

RESPONSE TO AGENCY'S REPORT OSC CASE # 14-0558

The agency was granted a liberal amount of time to generate this "report." I am extremely upset and find the agency report highly disturbing. It's just another form of de facto whistle blower harassment, bullying and intimidation riddled with lies to discredit me tantamount to liable, slander and character defamation with the explicit intent to have a chilling effect on me as the whistle blower and any other potential whistle blowers lest their careers be destroyed like mine was. Their wildly inaccurate account of the AIB and subsequent illegal actions to restrict and deny my legal access to care as a 100% disabled veteran are way beyond a mere materiel misrepresentation of facts being just another extension of badgering me as the witness that your office is fully aware of since I'd raised my protests regarding the agency's handling of this investigation from the onset. Furthermore the AIB "timeline" that they've included in their shoddy "investigation" is a badly and highly edited version and distortion of events deviating from the truth to justify their heinous and highly illegal actions against me as an employee, a disabled veteran, a patient and a human being. They've conveniently plucked out of context only the most damaging of inflammatory derogatory comments that are not founded in truth. The agency may have also committed a breach of settlement agreement to this extent since the AIB was explicitly NOT supposed to serve as any sort of agency precedent against me nor were they supposed to reference it in a document that will be made part of the public record. The settlement agreement also explicitly states that any issues that cannot be resolved in the EEO settlement agreement must be handled in an appropriate venue i.e. the violation of 38 CFR 17.107 contained within this OSC accepted investigation. Alas it's the proverbial fox guarding the henhouse of an agency infamous for whitewashing all reports as widely reported in media outlets. The report hardly addresses any issues in the draft facts of this case set forth by the OSC; rather the agency ignores the very essence, letter and spirit of the draft facts and defines it to whitewash yet another report. The settlement agreement does NOT waive my right as a veteran to pursue violations of law, rule and regulation against the agency via the OSC. I am hopeful that the OSC will grant this rejection request so that I may categorically and materially refute the agency's lies compelling a more thorough and accurate supplemental investigation. This is the same agency that cannot be trusted to conduct its own investigations. The same sad cast of corrupt characters from the disgraced Office of the Medical Inspector (OMI) just got recycled and rebranded the Interdisciplinary Crisis Response Team (ICRT) with the final moniker OAR.

My concern as I've stated in correspondence to the OSC is that the agency is lying about the facts surrounding the AIB to discredit me and tarnish my reputation. I obtained documents under FOIA that the 3 complaint letters that were referenced in their AIB timeline were determined to be unfounded at those respective times yet the agency includes them as some sort of attempt to sully me. Those issues were never part of the AIB. This complaint was and has been accepted by the OSC for investigation. Alas the OSC Disclosure Unit however doesn't actually conduct the investigation it's deferred to the respective agency creating a conflict of interest with the proverbial fox guarding the hen house. The issue with the illegal restrictions of access to

Rheumatology clinics despite the OSC draft facts. The ICRT didn't at all care about the shredding of the documents and when challenged with the e-mails they just dismissed it as "routine" - yeah maybe that's because that's what the VA does is destroy evidence. The ICRT seemed to agree with and side with management to justify their illegal police escort restrictions and illegal fee basis denials of care requests. The ICRT refused to acknowledge it as a restriction despite the fact that the language in the letters that I received clearly states the restrictions and it's in the OSC draft facts. Essentially they state that this portion of the case is not relevant since OSC doesn't have any jurisdiction. These comments were made off the record however I was accompanied by Dr. Lois Saltzman JD Esq who shares my misgivings, concerns and feelings regarding this farce.

I was treated as a hostile witness and don't feel good about this investigation and the typical agency white washing. It doesn't matter what the VA calls this group (OMI or ICRT) it's the same old fox guarding the hen house. Very discouraging and extremely demoralizing.

Now that I've had all day and night to think and reflect upon these interviews (interrogations), I'm very upset and angry with the conduct of Ms. Hill (ICRT chair). She no doubt engaged in badgering me as the whistleblower tantamount to witness badgering and intimidation. She was very aggressive with her line of questioning, tone and demeanor. She is a bully. She cared more about my prior EEO complaints v. the illegal restrictions to health care and illegal fee basis denials. When things weren't going her way during the line of questioning she pulls out this document in a condescending and intimidating way waving it in a taunting and humiliating and degrading manner. My colleague who accompanied me is a physician and an attorney and she shared similar observations and was not at all thrilled with the conduct of this ICRT. I want to lodge a formal complaint against Ms. Hill and I need to emphasize how angry and upset I am with her unprofessional conduct, behavior and demeanor. I also was NOT given enough time to fully explain the events of the illegal police escort restrictions. Ms. Hill pounced upon me and was enraged that I mentioned that Mr. Phil Moschitta (VA Northport NY director) perjured himself during sworn EEO testimony regarding the illegal restrictions to care and illegal police escort restrictions and illegal fee basis denials despite the fact that it was part of the OSC draft facts. Simply put this is not good, not pretty and REALLY REALLY REALLY BAD!!!

I do have some concerns however with the interviews:

*they never mentioned the issue with the shredding of the documents and destruction of evidence as per the e-mails provided by Dr. Mack as it pertains to this complaint so I didn't mention it since I don't know what I should reveal at this time or how close to the vest I should play my cards

*I felt that they were asking inappropriate questions regarding my Protected Health Information which was NOT germane to the complaint of the illegal restrictions to care

*they wanted to know if the OSC is concerned about the illegal restrictions of me as an employee or as a private citizen/ veteran

care, fee basis care and benefits. The intimidation is taking place in the form of overt coercion such as yelling, screaming and taunting and outright demanding to know the details of their respective interviews despite the fact that they've been ordered under oath to NOT discuss details with anyone. Dr. Mack stated that this happened to Dr. Mandar Tank (service chief primary care) on Friday 7/25/14 shortly after his telephone interview with the agency's ICRT. Dr. Tank felt compelled to spill the beans to Mr. Moschitta out of fear of implied retaliation. This wanton abuse of authority and projected overt and implied threats of retaliation does not bode well for a fair, honest, credible and transparent investigation since Mr. Moschitta is negatively influencing the testimonies via the bully pulpit.

The ICRT constantly deviated from the OSC draft facts. They dwelled too much on my veteran and patient status prior to the illegal restrictions. The facts are that as a 100% permanent and total service connected disabled veteran it is at MY discretion NOT the VA's when and where I decide to receive services. This is about ME the veteran victimized by Mr. Phil Moschitta (VA Northport NY director) and his henchmen breaking the law. For Ms. Hill to make inflammatory and provocative remarks about the OSC's "jurisdiction" and "purview" regarding patient/ veteran issues v. employment issues is irrelevant – the OSC investigates violations of law, rule and regulation. The VA is supposed to be about veterans and the OSC has publicly now taken on that role to ensure that veterans are receiving the benefits and quality services that they are entitled to by law. This is NOT about Ms. Hill with her intimidation, power suit and caked on makeup. I get it this works for the VA – that's what they do. I showed Ms. Hill that I also have a plethora of documents that I could easily wave in front of her face the same way that she threatened, taunted, badgered and harassed me treating me as a hostile witness yet Ms. Hill was NOT interested in crucial evidence that I have. In his zealous quest to break the law Mr. Moschitta violated my rights jeopardizing my life, safety and well-being. Mr. Moschitta (director), Dr. Marino (Disturbed Behavior Committee chair), Dr. Limb (Long Term Care service chief), Mr. Squicciarini (chief of police), Ms. Cheryl Carrington (HR specialist), Mr. Joseph Sledge (Public Affairs officer), etc. do NOT have the legal and clinical authority to restrict me as a 100% permanent and total service connected disabled veteran. Also, they broke the law in a criminally disparate and depraved selective manner against me despite no wrong doing on my behalf. The agency continues to further victimize me by illegally prying into my Protected Health Information. The agency's henchmen tasked with conducting this investigation had the local privacy officer Ms. Nicole Mattila determine if I'd received healthcare from any VA facility as a pretext to discredit me and to dismiss my legal right to healthcare when and where of my choosing based on my disability rating and status. The agency is cleverly trying to conceal and distort the facts that they denied my access to timely healthcare which jeopardized my safety, well-being and my life. The fact remains that they continued to deny my desperate pleas for healthcare.

run rough shod over whistle blowers in this nefarious method providing the VA yet another convenient loop hole to harass and intimidate potential whistle blowers having a chilling effect to force a submissive capitulation of silence lest employees fear this ingrained culture that is impossible to change despite Secretary McDonald's empty public pledges of reform with his own questionable integrity having lied about his own military record that was widely covered in media outlets.

