U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

February 18, 2016

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-13-3661 and DI-14-0558

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Northport VA Medical Center (Northport VAMC), Northport, New York, made to the Office of Special Counsel (OSC). OSC has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

Joseph Fasano, a veteran and nurse practitioner at the Northport VAMC, who consented to the release of his name, disclosed that Northport VAMC employees improperly and repeatedly accessed his VA medical records. *See* OSC File No. DI-13-3661. Mr. Fasano subsequently disclosed that Northport VAMC employees engaged in a variety of other improper actions, including manipulation of scheduling data and improper use of budgeted funds. *See* OSC File No. DI-14-0558. Mr. Fasano also disclosed that he was improperly barred from the Northport VAMC campus.

Mr. Fasano's allegations were referred to then-Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki delegated responsibility to submit the agency's reports to then-Chief of Staff Jose D. Riojas, who submitted the agency's report in OSC File No. DI-13-3661 on December 3, 2013. Renee L. Szybala, acting assistant general counsel, submitted the VA's supplemental report on May 28, 2014. Mr. Riojas submitted the VA's report in OSC File No. DI-14-0558 on January 5, 2015.

The agency's investigation in OSC File No. DI-13-3661 determined that VA employees improperly accessed Mr. Fasano's VA medical records 28 times. In response, the VA Office of the Medical Inspector (OMI), which conducted the investigation, recommended that the Northport VAMC take disciplinary and corrective actions, including employee training and an assessment of the breaches of access for violations of the Health Insurance Portability and Accountability Act. In its supplemental report, the agency confirmed that all corrective actions were completed and appropriate disciplinary

actions were taken. Specifically, letters of reprimand were issued to Thomas Sledge, medical administration specialist; and Barbara Inskip, nurse/quality management coordinator. Letters of counseling were issued to Eleanor Hobbs, nurse practitioner; AnnMarie Hyne, nurse; Sharon Chambers Murphy, program support assistant; Luesender Carter, file clerk; Florence Ford, nurse; Lauren Maguire, medical records technician; Lidia Desmond, medical administration specialist; Adetutu Okeowo, medical support assistant; and Marilyn Muller, program assistant for nursing service.

In its investigation in OSC File No. DI-14-0558, the agency did not substantiate Mr. Fasano's allegation that staff in the Primary Care, Agent Orange, and Rural Health Clinics at the Northport VAMC engaged in patient wait time data manipulation. However, the agency did find that six patients who were referred to Primary Care were never contacted to make an appointment. The agency's report states that the facility attempted to contact all six patients, none of whom reported any negative medical outcomes. The VA Office of Accountability Review (OAR), which conducted the investigation, recommended that the Northport VAMC comply with Government Accountability Office and VA Office of the Inspector General recommendations regarding scheduling practices, which are part of the agency's ongoing national efforts to standardize patient scheduling.

The investigation further determined that the Rural Health Clinic is not being used as a pretextual funding mechanism and that patients are being seen appropriately in the Rural Health Clinic. With regard to Mr. Fasano's access to the Northport VAMC campus, the investigation found that Mr. Fasano was properly barred as an employee for the duration of an Administrative Investigation Board (AIB). Mr. Fasano's access was reinstated following the conclusion of the AIB. I have determined that the agency reports in both cases contain all of the information required by statute, and that the VA's findings appear reasonable.

In Mr. Fasano's comments on the VA's reports in OSC File No. DI-13-3661, he questioned the validity of the agency's investigation and asserted that Northport VAMC staff use access to employees' personal health records as a way to engage in retaliation. Mr. Fasano questioned the agency's determination that a number of the improper breaches of his health record were attributable to mistake, and challenged the investigation's failure to provide detailed explanations for each breach deemed to be for the purposes of healthcare operations.

Mr. Fasano's comments in OSC File No. DI-14-0558 similarly questioned the separation of his roles as a patient and employee with regard to the bar placed on his access to the Northport VAMC campus. Mr. Fasano reiterated that the facility's bar on him as an employee inhibited his ability receive care as a patient at the Northport VAMC. Mr. Fasano also reported concerns with the manner in which his interviews were conducted.

I have reviewed the original disclosures, the agency reports, and the whistleblower's comments. Based upon my review, I have determined that the VA's reports contain all of the information required by statute and the findings appear reasonable. I thank Mr. Fasano for bringing these concerns to my attention. I note that he raised several important issues in his comments, including the pervasive problem of improper access to employee medical records. In this instance, however, it appears that the VA took appropriate corrective and disciplinary actions in response to those allegations that were substantiated.

As required by 5 U.S.C. §1213(e)(3), I am now transmitting the unredacted agency reports and whistleblower's comments to you and to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs.[1] I have also filed copies of the redacted agency reports and the whistleblower's comments in OSC's public file, which is available online at www.osc.gov.[2] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

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[1] The Office of Special Counsel (OSC) is authorized by law to determine whether a disclosure should be referred to the involved agency for investigation or review, and a report. OSC may refer allegations of violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety. 5 U.S.C. § 1213(a) and (b). Disclosures must include information that aids OSC in making its determination. Disclosures must include information sufficient for OSC to determine whether referral is warranted. OSC does not have the authority to investigate disclosures and therefore, does not conduct its own investigations. Rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

[2] The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version as an accommodation.