. The regulation also specifies that "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 the issuance". This was discussed on the Chief Medical Officer call, and on the monthly Disruptive Behavior Committee calls. A directive is in process to implement the regulations.

Department of  
Veterans Affairs

Memorandum

Date: **DEC 19 2011**  
From: Deputy Under Secretary for Health for Operations and Management (10N)  
Subject: Sexual Assault Reporting  
To: VISN Directors, Medical Center Directors  
Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

1. On May 30, 2011, the Government Accountability Office (GAO 11-530) report, "VA Health Care: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents," highlighted a number of opportunities for improvement regarding the reporting, monitoring and prevention of sexual assault incidents within VHA facilities.

2. In an effort to improve our reporting mechanism of sexual assault-related incidents occurring within VHA facilities, we are actively using the issue brief tracker. To enhance our capacity to capture data and monitor these events, all VISNs and medical centers are required to use the sexual assault template located within the tracker sharepoint to report all substantiated and unsubstantiated sexual assault related incidents involving Veterans, visitors, and/or staff. This information will be used to define the necessary appropriate actions to ensure that VHA is responding effectively to reports of sexual victimization of Veterans, visitors, employees and will be used to assist with actions focused on prevention.

3. When completing the sexual assault template, the following information must be included:

- a. Location of the assault (i.e., community living center, residential rehabilitation treatment program, inpatient medical unit, surgical clinics waiting area, etc., instead of a ward number or wing)
- b. Date of the incident
- c. Was the incident referred to the Disruptive Behavior Committee
- d. Status of the incident, to include next steps
- e. Uniform Offense Report (UOR) number in proper format (i.e., 20111161123-0478, year, month, day and time)
- f. All information relevant to understanding the severity of the incident.

4. VHA values the safety and well-being of all Veterans who receive services in VA medical centers, as well as the health and well-being of our visitors and staff. Thank you for your contributions to ensure that VHA facilities provide a safe and healing environment.

  
William Schoenhard, FACHE

5

1 15. On May 4, 2012, the Complainant's supervisor, Richard  
 2 Thomesen (RT) denied the Complainant's request for reassignment.  
 3 16. In May 2012, JA repeatedly threatened to deny the  
 4 Complainant's summer leave requests.  
 5 17. On May 25, 2012, Data Capture, Malaina Bell (MB) at  
 6 JA's direction, asked the Complainant to close a patient  
 7 encounter in CPRS, which he had already completed and closed.  
 8 18. From April 16, 2012 through June 6, 2012, JA  
 9 interfered with the Complainant's re-credentialing and re-  
 10 privileging process.  
 11 19. On June 5, 2012, WR denied the Complainant's request  
 12 to attend a Veterans Employee Committee meeting.  
 13 20. On June 7, 2012 and June 18, 2012, JA changed the  
 14 Complainant's work schedule with only two days notice.  
 15 21. On June 18, 2012, JA questioned the Complainant on  
 16 three separate occasions regarding encounter notes for a June 7,  
 17 2012 field event.  
 18 22. On June 19, 2012, JA questioned the Complainant with  
 19 regard to a referral note template for Primary Care.  
 20 23. On August 10, 2012, JA yelled at the Complainant in  
 21 front of his co-workers regarding a grievance he had filed.  
 22 24. On August 16, 2012, a co-worker told the Complainant  
 23 that JA has "had it out for him" since she was assigned to the

6

1 Health Screening Clinic.  
 2 25. On May 28, 2013, the Associate Chief of Staff of  
 3 Extended Care, Younghee Limb (YL) placed the Complainant on a  
 4 paid non-duty status pending the outcome of an Administrative  
 5 Investigation Board (AIB).  
 6 26. On June 28 and June 29, 2013, the Complainant was  
 7 subjected to nine hours of unprofessional, insensitive,  
 8 offensive, and aggressive forms of questioning during the AIB.  
 9 Whereupon,  
 10 PHILIP MOSCHITTA  
 11 a witness called for examination, after having been first duly  
 12 sworn or affirmed, was examined and testified as follows:  
 13 EXAMINATION  
 14 BY INVESTIGATOR STOKES:  
 15 Q All right. State your name and spell it for the record,  
 16 sir.  
 17 A First name is Philip, P-H-I-L-I-P, Moschitta,  
 18 M-O-S-C-H-I-T-T-A.  
 19 Q And, Mr. Moschitta, it is my understanding you do not have  
 20 a representative and that you're willing to proceed without one.  
 21 Is that correct?  
 22 A Yes.  
 23 Q Identify the facility and service where you are employed.

7

1 A Northport VA Medical Center, Northport, New York, VISN 3.  
 2 Q All right. And your first-line manager, could you identify  
 3 that person, the person that you report to?  
 4 A Michael Sabo, VISN Director.  
 5 Q That's S-A-B-O?  
 6 A Yes.  
 7 Q Last name. All right. What is your -- in line of chain of  
 8 command, you are not the Complainant's first-line or even  
 9 supervisor at all. Is that correct?  
 10 A Yeah. I have no chain of command to him.  
 11 Q Okay. What month and year did you begin working in the VA?  
 12 This is your total service.  
 13 A August of '73. It will be 40 years in a couple of weeks.  
 14 Q Oh, well, congratulations. What month and year did you  
 15 begin in your current position?  
 16 A Okay. It was February. Let's go back four years. So this  
 17 is '13. I assume February 2009.  
 18 Q All right, thank you.  
 19 A I'm here four and a half years.  
 20 Q All right. Okay. Now, the Complainant has identified the  
 21 bases of sex, disability, and prior and current EEO activity as  
 22 the reason that he believes he's being discriminated against.  
 23 So I'm going to ask you a couple of questions related to those

8

1 bases.  
 2 Identify your sex.  
 3 A I'm male.  
 4 Q All right. Are you aware of the Complainant's sex?  
 5 A Yes. He's male.  
 6 Q All right. In that you just -- that's by observation?  
 7 A And I've spoken to him many, many, many, many times.  
 8 Q Oh, okay. All right, sir. Now, do you have prior EEO  
 9 activity? That could be by being a responding management  
 10 official, a witness. You might have been a witness in EEO  
 11 activity. You may have even had your own complaint. That's  
 12 what I mean by do you have any prior EEO activity.  
 13 A Yes.  
 14 Q Okay. And are you aware of the Complainant's prior EEO  
 15 activity, activity prior to this one, this complaint?  
 16 A I'm not a hundred percent sure, because he's filed a number  
 17 of EEO's that kind of build upon one another.  
 18 Q Okay.  
 19 A So I think this one is, like, the all-encompassing one.  
 20 Q Okay.  
 21 A Okay? I'm not a hundred percent sure, you know.  
 22 Q All right. All right. Okay. He alleges that he had filed  
 23 one some time ago wherein he named as a responding management

<p style="text-align: right;">25</p> <p>1 Q Okay.</p> <p>2 A So that's why you have to look at what the issue is, not 3 from a 40,000-foot point of view. Each one's different.</p> <p>4 Q All right. Okay. Well, because he raised the name we're 5 obligated to -- more to the point, even without the name, 6 though, do you believe -- and I think you've answered this, in 7 thoroughness actually. But do you believe that you have 8 treated -- given the circumstances for each AIB, do you believe 9 that you've treated any one AIB person more favorably than 10 another?</p> <p>11 A Absolutely not.</p> <p>12 Q Okay.</p> <p>13 A We do AIB -- I don't work in a vacuum. Okay? What happens 14 is we get a recommendation and then we sit with HR. Many times 15 I sit with the management team. We discuss this and then we 16 come up with a decision.</p> <p>17 Q All right.</p> <p>18 A So it's not me, myself, sitting in a room in a vacuum 19 making the decision. It's based on all the facts at that point 20 in time, which the AIB then has to either say the facts are true 21 or the facts are false.</p> <p>22 Q Okay. All right. Now let's move on then to Event 26.</p> <p>23 On June -- actually, the dates he said were incorrect. It</p>	<p style="text-align: right;">27</p> <p>1 do you have any response to this, any knowledge of it?</p> <p>2 A Yes. I can give you, actually, a lot of information.</p> <p>3 Q Okay.</p> <p>4 A First of all, the AIB is totally transcribed verbatim and 5 so this is not hearsay.</p> <p>6 Q All right.</p> <p>7 A Okay? Now, the AIB ended. The transcriptions came in last 8 week. I did not get an opportunity to look at the 9 transcriptions until after the Board re-reads everything, makes 10 their recommendations and all that.</p> <p>11 So at this point in time when you say "unprofessional, 12 insensitive, offensive questioning" -- when I get the Board, 13 which will be in approximately -- well, it should be next 14 week, I can read his entire testimony and every question 15 answered and I can make a valid judgment at that point, because 16 right now I can tell you the three that I appointed are my 17 superstars.</p> <p>18 Q All right.</p> <p>19 A They are superlative and they are -- one is a peer Nurse, a 20 Nurse Manager. The other one is my Workplace Development 21 Coordinator and the other one is my Privacy Officer.</p> <p>22 Q Okay.</p> <p>23 A So without reading the testimony, I look at this and this</p>
<p style="text-align: right;">26</p> <p>1 should be on June 27th and June 28th, 2013, the Complainant was 2 subjected to nine hours of unprofessional, insensitive, 3 offensive, and aggressive forms of questioning during the AIB.</p> <p>4 I will say that he has testified that he's alleging that 5 three individuals -- and I will name them, Paul Haberman -- 6 A I know the three: Paul Haberman, Barbara Albanese, and 7 Steven Winch, because I appointed them.</p> <p>8 Q Okay. So he's alleging that all three of them, not -- he 9 didn't say which did what. But he did say that all three, he 10 would say, conducted questioning in this manner that he's 11 describing in Event 26.</p> <p>12 Do you have any response about that?</p> <p>13 A Yes. Could we go off record for one second?</p> <p>14 Q Certainly.</p> <p>15 INVESTIGATOR STOKES: We're off record.</p> <p>16 (Off the record.)</p> <p>17 (On the record.)</p> <p>18 INVESTIGATOR STOKES: We are back on record. We went off 19 record because Mr. Moschitta just needed some more clarity about 20 this question related to E-26.</p> <p>21 BY INVESTIGATOR STOKES:</p> <p>22 Q All right, sir. So, now, we mentioned the names of the 23 individuals that he's alleging treated him in this respect. And</p>	<p style="text-align: right;">28</p> <p>1 can't be possible.</p> <p>2 Q Okay.</p> <p>3 A Now, I have to read the testimony to give you a valid 4 judgment.</p> <p>5 Q Okay.</p> <p>6 A Now, since I had this question yesterday I punched one 7 phone call because of the nine hours of time it took.</p> <p>8 Q Right.</p> <p>9 A Okay. And when I get the testimony, which will be 10 validated -- now, the time I'm not sure. They said they thought 11 it was seven. He's saying it's nine. The part that's relevant 12 is -- and which is clearly documented -- is on 42 occasions 13 during the testimony he -- he and his union rep stopped and they 14 went outside to caucus.</p> <p>15 Q Okay.</p> <p>16 A Some of the caucusing took at least a half hour.</p> <p>17 Q All right.</p> <p>18 A So I think the testimony -- you know, because -- once we 19 pay for a transcriber to come in -- will show the exact 20 questions asked and all, and it will show every time they asked 21 a question there was, "Stop, we have to go out and talk about 22 it."</p> <p>23 Q All right. Okay.</p>