In their fiendish attempts to falsely impugn me and maliciously malign me the agency included events in their flawed AIB timeline that were NEVER part of the AIB. In fact I have incontrovertible evidence to the contrary refuting their lies. Since this will be part of the public record I'm now forced to prove my innocence yet again because the agency hijacked this "investigation" in their mean spirited zealous smear campaign to ruin my reputation. This is nothing more than whistle blower harassment and intimidation designed to have a chilling effect. This charade clearly demonstrates an agency in total chaos NOT committed to any reforms. As the self-proclaimed lead agency to enforce these reforms in light of the massive ongoing daily reported ongoing scandals I hope the OSC and Ms. Lerner (OSC chief counsel) are committed to their open letter to President Obama that the VA CANNOT be trusted to police itself or honestly investigate itself. To quote Rep Coffman of the VA Oversight Committee you are "...relying on the same people that drove the VA into the ditch...to drive it out of the ditch..." Accepting this sham report will only embolden a corrupt evil entity to continue with impunity. You are very aware of the very gross nature regarding the misconduct of this sham investigation including but not limited to a Q and A session inappropriately prying into my Protected Health Information that I was repeatedly hounded despite my protests to the agency's henchmen Ms. Elizabeth Hill Esq. and Mr. Scott Foster Esq. Is this how the OSC expects and tolerates a whistle blower to be harassed and treated? My colleague Dr. Lois Saltzman MD JD who accompanied me was equally shocked and repulsed stating that their behavior and misconduct during this investigation shocks the conscious.

The enclosed OPPE/FPPE documents prove that the agency is lying regarding their warped "AIB timeline." The so called "complaints" against me were UNSUBSTANTIATED as is clearly visible in the appraisal of my performance.



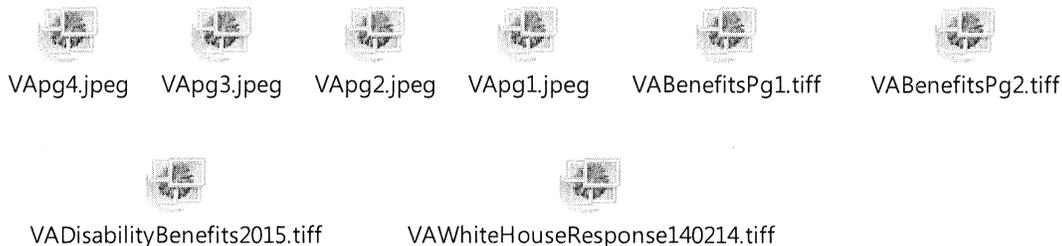
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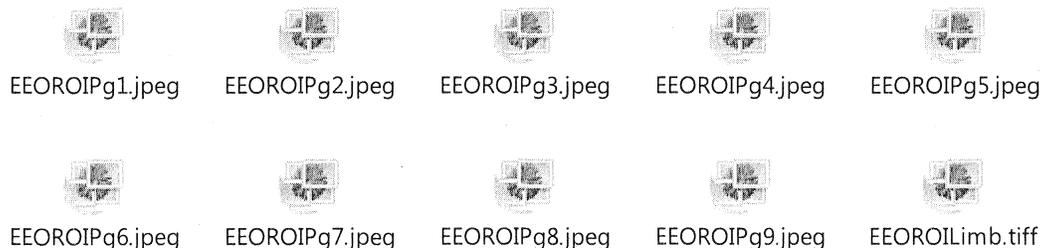
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The honeymoon period is over for the new Secretary. Since taking office he has accomplished nothing beyond mere insincere disingenuous misleading feel good optimism to Congress, veterans & the American public with all of his phony empty rhetoric. His stupid comments published in Op-Ed pieces and an Oscar worthy performance on 60 Minutes fail to address the dire circumstances veterans face because of this Born on the Fourth of July VA failures only mentioning remotely past accomplishments. How do you expect to change the VA when you're

the Northport VAMC grounds and placed on administrative leave pending the outcome of an Administrative Investigation Board (AIB), which was convened to look into the allegations against him. On the same day, Mr. Fasano was instructed in a letter from Dr. Younghee Limb, associate chief of staff for extended care, that he could not enter the Northport VAMC campus without 24-hour notice to the VA Police Department to arrange a police escort. The letter provides no information on how to appeal the restriction, and does not explain why the restriction was necessary during the period of the AIB's investigation.



In testimony dated July 25, 2013, from an Equal Employment Opportunity (EEO) complaint that was filed by Mr. Fasano, Phil Moschitta, facility director, stated that the decision to restrict Mr. Fasano's access was his alone, and that Dr. Limb was "merely the messenger" of the information. Mr. Moschitta further explained that workplace violence complaints are forwarded to the facility's Workplace Violence Committee. He stated that the Committee recommended to him that he place the police escort restriction on Mr. Fasano, and noted that the Committee is chaired by a clinician.



Mr. Fasano's PTSD would be severely exacerbated by the requirement of a police escort. Mr. Fasano made management aware of this, and it was recorded in the Patient Advocate Tracking System. However, no concessions were made to accommodate his disability. Thus, in order to receive care through the VA while under the restriction, Mr. Fasano made several requests for fee basis care, all of which Mr. Moschitta denied. The patient advocate, who facilitated the fee basis requests, told Mr. Fasano that Mr. Moschitta's response to the requests was "tough shit" and that Mr. Fasano should either "man up and come to Northport with a police escort or go to the other VISN hospitals." Mr. Fasano explained that Mr. Moschitta was aware that traveling to other hospitals in the VISN further exacerbated his PTSD and that this was not a viable option for him.

Mr. Fasano served as a nurse practitioner in the Northport VAMC Health Screening Clinic from May 20, 2010, until August 25, 2012. The Health Screening Clinic is the “first stop” for veterans who want to access Veterans Health Administration (VHA)-provided health care. Veterans who visit the Health Screening Clinic are examined, and if found qualified, are vested into the VHA system. Mr. Fasano explained that while he was assigned to the Health Screening Clinic, he made sure to note each patient’s military branch, era of service, and overall health, in order to provide them with appropriate information depending on the type of care they might require. For example, many veterans who served during the Vietnam War-era show signs of certain illnesses considered to be “presumptively” caused by exposure to Agent Orange. These veterans could receive a disability rating and be referred to the Agent Orange Clinic. Similarly, patients who needed additional care might be referred to the Primary Care Clinic for a more thorough examination, and patients who lived in a designated rural area might be referred to the Rural Health Clinic, which is discussed in more detail below. Mr. Fasano reported that he regularly referred patients who required additional care to all three of these Clinics.

After his assignment to the Health Screening Clinic, Mr. Fasano became aware that there was no way to electronically order a referral or consult from the Health Screening Clinic to the Primary Care, Agent Orange, or Rural Health Clinics. Standard practice requires that consults or referrals are ordered electronically via the Computerized Patient Record System (CPRS), which is the agency’s electronic health records system. Recording consults and referrals electronically in CPRS allows the system to show a variety of data about delivery of care, including how long a patient waits to be seen by a provider in another clinic. However, Mr. Fasano alleges that in the Health Screening Clinic, consults and referrals were achieved by using unapproved scheduling methods. For referrals to the Primary Care Clinic, an electronic note template requesting a consult or referral would be completed by the provider in the Progress Notes section of the patient’s record and then forwarded to Wendy Beiner, the clinic scheduling manager. Ms. Beiner would then handle the scheduling of the referral or consult appointment, which according to Mr. Fasano, could take months to achieve. Mr. Fasano stated that in some cases patients were never called for an appointment or were contacted long after the consult or referral was requested. However, because the consult or referral request was not correctly recorded in CPRS, there appeared to be no delay in the scheduling of the patient’s appointments and thus, the delivery of care.

Further, Mr. Fasano alleges that steps were taken to reduce the number of patients he referred to the Primary Care Clinic. For example, Dr. Mandar Tank and Dr. Sterling Alexander, Primary Care Clinic service chiefs, directed Ms. Beiner to include Mr. Fasano as a co-signer on clerical entries in the patient’s records. This would generate a notice to Mr. Fasano that he would have to resolve for each patient. Mr. Fasano alleges that Progress Notes are not an appropriate place to record clerical entries, and that the constant barrage of co-signer requests he received were an attempt to discourage him from continuing to refer patients to the Primary Care

from the Health Screening Clinic, are failing to use the CPRS consult functionality as required by the Directive. As a result, there also appears to be no method for tracking delayed consult responses after seven days, as required by the Directive.

It is notable that on June 27, 2011, a memorandum from William Schoenhard, Deputy Under Secretary for Health for Operations and Management, was distributed to VHA network directors, reminding them that all consults must be completed in compliance with Directive 2008-056, and that facilities need to be “attentive to any unresolved consult requests.” Further, the memorandum stated the importance of each facility having a robust process in place to review and address recent and long-standing unresolved consults, and provides contact information for facilities needing assistance in carrying out these processes. When Mr. Fasano received the memorandum, he immediately addressed his related concerns about consult scheduling to union president Richard Thomesen, but no action was taken on the part of management to address them.



MargeEEOROI.tiff

III. Rural Health Clinic is Not Properly Employed for Patient Care Purposes

Mr. Fasano explained that in 2010, the Northport VAMC received a \$4.5 million grant from the VA Central Office to start a rural health program. According to Mr. Fasano, in order to qualify for the grant, Northport VAMC officials used an outdated zip code designation for rural areas, which consisted of a number of towns on the eastern end of Long Island, New York. Patients living in these zip codes were then screened and used to justify receipt of the grant. Mr. Fasano contends that, although the zip codes are designate as rural, the towns they serve are not located in rural areas. The Rural Health Clinic, created with the grant funds, was placed under the supervision of JoAnne Anderson, who was later also placed in charge of the Health Screening Clinic and the Community Relations Office.

According to Mr. Fasano, the grant funds were used to purchase a new mobile clinic and to pay salaries for several new staff members. The mobile clinic is housed in a converted RV camper that Mr. Fasano contends cost approximately \$350,000. He alleges that although the mobile clinic was ostensibly purchased to provide portable clinic services to patients in the Rural Health Clinic, it is instead used on a limited basis in non-rural areas to conduct vesting exams or limited podiatry services. Similarly, grant funds were used to pay the salary of a dedicated Rural Health nurse practitioner, Linda Tripoli. However, Mr. Fasano alleges that Ms. Tripoli has never treated a single veteran through the Rural Health Clinic, and maintains no clinic panel, unlike all other providers in the facility, who have designated patient panels, profiles, and panel sizes. Ms.



Image (37).jpg



Image (38).jpg



Image (39).jpg



Image (40).jpg



Image (41).jpg

The AIB report that the agency referenced to justify their illegal actions against me including but not limited to violations of 38 CFR 17.107 also included the destruction of evidence as the Human Resources official ordered Dr. Mack to do in the above email strings. The HR Ms. Cheryl Carrington clearly states in bold faced capitalized fonts for Dr. Mack to destroy evidence since the AIB was wrought with lies, inconsistencies, contradictions, discrepancies, etc. So the same agency that orders the destruction of evidence in order to falsely impugn me is the same agency that conducted this bogus OSC directed investigation with which the agency labeled as unfounded which is beyond a mere coincidence. What else was destroyed in their destructive path of wanton corruption?

From: ssmith@osc.gov
To: joesepe@msn.com
Subject: RE: DI 14-0558
Date: Thu, 17 Jul 2014 15:12:06 +0000

Mr. Fasano,

Thanks for forwarding this information. We previously requested that the agency include these allegations in its investigation, thus, I do not think a new disclosure is warranted at this juncture. I received the attachments, but do not see in the attachments the order to destroy documents. Can you please resend the attachment that directs Dr. Mack to do so?

Thanks in advance,

Siobhan

From: Joseph Fasano [mailto:joesepe@msn.com]
Sent: Wednesday, July 16, 2014 7:26 PM
Subject: DI 14-0558
Importance: High

Hi Ms. Bradley as per my voice mail message I have disturbing new revelations. Dr. Ed Mack Chief of Staff (COS) provided me copies of e-mail correspondence he received ordering him to destroy and shred documents/ evidence pertaining to the retaliatory AIB against me which

were involved in a conspired effort to fabricate charges against me based on lies and evidence/witness tampering to the extent that Dr. Mack had the courage of conviction to risk it all by exposing and clarifying his serious misgivings as the proposing official to Mr. Michael Sabo (VISN 3 director) that there wasn't anything to substantiate any sort of adverse action(s) against me. Mr. Sabo essentially issued a cease and desist order upon reading Dr. Mack's expressed concerns. What's even more frightening is what other evidence was tampered, shredded, destroyed, altered, withheld and/ or changed in violation of law, rule and regulation? I was denied due process as an employee and as a 100% permanent and total disabled veteran and as a private citizen since these actions could negatively harm my licensure as a Nurse Practitioner and Registered Nurse in the state of New York since I'm licensed and board certified privately (not through the VA). This constitutes a violation of Veterans Health Administration (VHA) Handbooks 0700 regarding Administrative Investigations and VHA 5021 regarding Adverse Actions.

Lying is a violation of 38 CFR 0.735-12(b).

Fraud 18 USC 1001 and 1018

Destruction of documents, falsification of and tampering with evidence and witnesses 18 USC 2017 and 285.

Perjury 18 USC 1621

Conspiracy to conceal facts 18 USC 1001, 1003 and 241.

Violation of 4th Amendment - right to protection from unreasonable search and seizure and evidence gathering and collection.

Violation of 5th Amendment - right to due process.

Violation of 6th Amendment - right to confrontation clause since I was ordered to not have any contact or communication with any VA employee.

Violation of 14th Amendment - right to due process clause. Rights and freedoms not specifically mentioned in the Constitution but extend or derive from existing rights i.e. workplace/ employee rights. The Court has significantly expanded the reach of procedural due process requiring some sort of hearing before the government may terminate civil service employees. Part of due process is the preservation of evidence.