I told the patient I would send his complaint to administration.  
Administration is aware

Closing Date: 06/13/2013

**Notifications**

Informational:  
NONE

Action Request:  
NONE

ROC Number: 632.201300715

Date of Contact: 06/13/2013

Information Taken By: MARENGO, WILLIAM NONE

Contact Phone/Fax: NONE

Contacting Entities: Patient

Congressional Contact: NONE

**Patient**

Patient: FASANO, JOSEPH ANTHONY

**Issue**

Issue Description: Patient asking about his fee basis request and his complaint of patient abuse by staff towards him.

**Resolution**

Clinical Appeal : NONE

ROC Issue Details:

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
LL03	FEE BASIS REVIEW	FISCAL	
RI03		ADMINISTRATION	

Resolution Text: Fran and I contacted the patient this afternoon at approximately 4:30 PM. We reviewed with the patient in regards to his request for fee basis. It was explained to him that he had the option to utilize the VA in the Bronx, Manhattan or Brooklyn. I did explain that he was more than welcome to utilize the medical center here at Northport, but that he would need to be agreeable to be escorted by the VA police Department. He told me this was not acceptable, as it would be a hardship for him to utilize the other medical centers and that he was not willing to have police escort. I had explained to the patient that since he's never utilized any types of services from this medical center, I was informed from the fee basis Department (Marie Irwin) that these were the options available for him. He also asked what did we do about his complaint about filing patient abuse charges on particular staff (my earlier e-mail

632.201300717

Date of Contact: 07/16/2013

Information Taken By: MARENGO, WILLIAM NONE

Contact Phone/Fax: NONE

Contacting Entities: Patient      Methods of Contact: Phone

Congressional Contact: NONE

**Patient**

Patient: FASANO, JOSEPH ANTHONY      Treatment Status: Outpatient

**Issue**

Issue Description: Patient had called in regards to his request for fee basis. I was calling back with my supervisor as he was complaining that I did not get back with an answer regarding his request. Patient was complaining that he needed services on the outside for medical care.

**Resolution**

Clinical Appeal : NONE      Comp: NONE

ROC Issue Details:

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
LL03	FEE BASIS REVIEW	FISCAL	
LL03	SWS-PRIMARY/SPECIALTY CARE	SOCIAL WORK	

Resolution Text: I called the patient and asked for permission to have my supervisor on the call and he said no. He stated he did not trust my supervisor or her supervisor, John Sperandeo. My supervisor called the patient back, on the first attempt the phone was disconnected. The second time she left her information but the patient never called back. Fee Basis was made aware of patient 's complaint(the concern is that the patient has not used services at this VA or any other VA).

Closing Date: 07/16/2013

**Notifications**

Informational: NONE

Action Request: NONE

1 official Ms. Robinson, Ms. Wendy Robinson. So this one pertains  
2 primarily to Ms. Anderson, JoAnne Anderson.

3 So are you aware of any -- the one that pertained more to  
4 Ms. Robinson?

5 A Well, I'm looking at this one because you sent me, you  
6 know, a copy.

7 Q Right.

8 A I think Wendy's in here, too.

9 Q Yes. Oh, she is, but I mean -- Ms. Robinson is identified  
10 in this one. But prior to that he filed a separate one, before  
11 this one, in which he identified her as a responding management  
12 official. So are you --

13 A Truthfully, he has filed a number of EEO's, a number of IG  
14 complaints.

15 Q Okay.

16 A You know, I'm getting a blur.

17 Q Oh, okay. All right.

18 A So I know he's had all these complaints. I can't tell you  
19 if I really know a specific one. It's like a blur right now.

20 Q Okay, no problem. All right. Well, let's move on, then,  
21 to his disability. Well, first of all, this is just a yes or a  
22 no for you. Do you have a disability?

23 A No.

1 Q Okay, thanks. All right. Let's move on now to the  
2 specific events of Event 25 and Event 26.

3 And Event 25 reads: Whether -- well, actually all of these  
4 events are whether on the basis of sex (male), disability, and  
5 reprisal the Complainant was subjected to a hostile work  
6 environment.

7 And so the specific Event 25 is:

8 25. On May 28, 2013, the Associate Chief of Staff of  
9 Extended Care, Younghee Limb (YL), placed the Complainant on a  
10 paid non-duty status pending the outcome of an Administrative  
11 Investigation Board.

12 All right. So, sir, it's my understanding that you  
13 authorized the AIB. Why?

14 A Well, let's first deal with No. 25 specifically. Dr. Limb  
15 was merely the messenger because that's his supervisor.

16 Q All right.

17 A The decision for him to be placed on non-duty status with  
18 pay and to begin the Administrative Investigative Board was my  
19 decision.

20 Q Okay.

21 A So clearly she has no -- you know, her only role was, you  
22 know, she was informed as a supervisor and it has to come from  
23 her.

1 Q All right. Now, are you aware of the Complainant's alleged  
2 disability of Post-Traumatic Stress Disorder?

3 A The only one I'm aware of is in the -- all this  
4 correspondence in the last, I would say, three, four months he  
5 talks about. So I can only say yes if what he's saying is true.  
6 I don't know firsthand or, you know, that he actually has PTSD,  
7 but he -- all his correspondence references that he does.

8 Q Okay. And do you know or have any information at all as to  
9 whether or not his PTSD affects his essential job duties or  
10 carrying them out?

11 A Well, that is -- to the best of my knowledge that has never  
12 come up as an issue. You know, like I said, I know him almost  
13 my entire stay here at Northport. I've been involved very  
14 closely my entire stay here at Northport. And it's only within  
15 the last number of months -- few months because of his, you  
16 know, mentioning in letters that -- it never came up. So I've  
17 never heard that as an issue.

18 Q Okay, thank you. All right. Well, let's move -- well, one  
19 other question. Then are you -- do you know whether or not  
20 he -- what is your knowledge of the interference of PTSD with  
21 his normal life functions, his day-to-day life functions, if  
22 any?

23 A No idea.

1 Q Okay.

2 A She did not make that decision whatsoever.

3 Q All right. Well, all right. So, sir, what was your  
4 justification for your action?

5 A Okay. I don't have a date in front of me, so I'm going  
6 to -- I'm going to use around the 28th because I'm assuming the  
7 28th is when he was handed the paper.

8 Q Okay.

9 A Okay? So I can't tell you, exactly, the date. I don't  
10 have that in front of me, but I'll use these dates as being  
11 accurate.

12 Q Uh-huh.

13 A Let's see. I would say probably within that week, so we're  
14 only talking a few days prior to that letter. A coworker on his  
15 unit filed a workplace violence complaint against him.

16 Now, the way it works here, when someone files a workplace  
17 violence it goes to our Workplace Violence Committee. You know,  
18 we have a committee that deals with any kind of disruptive  
19 behavior: assaults, things of that nature. It's chaired by  
20 Dr. Moreno (ph.), who's Chief of Psychology Service, and it's  
21 composed of a number of individuals. I know one of them being  
22 our EAP individual, Employee Assistant Program Manager. I'm  
23 pretty sure the Chief of Police.

1 A If it took the nine hours, whether it's nine, seven, it  
 2 could be -- but I think when you look at the actual time of them  
 3 talking, more than half of it was waiting for them.  
 4 Q All right. All right. Okay. Because you don't have  
 5 definitive transcripts at this time to make a decision, I  
 6 believe I heard you say, about whether or not you deem it or see  
 7 it unprofessional and insensitive, because we want to move  
 8 forward with this investigation as well, do you believe based on  
 9 your understanding of the process and understanding of you  
 10 have -- what information you do have, that these individuals  
 11 handled this questioning in the manner that's described here?  
 12 A They were -- they are totally professional individuals.  
 13 And actually they handled my last Administrative Board. They do  
 14 an excellent job. They're fair and balanced people.  
 15 Q All right. So you have no reason to believe that they  
 16 discriminated against Mr. Fasano in the way they asked questions  
 17 because of his sex, his disability, or his EEO activity prior or  
 18 current?  
 19 A Correct.  
 20 Q Okay. All right. All right. We will leave it at that  
 21 unless you at a later time see that there is some reason for you  
 22 to amend your answer and send to us an amendment to the answer  
 23 agreeing with this allegation. All right.

1 do is they indicate whether or not the charges are sustained or  
 2 not, you know, things of that nature.  
 3 Q All right.  
 4 A When that occurs I -- you know if, hypothetically, they say  
 5 it's all unfounded, there's no issue, he goes back to work the  
 6 following day and that's the end of it. ] A  
 7 Q Okay.  
 8 A If, hypothetically, they say no, this, this, and this is  
 9 validated, that, that, and that, I take that Board, I give it to  
 10 HR, which will be the Labor Relations Section.  
 11 Q All right.  
 12 A I don't know who's assigned. It might be Cheryl  
 13 Carrington.  
 14 Q All right.  
 15 A Now, you've got to realize her job now is to try to read  
 16 the entire Board, digest it, and then they tell me what the  
 17 appropriate actions could be.  
 18 Q I see. Okay.  
 19 A Because the Board -- you know, just because the Board says  
 20 this, this, and this convinces them, it might not translate into  
 21 something that would stick up as far as a disciplinary action.  
 22 Q All right.  
 23 A So I would think -- now, what I asked them to do already --

1 A The only other thing I could say to you is if you want --  
 2 off the record.  
 3 (Off the record.)  
 4 (On the record.)  
 5 INVESTIGATOR STOKES: We are back on record. We went off  
 6 record again for some clarity with E-26. And I indicated to  
 7 Mr. Moschitta that I am considering -- we have finished  
 8 discussing E-26 unless he decides or determines at a later time  
 9 that he wants to amend his response to E-26 after he reviews  
 10 additional information and something changes in his response.  
 11 He could just send it to me by email if that's the case. All  
 12 right.  
 13 BY INVESTIGATOR STOKES:  
 14 Q We normally also obtain the conclusion of your -- of any of  
 15 the AIB's that's involved when a person is alleging  
 16 discrimination about them or -- and maybe the recommendations.  
 17 Has that happened? Has that occurred?  
 18 A No. The timeframe for this is the end of the month, which  
 19 is, I think, next week.  
 20 Q Okay.  
 21 A That the Committee, the Board, will give me -- now, once  
 22 again, what they do is they recommend. They don't recommend  
 23 specific actions because that's not in their purview. What they

1 because I know -- considering all the emails and letters he's  
 2 generated, I've asked HR -- like, whoever's handling this have  
 3 the whole week off and just take care of this, because it's a  
 4 lot to digest. And sometimes, you know, these Boards -- because  
 5 it could be, you know, 8, 10, 12 inches of paper, it could take  
 6 them sometimes a month to come back to me and say, "After we  
 7 read this 900 times, this is what we can do." So I'm going to  
 8 try to get that done in a week.  
 9 Q All right.  
 10 A All right. So I would say August -- like the first -- end  
 11 of the first week of August would be the earliest that I can  
 12 tell you definitively if there's going to be action against him.  
 13 Q All right. Okay. And so while we normally receive that --  
 14 and I'm going to take this off record.  
 15 INVESTIGATOR STOKES: We're off record.  
 16 (Off the record.)  
 17 (On the record.)  
 18 INVESTIGATOR STOKES: We're back on record. I just wanted  
 19 to go off record to indicate to Mr. Moschitta that whether or  
 20 not the documents will be included will be determined at a later  
 21 time depending on whether or not the documents are available  
 22 when we finalize the EEO complaint Report of Investigation. All  
 23 right.

identifies the staff). I explained to the patient that I did share his complaint with the appropriate management. . It was noted that after we reviewed the above, the patient would re- ask the same question. We did this at least two times and reiterated the same answer. We encouraged him that he should put his complaints in writing, as this would give him the opportunity to elaborate on his particular claims. He stated he was going to do such, and also shared that he was going to have congressional representatives involved. We explained that with his right. At this point we ended the call.

Closing Date:

**Notifications**

Informational:

Action Request:

**Cover Sheet**

ROC Number:   
 Date of Contact:   
 Information Taken By:   
 Contact Phone/Fax:   
 Contacting Entities:  Methods of Contact:   
 Congressional Contact:

**Patient**

Patient:  Treatment Status:

**Issue**

Issue Description:

**Resolution**

Clinical Appeal:  Comp:

ROC Issue Details:

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
IF05	Directors office	ADMINISTRATION	
IF05	PSYCHOLOGY HEALTH	MENTAL HEALTH	

**Cover Sheet**

**ROC Number:**   
**Date of Contact:**   
**Information Taken By:**   
**Contact Phone/Fax:**   
**Contacting Entities:**  **Methods of Contact:**   
**Congressional Contact:**

**Patient**

**Patient:**  **Treatment Status:**

**Issue**

**Issue Description:** The patient had contacted me one week ago to report that a VA police officer, a clerical worker and the OIF OEF patient advocate was noted to be viewing his chart. I explained to the patient that I would notify the privacy officer to look into his complaint. I had encouraged him to put these types of complaints in writing and send them to the medical center. I had spoken with our privacy officer who was aware of these complaints, and had spoken with patient. The privacy officer stated that he told the patient he would look into his complaints and get back to him.

On Monday, July 15th patient left a voicemail voicing three complaints:

- 1 & His request for fee basis for medical/psychological/psychiatric services was never addressed (but on June 13th, Fran and I had contacted him and had reviewed his options).
- 2 & His complaint of staff viewing his chart was never addressed. This complaint is being actively reviewed by the privacy officer, which the patient is aware of as he had spoken directly with the privacy officer in detail about his concerns.
- 3 & He stated in his voice mail that myself nor any provider ever screened him for suicidal ideations, which as per the patient he claims are part of the VA guidelines. He went on to state that he was reporting this to the central office and ended the phone call by asking me to call him back. I shared this information with my supervisor. On July 16th, I contacted the patient from my supervisor's office to discuss his concerns. I started the conversation by asking him permission to put the phone on speaker phone. The patient asked me who is my supervisor, and I explained she is the associate chief of social work service. He responded by stating that he would not feel comfortable with speaking with Mr. Sperandeo or Mrs. Bugaoan without his lawyer and that he would only speak with me. I explained that I would have to share this information with my supervisor and get back to him. My supervisor attempted to contact the patient but someone hung up the phone before she could identify herself. My supervisor attempted to call the patient back a second time and explain why she needed to be present during the phone call. The phone went to voicemail, my supervisor identified herself and asked the patient to contact her. No return phone calls have been made by the patient.

**Resolution**

**Clinical Appeal :**  **Comp:**

**ROC Issue Details:**

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
IF05	COS	ADMINISTRATION	
IF05	Performance Improvement	ADMINISTRATION	
IF05	SWS-PRIMARY/SPECIALTY CARE	SOCIAL WORK	

1 So based on the complaint, based on how they investigated,  
 2 they then made a recommendation to myself that there was enough  
 3 substance here that the individual should be put off duty  
 4 because they did not feel comfortable him being in the building,  
 5 and that I should convene an Administrative Investigative Board.  
 6 Q Okay.  
 7 A So that's how those two decisions came about.  
 8 Q All right. So the Complainant is alleging that he was  
 9 given no justification for his being put on this paid non-duty  
 10 status, and he contends that it's inappropriate for him to be in  
 11 that situation without some information about the reason. And  
 12 he goes further to say that it's inappropriate for him to be  
 13 prohibited from entering the facility unless escorted by Police.  
 14 Do you have any response to his contention?  
 15 A Well, number one, he was informed that there was a  
 16 workplace violence complaint. Okay? So that's not true. He  
 17 knew why he was being taken out. Now, the specifics of it --  
 18 I'm not familiar if they go over each line with him. Okay?  
 19 Because now there's a Board to see what the issues really are.  
 20 Q Okay.  
 21 A All right? So -- but as far as why he was removed or,  
 22 rather, put on a non-paid [sic] status, he was made aware of  
 23 that.

1 Q Okay.  
 2 A Okay? He was also made aware that his point of contact is  
 3 Dr. Limb, because that's his supervisor, and the rest of that.  
 4 With regards to a Police escort, once again that was a  
 5 recommendation from the Workplace Violence Group that this  
 6 individual -- there was what they felt enough -- how would you  
 7 say -- indications from their review that there was concerns  
 8 about his ability to create, you know, some harm to others. And  
 9 so that's why he's allowed to come on the premises for medical  
 10 care. You know, I do know he's a veteran.  
 11 Q Okay.  
 12 A So if he has to come on the premises for medical care or if  
 13 he wants to come on the premises to -- what do you call it --  
 14 see a union rep or whatever, he has to have a Police escort.  
 15 Now, the Police escort is for two reasons. Number one is to  
 16 safeguard staff from him and, number two, to safeguard him from  
 17 being put into a further awkward position. If in fact, say, the  
 18 allegation is not true, it also safeguards him from having  
 19 people who might be making false allegations come up with any  
 20 further false allegations.  
 21 Q Oh, okay.  
 22 A So that's -- you know, that's the balancing here. I don't  
 23 know if that answers the question, but that's pretty much the

1 rationale.  
 2 Q Okay. All right. So to make sure that I have a  
 3 comprehensive investigation and talk to the appropriate people,  
 4 since I am talking to you now and you have the -- you  
 5 authorize -- if the recommendation came from the Workforce  
 6 Violence Committee, but, if I understand you correctly, you  
 7 certainly are in a position where you can reject or accept their  
 8 recommendation. Is that accurate?  
 9 A Accurate. A hundred percent accurate.  
 10 Q Okay. Thank you. So I don't need -- my conclusion is, and  
 11 I'll give your response to it, I don't really need to talk to  
 12 them since they recommended to you.  
 13 A Right. This group, just so we understand, is chaired by a  
 14 clinician and it's looked upon in the clinical sense. This is  
 15 not just for employees. We have, you know, employees that feel  
 16 they're harassed by patients.  
 17 Q Okay.  
 18 A So, you know, the same type of situation occurs where we'll  
 19 have certain patients -- because we can't deny them their care.  
 20 But when the patient comes aboard he has to have a Police  
 21 escort.  
 22 Q All right. Okay. All right. So the Complainant goes on  
 23 to indicate that he feels this is discrimination because of his

1 sex, because reference has been made to his size as a male and  
 2 that he -- because of his size he's an intimidating force. And  
 3 it's because of his disability, because he has made it clear to  
 4 all parties for quite some time that he has PTSD, and these  
 5 actions related to this investigation by the AIB and the removal  
 6 from work exacerbates his PTSD.  
 7 Do you have any comments about that?  
 8 A Well, I never heard anyone make any kind of disparaging  
 9 remarks about his size or any of this stuff. So I have no clue  
 10 on that. Regarding, once again, his disability -- and I know  
 11 him. Like I say, you know, I've been involved with him on a  
 12 number of issues over the last three and a half years.  
 13 It's only within the last number of months -- I will say  
 14 since this happened, okay -- and it's because of his writings,  
 15 that he indicates that he's got any kind of disability. I don't  
 16 think anyone really knew that unless, you know, he told them. I  
 17 mean, you know, privately -- because that's never come up as an  
 18 issue.  
 19 Q Okay. All right. And then with respect to the prior and  
 20 current EEO activity, he believes that you are aware of all his  
 21 EEO complaints by virtue of your position as Director, and that  
 22 he was specifically told by his union rep that you had -- you  
 23 disapproved of his complaint against Ms. Anderson.