Joe

631-384-2769



LimbAIBEmails.jpeg



Image (50).jpg



Image (51).jpg



Image (52).jpg



Image (53).jpg



Image (54).jpg



Image (55).jpg



Image (56).jpg



Image (57).jpg



Image (58).jpg



Image (59).jpg

From: ssmith@osc.gov

To: joesepe@msn.com

Subject: RE: DI 14-0558

Date: Mon, 21 Jul 2014 15:48:26 +0000

Mr. Fasano,

Why don't you forward a representative sample of the emails, and I will review and see if we need to follow up with the agency.

Thanks!

Siobhan

From: Joseph Fasano [mailto:joesepe@msn.com]

Sent: Monday, July 21, 2014 11:46 AM

To: Bradley, Siobhan Smith

Subject: RE: DI 14-0558

Importance: High

Hi Ms. Bradley thank you so much for the prompt review and reply. I have some additional e-mails from my former supervisor Dr. Younghee Limb (whose name is signed on the restriction to care letter dated 5/28/13) that Dr. Mack provided for me over the weekend. This string of e-mails implicates a whole lot of folks going all the way to the Secretary's office involved in the decision to illegally restrict my access to care including but not limited to Mr. Joseph Sledge (Public Affairs Officer) who crafted the letters that I received restricting my access to care. Mr. Sledge is also Mr. Thomas Sledge's brother who illegally accessed my medical records on 8/6/13 when he was ordered to disenroll me. It's very disturbing and chilling that so many senior admin officials

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Violation of 14th Amendment - right to due process clause. Rights and freedoms not specifically mentioned in the Constitution but extend or derive from existing rights i.e. workplace/ employee rights. The Court has significantly expanded the reach of procedural due process requiring some sort of hearing before the government may terminate civil service employees. Part of due process is the preservation of evidence.

The Nuremberg Tribunal taught us that "crimes...are committed by men, not by abstract entities (VA)." Refusing to out these supervisory criminals in the VA abstract entity responsible for these crimes is a hell of an incentive to keep going. While Mr. Moschitta and Mr. Sabo continue their harmful retaliatory anti disabled veteran agenda, the VA and the agency's Office of the Medical Inspector (OMI) continue to deny the existence of a phantasmagorical technocratic criminal who abuses crippled veterans. Having done everything within his power to save Mr. Moschitta, Mr. Sabo is now trying to save him materially enabling Mr. Moschitta's destructive actions against disabled veterans. What remains to be seen is whether the Acting VA Secretary Mr. Sloan Gibson is either a creature of artifice or an actor of truth with his open pledge to reform the agency's OMI and IG in response to a scathing letter that Ms. Lerner OSC Chief sent to Mr. Obama.

Joe

Did you receive emergency services, other than at a VA facility, during the relevant time period? Yes I saw my Neurologist on an emergency basis due to exacerbations of migraine headaches for which I am service connected for as part of my overall disabilities exacerbating my Post Traumatic Stress Disorder (PTSD) due to the agency's unlawful actions against me. My disenrollment negatively effected me since was denied emergency care by design of the director's restrictions at his direction. 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.

If so, did you submit the charges for these services to the VA for reimbursement? No I was told by the William Marengo RN Patient Advocate that Phil Moschitta's (director) response to all Fee Basis requests was an emphatic "tough shit!" I've provided copies of Mr. Marengo's documentation in the Patient Advocate Tracking System (PATs) as part of evidentiary proof in this complaint.

Was this request for reimbursement denied? *Vide supra*. 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) which were provided to OSC as part of this complaint. 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.

You alleged a violation of 38 U.S.C. 1703. This relates to agency-contracted services for VA patients where the VA cannot economically provide the necessary care to the veteran because of geographic inaccessibility or inability to furnish the care required. Note that the possibility of contracted services is not required, but may be undertaken by the Secretary. Is the Northport VAMC geographically inaccessible to you, or incapable of providing you care? (Please note that this does not include restrictions placed on you by management requiring a police escort.) The VA Northport was incapable of providing me care due to the unprecedented and illegal restrictions interfering with my ability to access my benefits and entitlements by law as a 100% Permanent and Total Disabled Veteran including but not limited to health care. The agency was fully aware that the severity of the restrictions made it impossible to provide this care to me.

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

II. Was procedure specified?

Goal: 100% yes for compliance

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

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

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

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

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

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

Goal: 100% Yes for compliance

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

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

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

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

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

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

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

While you were restricted from accessing services at the Northport VA, were such services unavailable at other VA facilities? I do not know. (Please note that this does not include restrictions placed on you by the relative distance from your home to other VA facilities. This relates only to the availability of services at other VA facilities or through existing VA contracts or agreements.)

You alleged a violation of 38 CFR 1736(5). This is an allegation that you were completely removed as an enrollee from the VA Healthcare System, nationwide. Please provide supporting documentation or information for this allegation. We understand you are alleging that Mr. Moschitta directed your disenrollment. We are now asking for additional proof of disenrollment. For example, have you received a letter or other correspondence communicating your disenrollment? If so, please provide copies of these documents. Have you been denied services specifically on the basis that you are no longer enrolled in the VA Healthcare System? If so, please provide dates and locations of the denials of service. This information was provided by a high ranking confidential official (who is willing to speak with OSC should this complaint be investigated) in a conversation with Thomas Sledge who illegally entered my VA medical record on 8/6/13. He testified to the agency's OMI team investigating the privacy breaches to this extent as well. Mr. Sledge's and Ms. Kristen Siever's (his boss) entries into my medical record were deemed "malicious" by the agency's OMI team. 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).

You alleged a violation of 38 CFR 1737. This regulation relates to provision of services to veterans not enrolled in the VA Healthcare System. This provision applies only if you have been officially disenrolled from the VA Healthcare System as described above. Please provide documentation of disenrollment as described in Item 4 above. Vide supra. 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

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% permanent and total disabled Joseph Anthony Fasano veteran employee.

You alleged a violation of VHA Handbook 1601A.04. This is a VHA Handbook describing the basic components of the Benefits Package provided by the VA Healthcare System and the steps that should be taken to request reconsideration of benefits determinations, including reimbursement for unauthorized non-VA services. Please briefly explain how this specific Handbook was violated in this matter. 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.

You alleged that your files on the following VA-maintained databases were improperly accessed: VIS (VBA, SHAARE), HINQ, C-FILE, VISTA, and VA7710Q. Please provide a brief summary of the information maintained by each database, the normal uses for each database, and the categories of employees who would access each database regularly. 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

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). So at my access level precious little documentation can be obtained without an OSC directed investigation. 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 which is now considered total and permanent by the Veterans Benefits Affairs, 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.

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. 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. 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

Veterans Integrated System Network (VISN) Administrator	All menus	Access to all menus for VISN facilities and some VISN to VISN access
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Separation of Duties (SOD)/ Continuous Readiness Information Security Program (CRISP) training is part of the Chief Business Office (CBO) training module: **SOD**: the assigning to different individuals the responsibilities of authorizing transactions, recording transactions and maintaining custody of assets. Designed to decrease opportunities for one person to perpetrate and conceal errors of fraud, waste and abuse (FWA) and decrease the risk of errors. This process further proves the CBO's involvement in the illegal privacy breaches (of various platforms) in connection with the illegal disenrollment and illegal fee basis denials.

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

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

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

Deputy CBO memorandum – VistA Security Controls – SOD, CBO Fact Sheet – VistA Fee – IFCAP SOD

Manual M-1 Operations Part I Medical Administration Activities, 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.