1 BY INVESTIGATOR STOKES:  
 2 Q And let me now just say that because you -- I didn't ask  
 3 you questions about all 26 complaints or events. But since he's  
 4 claiming a hostile work environment, do you believe that you are  
 5 in a position, in summary, to speak to whether or not you  
 6 believe that those events subjected him or he's been subjected  
 7 to a hostile work environment?  
 8 A He has not been subjected to a hostile work environment. I  
 9 am positive of that. You know, I have seen the allegations, all  
 10 20-some-odd events, and I know the individuals. And when I look  
 11 at some of these events, you know, a lot of these issues are  
 12 just -- I don't see them as even provable or disprovable. Okay?  
 13 Q Okay.  
 14 A For example, I got -- I opened up the thing in front of me.  
 15 Q Right.  
 16 A All right. You take Number 8: On April 14th JA -- which  
 17 is JoAnne Anderson -- was disruptive and intrusive while the  
 18 Complainant was performing clinical encounters. That's in 2012.  
 19 Q Right.  
 20 A There's no witnesses. I mean, I don't know how you -- how  
 21 are we going to prove or disprove it? I have no clue. She  
 22 doesn't even remember what's happened.  
 23 October 11th, 2011, unprofessional, confronted Complainant

1 Q All right.  
 2 A So I was aware of all of this through his -- you know, our  
 3 dialogue, not that we had a formal meeting.  
 4 Q Okay. Okay. All right. So you did not -- so the action  
 5 you took was to meet with them and to discuss it. And was any  
 6 other action taken or needed in response, to your knowledge, of  
 7 his claim of hostile work environment?  
 8 A Well, it came -- I don't remember when I became  
 9 knowledgeable. It was at the end of this timeframe, so that at  
 10 that point in time part of the reason they wanted to meet with  
 11 me is to see if I would assist him and also get him out of that  
 12 service.  
 13 Q I see. Okay.  
 14 A So that really -- and I said, "Well, why do you want to  
 15 leave?", and that's how we got into, you know, this hostile  
 16 environment and his interactions with JoAnne Anderson.  
 17 Q I see. Okay.  
 18 A And then he moved on to his third location, this Medical  
 19 Center, under the third service, and that's where he's had these  
 20 issues now.  
 21 Q Okay. And is that -- the third service, is that with  
 22 Dr. Limb?  
 23 A Yes. He went from Ambulatory Care to -- actually he worked

1 while he was seeing a patient regarding a time and leave issue.  
 2 You know, I don't even know how we would look into this.  
 3 Q All right. Okay.  
 4 A Now, this individual in particular is a Nurse Practitioner,  
 5 which is his peer, a super performer, a super professional.  
 6 And, you know, like I say, I know him from the very beginning.  
 7 And actually it's interesting, because he'll tell you I'm the  
 8 one who saved his job because at the time they wanted to remove  
 9 him. I -- because he's a veteran I reassigned him to Timothy  
 10 Anderson (ph.) in Rural Health.  
 11 Q Okay. All right.  
 12 A It's just an interesting -- an interesting thought.  
 13 Q Yeah. So you were -- you had been made aware of his claim  
 14 of hostile work environment --  
 15 A About any of these dates, no. I only know because, you  
 16 know, I got this complaint.  
 17 Q Right, right. But I mean had you been made aware from him  
 18 or by him in any manner that he was -- he considered himself in  
 19 a hostile work environment?  
 20 A Well, I got the complaint. I met with him and Rich  
 21 Thomsen because I meet with Rich, you know, almost weekly or  
 22 every couple of weeks because he's the union president, and him  
 23 and Mr. Fasano are very close.

1 for the Director's Office because Rural Health and this  
 2 individual work for me. And then from there he went to  
 3 Long-Term Care, which is Dr. Limb.  
 4 Q All right. Okay. And Long-Term Care is where he is now.  
 5 Okay. Is that --  
 6 A Correct.  
 7 Q Okay. All right. Well, sir, I thank you very much for  
 8 your time.  
 9 Is there anything else that you feel that I haven't asked  
 10 you that you think is relevant to this matter?  
 11 A No. I think it's a, you know, interesting dialogue. It's  
 12 a convoluted and complex case.  
 13 Q All right.  
 14 A That's all I can say because, you know, every time you turn  
 15 something over it's another issue.  
 16 Q Okay.  
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 23

IF05	SWS- PRIMARY/SPECIALTY CARE	SOCIAL WORK	
IF05	COS	ADMINISTRATION	

**Resolution Text:**

I explained that from his previous phone calls in regards to his complaints that they were shared with administration. He also stated that he sent a letter of his complaints to Congressman Steve Israel and to the Sec. of Veterans Affairs, Mr. Shinseki. He started to repeat the same complaints and I assured him that his complaints were shared with administration. I ended the call by explaining that his written complaints would receive a response.

**Closing Date:** 06/19/2013

**Notifications**

**Informational:**

NONE

**Action Request:**

NONE

Patient Advocate Tracking System (PATS)  
Questions, Feedback: National Help Desk 888-596-4357

**Cover Sheet**

**ROC Number:** 632.201300712

**Date of Contact:** 06/28/2013

**Information Taken By:** MARENGO, WILLIAM NONE

**Contact Phone/Fax:** NONE

**Contacting Entities:** Patient **Methods of Contact:** Phone

**Congressional Contact:** NONE

**Patient**

**Patient:** FASANO, JOSEPH ANTHONY **Treatment Status:** Outpatient

**Issue**

**Issue Description:** Patient complaining of a Police Officer going in his medical records and as per patient, 4 days later a personal action was taken.

**Resolution**

**Clinical Appeal:** NONE **Comp:** NONE

**ROC Issue Details:**

Issue Code	Location	Facility Service or Section	Employee Involved
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IF05	Directors office	ADMINISTRATION	
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**Resolution Text:** This summary was shared with all services listed above

**Closing Date:** 07/17/2013

**Notifications**

**Informational:**  
NONE

**Action Request:**  
NONE

1 Do you have any comments? That's why he believes you're  
2 discriminating against him because of his prior and current EEO  
3 activity. Any comment about that?

4 A Well, you know, I meet -- Rich Thomesen is a union rep.

5 Q Yes.

6 A He's also the president of the union. I meet with Rich. I  
7 meet with -- I met with him many, many times over the last three  
8 years. That's why I say I know him very well. He's worked --  
9 you know, the first -- just a little background. You know, I  
10 got involved with him when I first got here because he was  
11 having difficulties in a certain service.

12 Q All right.

13 A And I think it was heading towards removal of him during  
14 his probationary period. I intervened because he's a veteran  
15 and I reassigned him. Then he had difficulties in where I  
16 reassigned him. And then we -- he moved on to this next area.  
17 He had difficulties in Long-Term Care and then he was placed on  
18 the current ward where this issue came up. So I've been  
19 involved with him every step of the way.

20 So when you say I have knowledge of this, that -- you know,  
21 during my conversation with him, and Rich and I have a lot of  
22 different -- I think I have a broad-based knowledge of the whole  
23 situation. It's just that I can't say -- it's become like a bit

1 Did you in any way discriminate against Mr. Fasano based on  
2 his sex, disability, or prior and/or current EEO activity with  
3 respect to authorizing the AIB?

4 A Absolutely not.

5 Q Okay, thank you. All right. Did -- is there a -- and I  
6 can obtain this from whomever you suggest that I go to. Is  
7 there a written policy for handling AIB's to your knowledge?

8 A There must be. HR would have that. They are the subject  
9 matter experts. And also District Counsel.

10 Q All right. And so --

11 A Because when we form a Board, whoever's on the Board has to  
12 get training --

13 Q Okay.

14 A -- on how to conduct it. And they usually have a contact  
15 with District Counsel or HR as technical experts.

16 Q All right. And do you believe that you were in compliance  
17 with all of the policy related to AIB as well as workplace  
18 violence and anything related to this paid non-duty status and  
19 everything related to this Complainant?

20 A Oh, absolutely.

21 Q Okay.

22 A I mean, we don't do many AIB's, you know, because, you  
23 know, you do fact-findings. You can do, you know, focus

1 of a blur because --

2 Q Okay.

3 A I can't tell you, yes, I know this specific case. Now,  
4 JoAnne Anderson was one of my direct reports.

5 Q Okay.

6 A I moved him into her area, which was Outreach.

7 Q All right.

8 A And then he had difficulty there with supervisory issues.

9 You know, if she asked if he, you know, put in -- you know, "Did  
10 you put your leave in for yesterday," he took exception with  
11 that. If he -- you know, it was just typical supervisory  
12 issues.

13 Q Okay.

14 A Now, as far as, you know, in our conversations I -- you  
15 know, I have to look at it from; you know, a different  
16 perspective as Director to ensure that, you know, he's being  
17 treated fairly and all. So I am not -- there's no way that I  
18 hinted at him or said to him that, you know, "You're wrong," and  
19 this and that. You know, we looked at each allegation and we --  
20 you know, we then decide on that.

21 Q Okay. All right. So then specifically let me just say it  
22 sounds as though you have said -- but I will ask you  
23 specifically.

1 reviews. There's a lot of different things. This one here  
2 there was enough concern and allegations thrown around that we  
3 needed a formal Investigative Eoard.

4 Q Okay.

5 A Okay? Now, the issue of a recommendation that this  
6 individual -- from the Workplace Violence Group -- that it would  
7 not be in his best interest or the agency's best interest to  
8 have him on duty, that gave me the authorization to basically  
9 remove him from duty. And obviously, because we don't know if  
10 he's guilty or innocent, we'll say, he has to get paid. So  
11 that's why he's put off with pay.

12 Q All right. Okay. And so you just raised another point.

13 And I certainly -- this -- you can tell me who to go to. I'm  
14 guessing your EEO Manager, but I may be wrong. And that is we  
15 have requested a list of similar AIB's on other employees, going  
16 back two years, where you have authorized them. This is for  
17 comparative, you know, basis. We will do -- take care of all  
18 redaction as appropriate. But is that a person that I should go  
19 to for that kind of information?

20 A I would guess HR, Human Resources, would know. Whether  
21 EEO -- an AIB has nothing to do with EEO.

22 Q Okay.

23 A Okay? In the four years I've been here maybe there's been

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Q Okay. So with the reports of contact for workplace violence, that is also something -- those are documents that we would also need that initiated this. That would be through HR as well; is that correct?

A I'm not a hundred percent sure.

Q Okay.

A Because as long as there's no disciplinary action -- okay? Because AIB is not a disciplinary action.

Q Right.

A If they have any follow-up, I would think you might have to contact Dr. Moreno, the Chairman of Workplace Violence because, you know, he would have whatever he has, then base the decision on to say, "Yes, this is serious enough, and these are our recommendations."

Q Okay. All right. And Dr. Moreno's first name again?

A Wait, wait. I'll tell you in one second. One second. I always call him Dr. Moreno.

Q Okay.

A Michael.

CERTIFICATE  
 This is to certify that the attached proceedings in the matter of the affidavit of PHILIP MOSCHITTA, on Thursday, July 25, 2013, were held according to the record and that this is the original, complete, and true and accurate transcript that has been compared to the reporting or recording accomplished at the proceeding.

\_\_\_\_\_/s/\_\_\_\_\_  
 Linda L. Brown  
 Transcriber

Free State Reporting, Inc.  
 1378 Cape St. Claire Road  
 Annapolis, MD 21409  
 (410) 526-8973

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Q Michael. Okay. All right, thank you very much, sir. We were on record all of this time, but we are now going off record.  
 (Whereupon, the interview was concluded.)

ERRATA SHEET

In the matter of: ) Complaint No:  
 JOSEPH FASANO, ) 200H-0632-2012104167  
 Complainant, )  
 vs. )  
 DEPARTMENT OF VETERANS AFFAIRS, )  
 Northport VA Medical Center, )  
 Northport, New York, )  
 Respondent. )

TESTIMONY OF: PHILIP MOSCHITTA

The above information has been furnished without a pledge of confidentiality, and I understand that it may be shown to the interested parties to this complaint, subscribed and sworn to me, subject to the penalties of perjury on this date.

I have reviewed the transcript of my testimony. I wish to make the following corrections/changes:

PAGE LINE AS TRANSCRIBED CHANGE TO

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Free State Reporting, Inc.  
 1378 Cape St. Claire Road  
 Annapolis, MD 21409  
 (410) 626-8973

IF05	Patient Adv/Rep Office	ADMINISTRATION	
RE01	Police Officer	POLICE/SECURITY	
RE01	Privacy Officer	ADMINISTRATION	

**Resolution Text:** I told the patient I would notify the Police and Privacy Officer of his complaint. Patient also stated he was sending his complaint in writing to the VA. Notified Chief of Police and he explained that his officers do go have access to the patient's charts. He was aware and stated the officer needed some information on the patient. Privacy Officer also aware.

**Closing Date:** 06/28/2013

**Notifications**

**Informational:**  
NONE

**Action Request:**  
NONE

Patient Advocate Tracking System (PATS)  
Questions, Feedback: National Help Desk 888-596-4357

**ROC Number:** 632.201300712

**Date of Contact:** 06/28/2013

**Information Taken By:** MARENGO, WILLIAM NONE

**Contact Phone/Fax:** NONE

**Contacting Entities:** Patient **Methods of Contact:** Phone

**Congressional Contact:** NONE

**Patient**

**Patient:** FASANO, JOSEPH ANTHONY **Treatment Status:** Outpatient

**Issue**

**Issue Description:** Patient complaining of a Police Officer going in his medical records and as per patient , 4 days later a personal action was taken.

**Resolution**

**Clinical Appeal :** NONE **Comp:** NONE

**ROC Issue Details:**

Issue Code	Location	Facility Service or Section	Employee Involved
RE01	Police Officer	POLICE/SECURITY	
IF05	Patient Adv/Rep Office	ADMINISTRATION	

**Resolution Text:** I told the patient I would notify the Police and Privacy Officer of his complaint. Patient also stated he was sending his complaint in writing to the VA. Notified Chief of Police and he explained that his officers do go have access to the patient's charts. He was aware and stated the officer needed

21

1 three.  
 2 Q Oh, okay. All right.  
 3 A It's not, you know -- it's not that there's a lot and I  
 4 don't know how you're going to compare, because each situation  
 5 is on its own.  
 6 Q Okay.  
 7 A You know what I'm saying there? So --  
 8 Q All right.  
 9 A I only know of -- there might have been three. I know  
 10 another one. There might have been three, not a lot.  
 11 Q Okay. So HR -- someone in HR. Would Ms. Carrington, you  
 12 think --  
 13 A Right.  
 14 Q Was that the consultant that was used in this one or you  
 15 don't know?  
 16 A Oh, I'm not a hundred percent sure, but she would be able  
 17 to figure out, you know, the AIB's.  
 18 Q Oh, okay. Thank you so much. All right.  
 19 So now, let's specific -- I'm going to be specific. And  
 20 I'm going to have to take you off record a moment for this, off  
 21 line.  
 22 INVESTIGATOR STOKES: We are now off record.  
 23 (Off the record.)

22

1 (On the record.)  
 2 INVESTIGATOR STOKES: We went off record because I wanted  
 3 to identify for Mr. Moschitta that the Complainant has  
 4 identified a specific individual that he believes was treated  
 5 more favorably, and we have designated that person as Person A  
 6 to protect his privacy.  
 7 BY INVESTIGATOR STOKES:  
 8 Q And so you indicated while we were off record, I believe,  
 9 that you have no recollection of Person A. Is that correct?  
 10 A The name you gave me, I have no recollection. You know,  
 11 that doesn't mean it didn't happen. But the truth is, there are  
 12 not that many AIB's.  
 13 Q Okay.  
 14 A You know, there's a lot of different ways you look into  
 15 problems. I'm wondering if Mr. Fasano is mixing up, you know, a  
 16 Board of Investigation versus a fact-finding. You know,  
 17 there's -- because I just don't remember that one at all.  
 18 The other thing is when you say "favorable", you know,  
 19 that's a pretty open-ended comment.  
 20 Q Well, I'll be specific about that. He indicates that with  
 21 Person A, Person A was not -- was allowed to return to campus or  
 22 to the facility without having a Police escort. Person A, as he  
 23 indicated, was not paraded, as he indicated, such that his

23

1 colleagues or his coworkers could see him being escorted off the  
 2 premises by a Police escort.  
 3 So he's suggesting -- or not suggesting. He testified that  
 4 the humiliation that he feels that what he had to encounter  
 5 based on some of the actions, Person A did not -- did not  
 6 seemingly go through. That's what he means by -- some of what  
 7 he means by being treated more favorably.  
 8 A Now, let's -- once again I'll make this nice and clear  
 9 because this is a simple question. You know, each case has its  
 10 own merits. The last AIB before this one, which I remember very  
 11 clearly, that individual was reassigned and worked here the  
 12 whole time.  
 13 Q All right.  
 14 A Okay? Because the facts of that AIB -- there was no  
 15 indication that this individual could have been a danger to  
 16 himself or others.  
 17 Q All right.  
 18 A Okay? Based on the clinical judgment of the Workplace  
 19 Violence Committee, they felt this individual had the potential  
 20 for violence and could be put in jeopardy by coworkers.  
 21 Q All right.  
 22 A So that's why I'm saying you can't take an AIB and say,  
 23 well, five of them a person was sent home, ten of them they were

24

1 here. It's the merits of the case.  
 2 Q All right. Okay.  
 3 A An AIB -- in this case here, the workplace violence, once  
 4 they looked at the chart, once they looked at a number of  
 5 issues -- when I say the "chart", you know, he documents in the  
 6 chart.   
 7 Q Okay.  
 8 A What happened was an individual and him had a disagreement  
 9 about something to do with a patient's care.  
 10 Q All right.  
 11 A He became belligerent and she filed the workplace violence.  
 12 When they looked at it and they looked at some of his notes --  
 13 and they also spoke to some individuals that overheard them  
 14 talking. His comments, and I'm not going to quote them  
 15 because --  
 16 Q Okay.  
 17 A -- could lead someone to think that something's wrong here.  
 18 Q All right.  
 19 A Okay? Now, we can do an AIB on somebody, for example, that  
 20 the allegation is they stole \$50.00.  
 21 Q All right.  
 22 A Well, you're not going to take somebody -- there's no  
 23 danger there.