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

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

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

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

You alleged that your former Service Chief violated the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when he asked for a letter from your wife's provider explaining the nature of her childbirth in order to justify your requested paternity leave. Generally, the HIPAA Privacy Rule applies only to disclosures made by a healthcare provider, not to questions from an employer. For additional information on this issue, please visit <http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/employers.html>. You also alleged that the documentation provided to the agency regarding your wife's healthcare information should have been destroyed pursuant to VHA Handbook 6500. Please provide a specific citation to the section of the Handbook that you believe was violated in this matter. Please explain why you believe this documentation should be handled pursuant to the requirements of VHA Handbook 6500. Please provide detailed information supporting your belief that this documentation is still improperly on file within the Northport VAMC. For example, have you recently seen this document outside of your Official Personnel Folder or other employee documentation database? If so, please provide the relevant dates and locations of such access. 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

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. 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

me or discrediting my EEO case. This guidance is according to Aaron Lee National VA AIB Training Facilitator.

You alleged a violation of the Identity Theft and Assumption Deterrence Act of 1998. This statute specifically relates to the knowing possession, production, or transfer of false identification documents. You alleged that the improper access to your records is a violation of this statute. However, access alone does not constitute possession, production or transfer of false identification. We understand you received a letter from the agency indicating that your records were accessed and that you are entitled to credit monitoring as a result of this access; however, this is a standard response to this type of action and does not indicate that an actual theft has occurred. Thus, please provide information indicating that you have discovered your identity has been stolen and used improperly as a result of the improper access to your medical records. Similarly, you alleged a violation of the Fair and Accurate Credit Transactions Act of 2003. However, you provided no information to support your contention that your identity was, in fact, violated. Please provide the information described in Item 12 above. **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. 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.

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

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. Despite many OSC directed investigations with many ongoing at the VA Northport NY in the wake of my investigation the agency fails to implement a corrected plan therefore the agency has failed to meet any of their phony overtures from mine and prior cases to improve their dismal track record! 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. **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.** 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. 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.

You alleged a violation of the FTC's Red Flags Rule, which requires organizations to implement written programs to detect the warning signs of identity theft in their operations. It is not clear that the VA is subject to this rule as a creditor, as the United States Court of Appeals for the District of Columbia in 2010 affirmed the interpretation that physicians are not creditors for purposes of the statute. In light of this, please explain your position that the Red Flags Rule applies to the VA. Please see responses to above related questions. Since the VA does collect fees such as copays, deductibles, etc. holding accounts billable to 3rd party billing they are subject to this rule as per my relevant e-mailed correspondence.

Whistleblower retaliation & FOIA impedence

transparent governance does not involve instructing agencies to discourage records requests by charging exorbitant and unreasonable fees in a discriminatory, retaliatory, punitive and hostile manner. This antagonistic message is effectively placing unnecessary tighter restrictions on information requests, as Messrs. McDonald (VA Secretary) and Gibson were vowing to run a more open VA in response to a scathing letter that the OSC chief Ms. Lerner sent to Mr. Obama regarding the agency's corrosive culture of whistleblower retaliation, stonewalling and bogus investigations. It appears that the VA Northport NY administration is weaponizing the FOIA process against me as a veteran and a patient to artificially suppress filings thus interfering and obstructing my participation in the aforementioned OSC investigations and other investigative protected activities. This is tantamount to veteran abuse and patient abuse. Ms. Mattila's veiled threats serve only to discourage me as a veteran and a patient. This is contrary to Messrs. McDonald's and Gibson's public pledges to reform the VA anathema to the VA's response to the OSC letter to Mr. Obama. Mr. McDonald vowed to transform the VA by "seeing things through the lens of the veteran." As a 100% total and permanent service connected disabled veteran I am very disturbed that I can continue to be treated so badly by the VA to the extent that I'm threatened with outrageous FOIA fees as a retaliatory response to scandals that I've exposed to the OSC. *According to the Office of Government Information Services (OGIS) if fees are charged, you may request a waiver of those fees if you can show that the records, when disclosed to you, will contribute significantly to the public's understanding of the operations or activities of the government which in the foregoing ongoing OSC investigations is fully demonstrated.* The agency's privacy officer has refused to provide crucial emails that I've requested and is flat out lying that many records don't exist when I know in fact that they do. Your prompt assistance in this manner is greatly appreciated. Thank you.

Joe

631-384-2769

For whistleblowers, a bold move can be followed by one to department basement - The

Washington Post

Bradley, Siobhan Smith

8/04/14

To: 'Joseph Fasano'

Mr. Fasano,

Esq can attest to this). Mr. Bradley please advise. Thank you.

Joe

631-384-2769

http://www.washingtonpost.com/politics/for-whistleblowers-bold-move-can-be-followed-by-one-to-department-basement/2014/08/03/39d12656-182f-11e4-9e3b-7f2f110c6265_story.html

CRT keeps getting worse DI-14-0558

Hi Ms. Bradley according to the recent Sensitive Patient Access Report (SPAR) with run dates 6/15/14 - 6/30/14 and 7/15/14 - 7/31/14 (which predates the recent ICRT onsite visit) that I've attached to this e-mail, the VA Northport NY Privacy Officer Ms. Nicole Mattila was ordered by the agency's Ms. Gladys Felan RN Office of the Medical Inspector (OMI) to "determine if Mr. Fasano is enrolled in VA care at Northport or any other VA facility...What OMI needs to know is if the whistleblower was receiving care as a patient from the Northport VAMC or any of the other facilities in 2013..." Of course I'm enrolled in VA healthcare (what difference does it make). In order to have the Compensation and Pension (C + P) disability exams at the VA in Brooklyn NY I had to be enrolled/ registered for care. Although you have a copy of my Veterans' ID Card (VIC) that I emailed to you ca. autumn of 2013 I am again enclosing it for the purposes of this email and investigation. I'm already eligible/ enrolled in VA healthcare by default as a 100% permanent and total service connected adjudicated disability claims therefore I can access all VA services, healthcare, benefits, etc. at any time at any place at any VA facility of my choosing at my discretion. It's very disturbing that the agency's ICRT tasked with this investigation requested and had this info prior to interviewing me for the express purpose of tricking me, however, I remain steadfast with the truth. I will have copies of the recorded transcripts available to forward to you by next week according to the ICRT. The agency's ridiculous assertions and interpretation of this case imposes artificial jurisdictional boundaries that don't apply. I am Joseph Fasano the person/ patient/ veteran/ employee - I am all the same person therefore I can be harmed in any of those roles/ capacities at any time and location and the harm done to me as the person Joseph Fasano transcends these agency imposed artificial boundaries. Sometimes there exists an overlap which the agency applies as the cleaving of a person which is a function of artifice. This goes against public policy for health, safety and well-being so the OSC does have jurisdictional authority and Joe Fasano is within the purview of the OSC despite the agency's desperate attempts to create these artificial boundaries in order to white wash this case. This harm happened to me regardless of the symantec nomenclature that the agency is using to supplant their responsibility in violation of law, rule and regulation that severely endangered my life, safety and well-being since the illegal restriction order that I received NEVER guaranteed that I would receive healthcare and access to the other benefits that

We will reach out today to the agency to discuss the parameters of the investigation. I will update you accordingly.