**ROC Number:**   
**Date of Contact:**   
**Information Taken By:**   
**Contact Phone/Fax:**   
**Contacting Entities:**  **Methods of Contact:**   
**Congressional Contact:**

**Patient**

**Patient:**  **Treatment Status:**

**Issue**

**Issue Description:**

Patient contacted the patient advocate's office yesterday complaining he could not receive services here without having police escort due to a issue related to his employment here. He stated he did not know what the charges were that were against him and felt all of his rights are being violated. Patient brought up being 100% service-connected and that his private life being treated for medical/psychological/psychiatric services should be treated as a separate issue. He was asking for the police escort to be removed or that the medical center authorize him to get fee basis for his medical, neurological, dermatological, psychiatric and psychological needs. Patient stated he needed to be seen by his medical Dr., psychologist, psychiatrist, dermatologist, and his neurologist. I spoke with Dr. Mack yesterday and he stated have the patient's providers put in a request for fee basis. When I looked in CPRS it was noted that the patient was never been seen here. Patient is still waiting for an answer as he wants the medical center to pay for all services. Patient had asked if his chart was flagged, but when viewed in CPRS there was no flag identified. I did contact Dr. Marino who stated that the medical center was aware of his complaints and that for any reasons coming to the medical center, the patient would need police escort. (Please note the chart does not identify this.)

He called again today, (multiple calls to Fran Maida's voicemail). On the voicemail he is asking the patient advocate office to assist in filing patient abuse charges against the medical center director, Mr. Moschitta, the psychology service chief, Dr. Marino , and the geriatrics service chief Dr. Limb. Fran reported this information to Jennifer Newburger chief of quality management to address the patients complaint and request.

**Resolution**

**Clinical Appeal :**  **Comp:**

**ROC Issue Details:**

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
IF05	COS	ADMINISTRATION	
IF05	SWS-PRIMARY/SPECIALTY CARE	SOCIAL WORK	
IF05	Directors office	ADMINISTRATION	
IF05	Compliance Officer	ADMINISTRATION	

**Resolution Text:**

some information on the patient. Privacy Officer also aware.

Closing Date: 07/01/2013

**Notifications**

Informational: NONE

Action Request: NONE

ROC Number: 632.201300713

Date of Contact: 07/03/2013

Information Taken By: MARENGO, WILLIAM NONE

Contact Phone/Fax: NONE

Contacting Entities: Patient

Methods of Contact:

Congressional Contact: NONE

**Patient**

Patient: FASANO, JOSEPH ANTHONY

Treatment Status:

**Issue**

Issue Description: Patient called and complained of several staff going into his chart. 5-21-13-file clerk Ms. L Carter-3 times 5-24-13 Police Gino Marcella 6-11-13 Eleanor Hobbs NP Employee Health 6-12-13 Kathy Washburn Advocate for OIF/OEF He wanted to know why

**Resolution**

Clinical Appeal : NONE

Comp:

**ROC Issue Details:**

Issue Code	Location	Facility Service or Section	Employee Involved
IF05	Patient Adv/Rep Office	ADMINISTRATION	
RE01	Privacy Officer	ADMINISTRATION	

Resolution Text: I explained to the patient that I could not answer the reasons each staff member went into his chart but would notify the Privacy Officer. Patient also stated he had sent this to the VA as a written complaint. I instructed the patient that he would get a response from the VA once they had looked into his complaint. Notified the Privacy Officer and he was aware. He told me he was actively looking into the patients complaints.

Closing Date: 07/05/2013

Name	Title
<b>Patricia Helgesen</b>	<b>Compliance Officer</b>
William Marengo	RN Patient Advocate
Luesender Carter	File Clerk
Omaida Wilson	Lead Financial Accounts Tech
<b>Steven Wintch</b>	<b>Privacy Officer</b>
<b>April Miles</b>	<b>Medical Support Assistant</b>
<b>Staci Beauchamp</b>	<b>Medical Support Assistant</b>
<b>Devon Westerlind</b>	<b>Medical Support Assistant</b>
Fran Maida	Patient Advocate
Kristin Sievers	Supervisory Program Specialist
Mary Ellen Conroy	IT Specialist
Thomas Sledge	Medical Admin Specialist
<b>Linda McGinty</b>	<b>Information Security Officer</b>
Christine Daurizio	Release of Information Clerk
Maria George	Medical Reception Admin Specialist
Christopher Japour	MD Chief of Podiatry
Gino Nardelli	Police Officer
April Esposito	Supervisory Program Specialist
Marie Irwin	Supervisory Program Specialist
Daniel Carroll	Medical Support Assistant
Maribel Haddock	Medical Support Assistant
Nyny Romero	Medical Support Assistant
<b>Ruth Zingerman</b>	<b>Medical Record Technician</b>
<b>Lidia Desmond</b>	<b>Medical Admin Specialist</b>
<b>Marilyn Muller</b>	<b>Medical Support Assistant</b>
Kiyomi Hasegawa	File Clerk
Barbara Inskip	RN Utilization Management Nurse
Regina Divico	Health Technician
Angeles Gallimore	Registered Nurse
Eleanor Hobbs	Occupational Health Nurse Practitioner
Stacy Anne Harris	Licensed Practical Nurse
Kathy Washburn	Patient Representative
<b>Frank Mirabelli</b>	<b>Release of Information Clerk</b>
Florence Ford	Registered Nurse
Lauren Maguire	Medical Record Technician
Maureen Insignares	Medical Admin Specialist
Scott Diaz	Patient Relations Assistant
<b>Craig Pesko</b>	<b>Pharmacist</b>
Annette Cuti	Medical Support Assistant
Annamarie Hyne	Registered Nurse
Douglas Young	Accounts Receivable Technician
Adetutu Okeowo	Medical Support Assistant
<b>Harold Clough</b>	<b>Registered Nurse</b>
Jessica Amador	Medical Support Assistant
<b>Vladimyr Valcourt</b>	<b>Health Systems Specialist</b>
Angel Thomas	Program Support Assistant

Sharran Chambers-Murphy	Program Support Assistant
<b>Niharika Walia</b>	<b>Medical Record Technician</b>
Vanessa Brown	Registered Nurse OIF/OEF Program Mgr
<b>Catherine Fasano</b>	<b>Registered Nurse</b>
Chirag Shah	MD Pulmonary Fellow
Jason Buckery	Vendor Service Representative
Marcia Bowens	Clinical Program Manager
Janice Scott-Naylor	Legal Admin Specialist
Catherine Feuerstein	MD Podiatrist
Mathew Kalmar	MD Podiatrist
Joseph John Manlolo	MD Gastroenterology Fellow

Office/Dept	Location	Investigated by OMI
<b>Directors Office</b>	<b>Building 10</b>	<b>No</b>
Social Work Dept	Building 200	Yes
Business Office	Building 200	Yes
Business Office	Building 10	Yes
<b>Business Office</b>	<b>Building 10</b>	<b>No</b>
<b>Business Office</b>	<b>Building 200</b>	<b>No</b>
<b>Business Office</b>	<b>Building 10</b>	<b>No</b>
<b>Business Office</b>	<b>Building 10</b>	<b>No</b>
Social Work Dept	Building 200	Yes
Business Office	Building 200	Yes
OI & T Office	Building 12	Yes
Business Office	Building 200	Yes
<b>OI &amp; T Office</b>	<b>Building 12</b>	<b>No</b>
Business Office	Building 200	Yes
Business Office	Building 10	Yes
Orthopaedics Dept	Building 200	Yes
Police Service	Building 6	Yes
Business Office	Building 10	Yes
Business Office	Building 10	Yes
Social Work Dept	Building 11	Yes
Business Office	Building 200	Yes
Business Office	Building 200	Yes
<b>Business Office</b>	<b>Building 200</b>	<b>No</b>
<b>Business Office</b>	<b>Building 200</b>	<b>No</b>
<b>Nursing Service</b>	<b>Building 200</b>	<b>No</b>
Business Office	Building 200	Yes
Performance Improvement	Building 10	Yes
Business Office	Building 200	Yes
Nursing Service	Building 200	Yes
Chief of Staff Office	Building 200	Yes
Nursing Service	Building 200	Yes
Chief of Staff Office	Building 9	Yes
<b>Business Office</b>	<b>Building 200</b>	<b>No</b>
Nursing Service	Building 200	Yes
Business Office	Building 200	Yes
Business Office	Building 200	Yes
Community Relations	Building 200	Yes
<b>Pharmacy Service</b>	<b>Building 200</b>	<b>No</b>
Radiology Service	Building 200	Yes
Chief of Staff Office	Building 200	Yes
Business Office	Building 10	Yes
Nursing Service	Building 200	Yes
<b>Nursing Service</b>	<b>Building 200</b>	<b>No</b>
PM & R Service	Building 200	Yes
<b>Directors Office</b>	<b>Gainesville VA</b>	<b>No</b>
Social Work Dept	Building 6	Yes

Business Office	Building 10	Yes
<b>Business Office</b>	<b>Building 200</b>	<b>No</b>
Chief of Staff Office	Building 200	Yes
<b>Performance Improvement</b>	<b>Building 200</b>	<b>No</b>
Pulmonary		Yes
VBA		Yes
OMI	Washington DC	Yes
		Yes
	Building 200	Yes
	Building 200	Yes
	Building 200	Yes

A very disturbing event occurred at the Veterans Health Administration Medical Center in Northport New York on 8/29/2012 involving sexual harassment & discrimination on par with the infamous 1991 Navy Tail hook scandal. A scantily clad female stripper named Sasha Gaulin ([www.firegypsy.com](http://www.firegypsy.com)) was hired to perform an erotic & sexually provocative fire dance (which is listed on her website under the tab "Upcoming Shows" titled Northport VA Event Fire Performance). The idea & approval was initiated & endorsed by Mr. Phil Moschitta to host this demeaning provocative spectacle fueled not just by the incendiary fire dance but also by male chauvinistic testosterone. Despite the protests of employees & visitors to this humiliating debacle, Mr. Moschitta insisted that, "the show must go on." This nearly naked female erotic performer was paraded in a humiliating display of misogynistic & chauvinistic perverted bravado in front of the patients, employees & visitors as part of the Labor Day festivities on federal property utilizing tax payer dollars & federal resources to host this disgusting event.