Thanks,

Siobhan

From: Joseph Fasano [mailto:joesepe@msn.com]

Sent: Thursday, July 31, 2014 1:01 PM

Subject: RE: More ICRT Bad News

Importance: High

Hi Ms. Bradley additionally please consider:

1. The agency's ICRT's ridiculous interpretation of this case imposes artificial jurisdictional boundaries that don't apply to this case.
2. I am Joseph Fasano the person/ patient/ veteran/ employee - I am all the same person therefore I can be harmed in any of those roles/ capacities at any time and location. Sometimes there exists an overlap which the agency applies as the cleaving of a person which is a function of artifice. This goes against public policy for health, safety and well-being so the OSC does have jurisdictional authority and Joe Fasano is within the purview of the OSC despite the agency's desperate attempts to create these artificial boundaries in order to white wash this case. This harm happened to me regardless of the symantic nomenclature that the agency is using to supplant their responsibility in violation of law, rule and regulation that severely endangered my life, safety and well-being since the restriction order that I received NEVER guaranteed that I would receive healthcare and access to the other benefits that I'm entitled to as a 100% permanent and total service connected disabled veteran. The order merely stated that I was to contact the VA police 24 hours in advance however it NEVER mentioned that I would have access to healthcare and benefits within those 24 hours posing a clear and imminent danger to my life and safety. Also as I've previously mentioned Mr. Moschitta (director), Dr. Limb (service chief long term care), Dr. Marino (chair disturbed behavior committee), Mr. Squicciarini (police chief), Ms. Carrington (HR specialist), Mr. Sledge (PAO), etc. do NOT have the legal and medical authority to impose these severe restricitons with or without due process that endangered my life and safety. Neither does the VA Northport NY police.

Joe

631-384-2769

**WHISTLE BLOWER HARASSMENT, WITNESS BADGERING, TAMPERING,
INTIMIDATION**

Office of the Special Counsel (OSC) CASE # DI-14-0558

Please be advised that I was interviewed by the Veteran's Administration (VA) Interdisciplinary Crisis Response Team (ICRT) on Tuesday 7/29/2014 for approximately two hours and fifteen minutes and on Wednesday 7/30/2014 for approximately 40 minutes. Both sessions were conducted in Building 9 Room 202. I was accompanied by a colleague Dr. Lois Saltzman JD Esq. The sessions were recorded by a stenographer. The ICRT was chaired by Ms. Elizabeth Hill JD with her side kick Mr. Scott Foster JD (both Human Resources specialists). There were no clinicians on the interview panel and the ICRT lacked any clinically knowledgeable staff.

Hi Ms. Bradley OK so I was interviewed again today at 2:15 for approximately 40 minutes. The main focus yesterday and today and from the general consensus from others is that the ICRT main focus was on the scheduling v. the illegal police escort restrictions and illegal fee basis denials. The ICRT dismissed and/ or glossed over the crucial OSC draft facts regarding the illegal police escort restrictions and the illegal fee basis denials of care. The ICRT refused to consider anything that was an inconvenience to their biased views. The general consensus is that this ICRT is just a typical VA whitewash without any changes from prior Office of the Medical Inspector whitewashes despite the acting VA Secretary's Mr. Gibson's empty public pledges to reforms in response to the OSC's Chief Ms. Lerner's scathing letter to President Obama. Mr. Scott Foster of this ICRT cited irrelevant examples of when there isn't due process such as obtaining restraining orders in civil/ criminal courts when that stupid example has NOTHING to do with this OSC case or with 38 CFR 17.107! The ICRT chair Ms. Elizabeth Hill stated that that the OSC does not have "jurisdiction in any matters related to patients, patient care, veterans or veteran's issues" and that "this complaint is NOT within the OSC purview" despite that it's in the OSC draft facts and that 38 CFR 17.107 is about patients and veterans. The ICRT flat out refused to investigate the charges in the OSC draft facts pertaining to the Endocrinology and Rheumatology clinics despite the OSC draft facts. The ICRT didn't at all care about the shredding of the documents and when challenged with the e-mails they just dismissed it as "routine" - yeah maybe that's because that's what the VA does is destroy evidence. The ICRT seemed to agree with and side with management to justify their illegal police escort restrictions and illegal fee basis denials of care requests. The ICRT refused to acknowledge it as a restriction despite the fact that the language in the letters that I received clearly states the restrictions and it's in the OSC draft facts. Essentially they state that this portion of the case is not relevant since OSC doesn't have any jurisdiction. These comments were made off the record however I was accompanied by Dr. Lois Saltzman JD Esq who shares my misgivings, concerns and feelings regarding this farce. I was treated as a hostile witness and don't feel good about this investigation and the typical agency white washing. It doesn't matter what the VA calls this group (OMI or ICRT) it's the same old fox guarding the hen house. Very discouraging and extremely demoralizing. Now that I've had all day and night to think and reflect upon these interviews (interrogations), I'm very upset and angry with the conduct of Ms. Hill (ICRT chair). She no doubt engaged in badgering me as the whistleblower tantamount to witness badgering and intimidation. She was very aggressive with her line of questioning, tone and demeanor. She is a bully. She cared more about my prior EEO complaints v. the illegal restrictions to health care

at least dumbed it down instead of focusing on the draft facts of this investigation. I feel very demoralized after this encounter and I have no hopes that the agency will mend its ways. I had to

forcefully discuss and bring up the whole denial of fee basis care which they weren't happy about and told me to stop talking about 38 CFR 17.107. Not good, not pretty, really really bad.

I think that there may be witness tampering/ intimidation/ coercion taking place at the VA Northport NY by Mr. Moschitta (director) re OSC case # DI-14-0558. In conversations with Dr. Ed Mack (Chief of Staff) Mr. Moschitta is accosting him and other witnesses for detailed information on their witness status including but not limited to Dr. Younghee Limb (service chief long term care), Mr. William Marengo RN (patient advocate) since Mr. Moschitta fears that they will provide testimony unfavorable to him and the agency re the illegal restrictions to care, fee basis care and benefits. The intimidation is taking place in the form of overt coercion such as yelling, screaming and taunting and outright demanding to know the details of their respective interviews despite the fact that they've been ordered under oath to NOT discuss details with anyone. Dr. Mack stated that this happened to Dr. Mandar Tank (service chief primary care) on Friday 7/25/14 shortly after his telephone interview with the agency's ICRT. Dr. Tank felt compelled to spill the beans to Mr. Moschitta out of fear of implied retaliation. This wanton abuse of authority and projected overt and implied threats of retaliation does not bode well for a fair, honest, credible and transparent investigation since Mr. Moschitta is negatively influencing the testimonies via the bully pulpit.

The ICRT constantly deviated from the OSC draft facts. They dwelled too much on my veteran and patient status prior to the illegal restrictions. The facts are that as a 100% permanent and total service connected disabled veteran it is at MY discretion NOT the VA's when and where I decide to receive services. This is about ME the veteran victimized by Mr. Phil Moschitta (VA Northport NY director) and his henchmen breaking the law. For Ms. Hill to make inflammatory and provocative remarks about the OSC's "jurisdiction" and "purview" regarding patient/ veteran issues v. employment issues is irrelevant – the OSC investigates violations of law, rule and regulation. The VA is supposed to be about veterans and the OSC has publicly now taken on that role to ensure that veterans are receiving the benefits and quality services that they are entitled to by law. This is NOT about Ms. Hill with her intimidation, power suit and caked on makeup. I get it this works for the VA – that's what they do. I showed Ms. Hill that I also have a plethora of documents that I could easily wave in front of her face the same way that she threatened, taunted, badgered and harassed me treating me as a hostile witness yet Ms. Hill was NOT interested in crucial evidence that I have. In his zealous quest to break the law Mr. Moschitta violated my rights jeopardizing my life, safety and well-being. Mr. Moschitta (director), Dr. Marino (Disturbed Behavior Committee chair), Dr. Limb (Long Term Care service chief), Mr. Squicciarini (chief of police), Ms. Cheryl Carrington (HR specialist), Mr. Joseph Sledge (Public Affairs officer), etc. do NOT have the legal and clinical authority to restrict me as a 100% permanent and total service connected disabled veteran. Also, they broke the law in a criminally disparate and depraved selective manner against despite no wrong doing on my behalf.