Many are dismayed & disenfranchised that Mr. Moschitta still has not offered any public apology for this offense to those victimized by this egregiousness nor has he been formally disciplined for his lascivious behavior. Mr. Moschitta continues his reign of terror with impunity against any vulnerable groups including minorities, crippled veterans, under privileged females, etc. The broadcasted message only instigated senior management's zeal for their mean spirited behavior.

This burlesque show was witnessed by all in attendance with the photographs plastered as male domineering trophies on open media & internet sources including but not limited to the VA Northport computers, e-mail, website, etc. The director basically labeled it as "entertainment for the troops." There is a photograph of Mr. Moschitta forcibly posing the female stripper by bear hugging her with her breasts pressed into his man-boobs.

This was humiliating to any of the patients that had divergent views on appropriate forms of entertainment (especially the elderly female nursing home patients) based on gender, sexual orientation, religion & sexual dysfunction due to age, mental/health status, paralyzing war wounds, etc. No prior sensing sessions were conducted by the director to determine the negative impact on all. This was also a form of sexual harassment, gender discrimination & religious discrimination towards the females, veterans, patients, employees & visitors based on gender (female), sexual orientation (gay/lesbian), religion (Muslim) & disability (Post Traumatic Stress Disorder, Military Sexual Trauma, Erectile Dysfunction & Late Effects of Injuries Due to [Paralytic] War Wounds). The director was quoted as saying that, "you people are just over reacting", "this is who I am", "I like living on the edge", "I would do this all over again" & "I see nothing wrong with this...I thought it was great."

Furthermore, this was very traumatic to any of the veterans, patients, employees & guests that were victims of Military Sexual Trauma. They were repeatedly victimized by this high profile public authority figure & were forced to relive their past sexual traumas & rapes. The scale of the fallout is still unknown to Mr. Moschitta's victims when considering the impact upon those with PTSD related to the above.

This involved disturbing elements of child welfare endangerment since there were many children in the audience. There were no advance warnings or postings for the parents & grandparents to exercise parental discretion due to the sexually explicit, highly provocative & dangerous stunts involving fire with a pseudo sado-masochistic overtone to the erotica (do you really want this posted on the VA Kids website?). There is a child day care center located on the VA Northport property & child pornography was down loaded on a VA Northport computer within the same vicinity of this striptease act.

Mr. Moschitta approved & conceived the idea of this erotic event on federal property. Mr. Moschitta planned & coordinated this pyrotechnic erotica with his subordinate leadership staff including but not limited to the VA Fire Department & VA Police since it involved a dangerous flammable form of entertainment in a hospital setting with

volatile gasses such as oxygen. The insurance costs & liabilities were huge considering the potential safety disasters to the stripper, veterans on oxygen, employees, visitors, etc.

It is highly unlikely that an equivalent corporate level public or private sector official would commit such an outrageous act. No commanding officer or post commander in the military would ever even think to do this or condone this amongst his subordinate chain of command. No commanding officer of a police precinct or fire department would tolerate such vileness. No public school or university principal, superintendent or dean would engage in such behavior. No hospital CEO or Chief of Staff would alienate his staff given the fact that the overwhelming majority of health care workers are female.

During 2012, Mr. Moschitta yelled/cursed at, threatened & forcibly detained Ms. Rosie Chatham (Chief Nursing Service) against her will blocking her egress to safety, yet Mr. Moschitta was never disciplined, investigated, suspended &/or limited from accessing the agency facility.

Mr. Moschitta endorses, fosters & supports subordinate supervisors attacking women labeling it, "...within the purview of a supervisor..." with the Cheryl Hansen incident when she was attacked by Dr. Tank. Do you condone Mr. Moschitta's hostile leadership style towards women by allowing women to be attacked & stalked by subordinate supervisors?

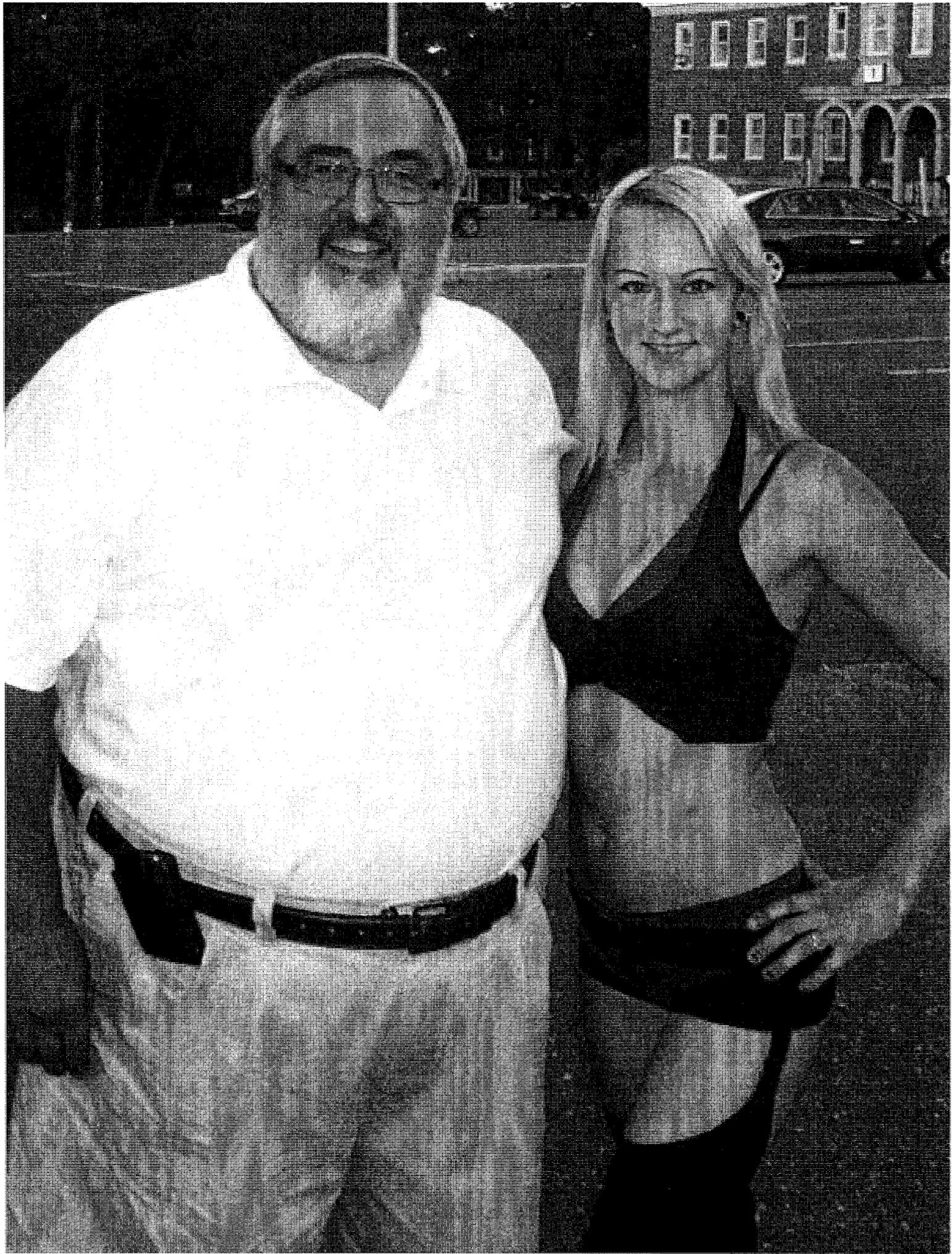
I demand that your office conduct a full investigation & independent Congressional probe into this disturbing incident as an overall systemic pattern of fraud, waste, abuse, mismanagement, intimidation & discrimination promulgated & fostered by Mr. Moschitta & Mr. Sabo in a very toxic & hostile work environment at the VA Northport despite a 2011 GAO report slamming the VAs negligence & failure to report sexual attacks at VA facilities. I demand that the VA be mandated to provide free counseling & compensation to anyone that was traumatized &/or victimized. I demand that the VA screen all veterans/patients that have exacerbated PTSD &/or MST due to this. I demand the immediate termination of Mr. Moschitta for committing such a heinous & insensitive act along with the immediate termination of Mr. Sabo since the VISN was contacted but failed to take proper corrective disciplinary action as he silently condoned this in cowardly acquiescence. It is obvious that Mr. Moschitta is attempting to define his VA legacy while transitioning into retirement in a lucrative consulting gig involving veterans; he must not be allowed in any capacity that involves vulnerable groups such as crippled veterans, females, minorities, the poor, etc. due to his parasitic, corrupt immoral behavior preying upon all resources. This fraternity stunt gone wild objectifies & humiliates women which is conduct unbecoming of a public official reflecting poorly upon the VA, the military, veterans, women, children & America by setting a very bad example for the children that were in attendance. This is anathema towards the VA I-CARE initiatives & contrary to the diversity that this country demands of the public sector. What's next - a Playboy bunny jumping out of a cake in the director's office? I sincerely hope that your office has the testicular fortitude & courage of conviction to do the right thing as requested.