WITNESS BADGERING TAMPERING INTIMIDATION DI 14-0558

and illegal fee basis denials. When things weren't going her way during the line of questioning she pulls out this document in a condescending and intimidating way waving it in a taunting and humiliating and degrading manner. My colleague who accompanied me is a physician and an attorney and she shared similar observations and was not at all thrilled with the conduct of this ICRT. I want to lodge a formal complaint against Ms. Hill and I need to emphasize how angry and upset I am with her unprofessional conduct, behavior and demeanor. I also was NOT given enough time to fully explain the events of the illegal police escort restrictions. Ms. Hill pounced upon me and was enraged that I mentioned that Mr. Moschitta perjured himself during sworn EEO testimony regarding the illegal restrictions to care and illegal police escort restrictions and illegal fee basis denials despite the fact that it was part of the OSC draft facts. Simply put this is not good, not pretty and REALLY REALLY REALLY BAD!!! Please advise and assist. Thank you.

Joe

631-384-2769

From: joesepe@msn.com

To: ssmith@osc.gov

Subject: RE: DI-14-0558

Date: Tue, 29 Jul 2014 13:51:12 -0400

Hi Ms. Bradley no I don't think that I'll be interviewed again. I didn't particularly get a warm fuzzy from this crew; especially with the glossing over something as egregious as the director and his henchmen practicing outside their legal scopes of authority by illegally restricting me which jeopardized my life, health and safety. I fear that the acting Secretary's ICRT response is just the polishing of a turd. They also seemed to deviate from the OSC draft facts at their discretion and didn't at all mention the director's actions against me or how that jeopardized my life, health, safety and well being. It doesn't matter if I hadn't sought VA healthcare prior to the restrictions. The facts are the restrictions severely exacerbated my severe PTSD as part of the OSC draft facts and that the VA police don't have the medical legal authority to make those decisions since they CANNOT be involved in the coordination of care of a patient; only a provider has this medical legal authority and ability. I also fear that they will just tow the agency line to justify these heinous actions against me. Thank you.

Joe

631-384-2769

From: ssmith@osc.gov

To: joesepe@msn.com

From: ssmith@osc.gov
To: joesepe@msn.com
Subject: DI-14-0558
Date: Tue, 29 Jul 2014 14:24:45 +0000

Mr. Fasano,

Just wanted to follow up with you on our call from yesterday regarding Mr. Moschitta. I spoke with our agency points of contact and they have taken steps to put a stop to any "information gathering" regarding interviews or witnesses by facility leadership. Please keep me apprised of any developments you have occasion to hear about. I also wanted to remind you that if any of your colleagues feel they are experiencing reprisal, they can file a complaint of prohibited personnel practices with our Complaints Examining Unit. I am happy to speak with individuals about the basics of that process, as well.

Regards,

Siobhan S. Bradley

Attorney, Disclosure Unit

U.S. Office of Special Counsel

1730 M Street, N.W.

Washington, D.C. 20036

Witness tampering/ intimidation

Joseph Fasano

7/28/14

Bcc: sbradley@osc.gov

Hi Ms. Bradley I think that there may be witness tampering/ intimidation/ coercion taking place at the VA Northport NY by Mr. Moschitta (director) re OSC case # DI-14-0558. In conversations with Dr. Ed Mack (Chief of Staff) Mr. Moschitta is accosting him and other witnesses for detailed information on their witness status including but not limited to Dr. Younghee Limb (service chief long term care), Mr. William Marengo RN (patient advocate)

Hi Ms. Bradley I forgot to mention others that should be called in as witnesses to testify including but not limited to:

Cheryl Carrington (Human Resources Labor Relations Specialist) - her fingerprints are all over the evidence. On the orders of Mr. Moschitta (director) Ms. Carrington coordinated all of the efforts and illegal adverse actions against me despite the fact that she knew they were breaking the law. Her emails directing Dr. Mack (and others) to destroy, shred and alter evidence evinces her and the agency of this criminal malfeasance.

Ms. Rosie Chatham RN (chief nurse) - according to Dr. Mack (COS) Ms. Chatham was present at many of these meetings and personally felt that I was being wrongfully persecuted and retaliated against.

Mr. William Marengo RN (patient advocate) - he will testify that he was ordered by Mr. Moschitta (director) and his supervisors Mr. Sperandeo and Ms. Begouin to NOT assist me as a patient/veteran. He will also testify that he felt that these actions were unlawful and interfered with his ability as the patient advocate to do his job and to properly assess my needs as a patient suffering with severe PTSD. He was fearful that this was life threatening and conveyed his concerns to Dr. Mack.

Ms. Maria Favale (associate director) - her role makes her by default implicitly involved.

Ms. Joanne Anderson RN (director's AA) - her role makes her by default implicitly involved and privy to top level information since she would've coordinated all actions as the director's AA.

Dr. Younghee Limb (service chief long term care) - as my supervisor she is also implicitly involved since her name is on all of the correspondence.

Ms. Kathleen Tulloch Esq (regional counsel) - she was the regional counsel involved in coordinated the legal oversight of these criminal and unlawful activities against me. She is also on the email strings that I sent to you recently and in recent email correspondence with your office.

Everyone from the Secretary's office that was involved in the representative email string that I sent to you that was provided by Dr. Limb.

Ms. Jennifer Newburger RN (registered nurse chief of Performance Improvement - again her involvement as seen on the e-mail strings is highly suspect as well. Also exceeded her legal scope of practice, credentials and clinical privileges).

Dr. Charlene Thomesen (chief of Psychiatry service - essentially she is Dr. Marino's boss so why was this fiasco allowed to continue).

Mr. John Sperandeo Social Worker and **Ms. Vivian Begouin** Social Worker (co-chiefs of the social work department - they supervise Mr. William Marengo RN Patient Advocate. Dr. Ed Mack [Chief of Staff] will testify that Mr. Marengo was ordered by Mr. Moschitta, Mr. Sperandeo and Ms. Begouin to illegally restrict/ deny my fee basis requests for non-VA care since the illegal restrictions exacerbated my severe PTSD. Mr. Marengo pleaded with Dr. Mack since Mr. Marengo stated that he could not assess my needs as a patient/ veteran since Mr. Moschitta, Mr. Sperandeo and Ms. Begouin were interfering/ obstructing with his role as the Patient Advocate. Mr. Marengo objected to their orders that they had to present when speaking with me on the telephone which is a violation of patient/ veteran privacy and protocol. Dr. Mack agreed with Mr. Marengo's assessment however felt powerless since Mr. Moschitta circumvented all legal processes in his illegal actions against me.)

Ms. Barbara Inskip RN (registered nurse assistant chief of Performance Improvement - again her involvement as seen on the e-mail strings is highly suspect as well. Also exceeded her legal scope of practice, credentials and clinical privileges. She also illegally accessed my medical records during that time frame).

Mr. Paul Haberman RN (as your office is well aware Mr. Haberman was "hand picked" by the director to chair the AIB against me. Dr. Mack felt that Mr. Haberman, Ms. Albanese and Mr. Wintch were running a "kangaroo court" and a "witch hunt" to trump up charges against me. Again Dr. Mack will testify that he felt the charges against me were "bullshit" and the actions taken against me wrong and illegal. Mr. Haberman et al as your office is aware and provided with the AIB transcripts exploited my disabilities making fun of me, taunting me and humiliating me during the course of their interrogation over a 2 day period for 9 hours. In fact 85 pages of the 225 page transcript were them referencing my disabilities which they adversely used and cited against me to justify their heinous actions according to Dr. Mack.