**Mr. Moschitta violated the public's confidence in VA & the federal government anathema to the guiding principles of ethical culture. Accepting this gift in the form of a stripper is a violation of Ethics Rules & is codified in 5 CFR Section 2635.101 (b) (9) - employees shall protect & conserve federal property & shall not use it for other than authorized purposes. He clearly violated this rule since he authorized the stripper to perform on federal property. How does authorizing a stripper to perform a dangerous erotic pyrotechnic orgasmic incendiary spectacle protect & conserve federal property? This violates the standards of ethical conduct.**

**This is also a violation of VA Directive 6001 on the use of government resources states that you are permitted limited use of government supplies & office equipment (for personal needs) if: there is minimal or no cost to the VA & it doesn't violate the Standards of Conduct. VA Directive 6001 states that federal employees are prohibited from using government communication system for: pornography. This prohibition includes anything that reflects adversely on the department such as things that raise EEO concerns or anything that is religiously, racially or sexually offensive.**

In government contracting parlance, this is referred to as an "unauthorized commitment" & violation of "ratification procedures."

Moschitta violated this when he authorized the stripper to perform an erotic sex act on federal property at a VA hosted/sponsored event. This was an unauthorized commitment since it represented a commitment to procure services made by an individual lacking contracting authority to hire a stripper. Ultimately this violated the Antideficiency Act & subsequent ratification since it involved Moschitta's approval as a senior government official for an unauthorized commitment made by a government employee (to hire a stripper) who didn't have the authority to make that commitment (in hiring the stripper) & the subsequent contractual award (to the stripper) or authorization of that commitment (of hiring the stripper) by a contracting officer or other official with that level of authority. Policy & procedure states that contracts may be entered into & signed on behalf of the government only by contracting officers. Such actions include all types of commitments which obligates the VA to expend funds for supplies/services. The government vis a vis voting taxpayer isn't bound by unauthorized commitments (to hire strippers) made by government employees without the authority to pay for the services ordered (erotic fire dance) unless an authorized official ratifies the action or other official with appropriate authority sanctions that commitment (to hire a stripper). This variance resulted in both a delinquent obligation & an unauthorized commitment since Moschitta approved the ratification which is the process whereby designated officials convert & authorize a commitment to a legal contract (of hiring a stripper). The action must be a proper use of appropriated funds i.e. not a "personal use" expense for strippers, booze, food, blondes, etc. & must be for services which VA has authority to contract &/or to expend appropriated funds not in violation of public law i.e. for strippers, booze, food, blondes, etc. Moschitta as the Ratification Official was ultimately culpable & responsible. A report should've been sent to the VA Business Oversight Board at Central Office. Moschitta violated VISN 3 Network Policy #10N3-90-003, VHA Handbook 7401.7 & VA Directive 7401.7.



# DAILY NEWS

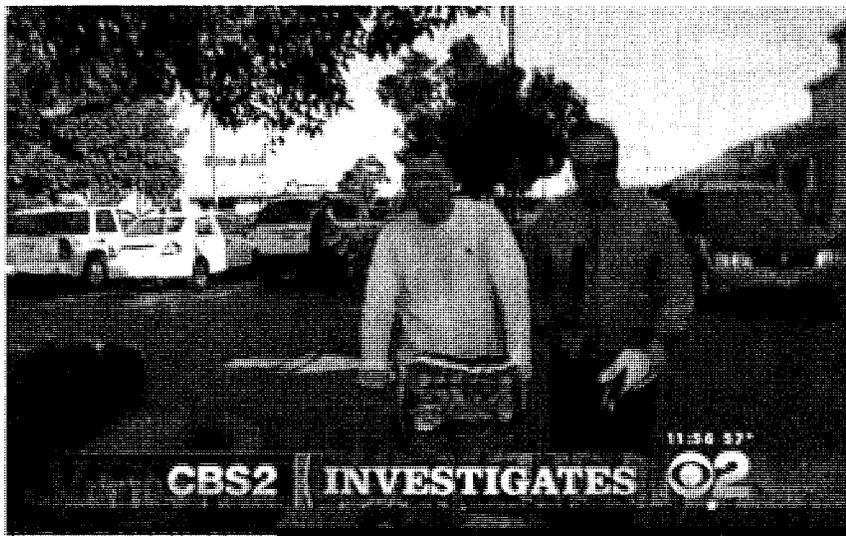
U.S

## Officer allegedly sends naked selfie to woman who asked for his help

Jason Fougere is under investigation after allegedly sexting a 31-year-old who sought help finding her missing uncle.

BY LEE MORAN / NEW YORK DAILY NEWS

THURSDAY, JANUARY 30, 2014, 9:44 AM

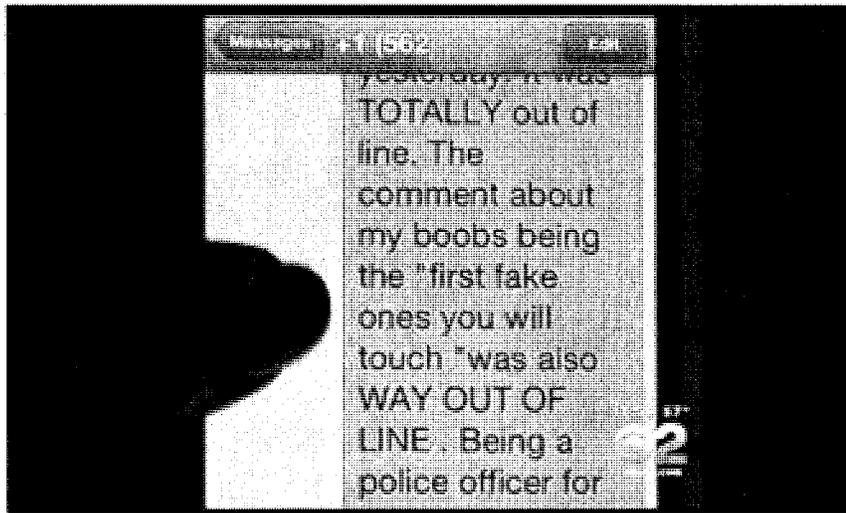


Officer Jason Fougere, left, has been reassigned as the V.A. investigates the claims.

A top cop allegedly responded to a desperate woman's appeal for help by sending her a naked selfie.

Federal Veterans Affairs Officer Jason Fougere allegedly texted the snap to the woman's cellphone after she contacted him in a bid to track down her uncle, an Army veteran.

Fougere is now under investigation after the 31-year-old, who has not been identified, came forward.



The woman says the police officer not only sent a nude pic --- he sent explicit text messages. Above, she tries to set him straight.

RELATED: PA. HIGH SCHOOL TEACHER ACCUSED OF HAVING SEX WITH STUDENT

She claims she first met with Fougere, to talk about her uncle's disappearance, in November.

A few days later, he allegedly sent her a text message asking her out for coffee.



Federal Veterans Affairs Officer Jason Fougere was working at the V.A. in Westwood, Calif., above, when the unidentified woman reportedly approached him for help.

He then got "more graphic and dirty" in his communications, she claims, saying he wrote: "Your boobs are humongous. They must be fake. Those will be the first fake t---s I touch."

RELATED: CANADIAN GIRL, 17, CONVICTED OF CHILD PORN FOR SENDING NUDE PICS OF BOYFRIEND'S EX

When she rejected his advances, she claims he sent her a naked selfie of himself holding a razor.

"It's shocking," the woman added to CBS Los Angeles, adding: "No one has ever sent me a nude selfie before. Let alone a police officer who I was going to him for help."

The Veterans Affairs Office said Fougere has been reassigned out of law enforcement, as an investigation into his conduct is carried out.

OTHERSTORIES





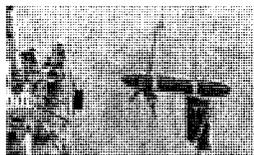
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Enclosed please find a series of VA regulations to cite as further violations of my privacy, Protected Health Information forming the basis for the agency's PPP's against me:

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 Helgensen 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 SHAARE - 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.

Forwarded e-mail correspondence between NFFE union and VISN 3/ VA Northport senior management.

From: [Richard.Thomesen@va.gov](mailto:Richard.Thomesen@va.gov)

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Date: Sat, 16 Nov 2013 13:02:58 -0500

Subject: FW: VA NORTHPORT ILLEGAL ACTIVITIES

NFFE views this action as hostile to a NFFE Member, In addition, disrespectful to Mr. Fasano as a Professional Nurse Practitioner and above all a Veteran who has served his Nation with distinction and Honor as an Officer, who was injured in the defense of our Nation and is a Disabled Veteran. NFFE would like a meeting with the Director of Northport and with the VISN Director to discuss this horrific situation. The action taken is unprecedented in my 27 years of service to at this Medical Center. NFFE demands to know what steps have been put into place so that this unprecedented breach of security of the Northport Electronic Medical Records System so it will not happen again? I will not be able to meet this week since I am to attend the National Partnership Counsel (NPC) meeting as the National Vice President of the NFFE VA Counsel where I will be sitting in for the President of the NFFE VA Counsel.

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

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 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. I will hopefully have a copy of that ROC later today. 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.

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 00 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.

Attached please find 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.

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 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 have an active EEO against) 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 VApp4). 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 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 affects 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 wellbeing 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.

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.

Hi Ms. Bradley I would like to add the enclosed unredacted agency "report" as part of my comments to OSC case # DI-13-3661. Upon further review it's very disturbing that the agency opts to continue their cover up and white wash without any trace of government transparency at a time when the privacy issues of Americans is such a sensitive topic in the wake of the NSA scandals. The agency chose to cowardly hide the massive privacy breaches instead of releasing the report as part of the public record, however, **I** choose to include this with my comments so that the American public and my fellow veteran brethren and their families remain informed on how their tax dollars are being wasted on VA corruption and criminal activity instead of being utilized for veterans as intended.

"Upon further review it's very disturbing that the agency opts to continue their cover up and white wash without any trace of government transparency at a time when the privacy issues of Americans is such a sensitive topic in the wake of the NSA scandals. The agency chose to cowardly hide the massive privacy breaches exploiting an ambiguity in the law instead of releasing the report as part of the public record which is irresponsible to the American tax paying public and my fellow veteran brethren and their families remain uninformed on how their tax dollars are being wasted on VA corruption and criminal activity instead of being utilized for veterans as intended."