Ms. Barbara Albanese RN - AIB co chair.

Mr. Steven Wintch - AIB co chair and disgraced former privacy officer.

A fatal wait: Veterans languish and die on a VA hospital's secret list

Joseph Fasano

4/30/14

To: Bradley, Siobhan Smith

Ok that sounds great!

Subject: RE: A fatal wait: Veterans languish and die on a VA hospital's secret list

Date: Wed, 30 Apr 2014 11:25:06 -0400

From: sbradley@osc.gov

To: joesepe@msn.com

Why don't we plan for me to call you around 1 pm?

From: Joseph Fasano [mailto:joesepe@msn.com]

Sent: Wednesday, April 30, 2014 11:22 AM

To: Bradley, Siobhan Smith

Subject: RE: A fatal wait: Veterans languish and die on a VA hospital's secret list

Hi Ms. Bradley. I am available any time from 12p.m. onwards tomorrow. Yes I do have supporting documentation. Do you prefer that I contact you or should I await your call? Thank you.

Joe

631-384-2769

Subject: RE: A fatal wait: Veterans languish and die on a VA hospital's secret list

Date: Wed, 30 Apr 2014 10:42:46 -0400

From: sbradley@osc.gov

To: joesepe@msn.com

Mr. Fasano,

referral rate to PACT of the veterans that I screened in the Health Screening Clinic yet greater than 85% continued to want the PACT services despite the PACT scheduling coordinator falsely coding all cancellations as "patient cancelled." I was alerted to the PACT management false assertions and shenanigans against me by my former supervisor at that time Ms. Margaret Mitchell. Ms. Mitchell actually testified to this in a transcript that she felt that although I was doing an outstanding job in my role as the HSC NP, there was a nefarious effort underfoot led by Drs. Tank and Alexander to discourage me from referring additional veterans. When she presented my actual data and stats compared to their bogus stats it was a startling revelation that their corrupt practices were widespread. Drs. Tank and Alexander even ordered Ms. Beiner to violate the VA progress note policy in efforts to discourage my referring to their service. Patients were either never contacted for an appointment or contacted very late. Veterans' scheduling preferences were not being honored in further efforts to discourage them. In many cases patients were purposely scheduled for clinic locations that presented a geographic hardship in further efforts to deter their accessing PACT. In many instances patients that were scheduled for an Agent Orange clinic appointment had to wait an additional 90 days to be seen by a Primary Care Provider yet this encounter was coded and entered as meeting the PACT scheduling encounter when in fact Agent Orange is a screening process for Vietnam veterans applying for disability benefits not necessarily PACT. I was so upset that my fellow brethren and comrades were being so misled and abused that I exposed this fraudulent practice to my former supervisor Ms. Mitchell, my union president Mr. Richard Thomesen, the informatics nurse Mr. Ed McKenna and the computer folks who all agreed with me. Furthermore I demanded that PACT should have the same electronic referral and consult ordering mechanisms that all other services are required to have installed to track the scheduling performance measures. The same is true for the Agent Orange clinic which is also supervised by Drs. Tank and Alexander. Alas the practice continues to this day according to my PACT physician colleagues and coworkers. In some instances like the Rural Health Program this is completely fictitious since it only exists on paper with an artificially propped up workload that is poached from the HSC and Podiatry clinic #s despite the VA Northport having received a \$4.5 million grant for a fake Rural Health Program ca. 2010 that has NEVER enrolled or treated any veterans nor does it have the intention to ever treat or enroll veterans in accordance with the funding mandate. The only way that VA Northport qualified for the Rural Health Program funding was to screen and collate all veterans living in designated "rural" zip codes on the eastern "twin forks" of Long Island and other miscellaneous towns commonly referred to as "out east." They exploited an archaic and outdated postal system since Long Island is entirely a NY metro area. I'd hardly consider multi million dollar wineries and vineyards "rural." Any farms that do exist are a relic of bygone days. Good luck trying to get a Rural Health Clinic appointment if you happen to live in one of these designated "rural" zip codes as happened to a friend of mine Coast Guard Petty Officer Leonard Mastrogiacomo who also happens to be a Lieutenant detective working for the NYPD IG office. He was repeatedly rebuffed and denied access to the Rural Health Program being told various tales ranging from going to the Riverhead satellite primary care clinic to denial of care despite the fact that he

padded bonuses tied to this fraud. This was done to artificially suppress demand whilst simultaneously exceeding workload benchmarks in efforts to divert those obviated funds for other unapproved uses. Also to discourage veterans from accessing these programs that their entitled to. These intentional delays in care with this fraudulent shell game have resulted in veterans dying, worsening illnesses and conditions, to seek care else where which is a form of denial of benefits, etc. First the veterans are misinformed by Central Intake regarding their eligibility status to discourage them from making appointments, accessing health-care, applying for benefits and submitting disability claims. Then veterans are denied their benefits and health care by being turned down. Again this is to suppress demand whilst falsely giving the impression of exceeding workload capacity in order to gobble up more resources and monies which is then laundered internally and diverted for other dubious reasons instead of going to veterans in accordance with law regarding line item spending for tax dollars that are earmarked for specific purposes. In many cases veterans are misled with wrong information being told they do not meet eligibility criteria for Agent Orange clinic, Rural Health Program, etc. again to propagate this fraud which is another form of a de facto waiting list that veterans are placed on while they die of their Service Connected conditions awaiting treatments and benefits that they and their family will never receive. This is also true of the Endocrinology and Rheumatology clinics at the VA Northport. They have the highest rates of cancelled consults with the service chiefs Drs. Anoop Kapoor and Ranjan Roy (respectively) deliberately discouraging appointments and consults to their services. They use bully tactics to intimidate others from not submitting consults or referrals to their services. In some cases they have even threatened to fire or actively tried to fire staff that were non compliant with their draconian demands. It's scary to think how many veterans died and suffered as a result. The Rural Health Program has two Mobile Health Clinics - essentially a converted Winnebago RV turned portable clinic and a converted 27 foot U-haul truck that was supposed to export health care to veterans residing in designated rural health zip codes. The converted Winnebago cost \$350,000 and is basically a very expensive advertisement to distribute flyers promoting the myth of a fake program that never performs as advertised. The only times these vehicles are used is to either enroll veterans into the VA health system called a "vesting" exam or to provide limited Podiatry services, however, sanitary issues have arisen since there is no real way to conduct a proper procedure in the absence of a wet sink since these vehicles pose a serious danger to the veterans, staff and community with their noxious CO exhaust fumes not being properly vented and a dirty water tank whose wretched odor renders their use impossible. A savvy investigator need only compare the vehicle maintenance logs to the actual vehicular odometer mileage v. the fictitious workload that it doesn't match up. I also complained about this to management and the union to no avail.

Subject: RE: A fatal wait: Veterans languish and die on a VA hospital's secret list

Date: Tue, 29 Apr 2014 09:24:06 -0400

From: sbradley@osc.gov

To: joesepe@msn.com

Mr. Fasano,

Thanks for your email. We are aware of the allegations at the Phoenix VAMC and watching the matter closely. Are you alleging that individuals at the Northport VAMC are engaging in the same type of scheduling coverups as what occurred in Phoenix? Or, that your situation with the Director could lead to a similar result? As you know, I plan to recommend that your allegations in your latest OSC matter be referred for investigation, so the story out of Phoenix would not have a bearing on that. However, if you are alleging that Northport VAMC scheduling processes are faulty or misleading, that is a different matter entirely, and one that would need to be reviewed. Let me know your thoughts at your earliest convenience.

Regards,

Siobhan Bradley

From: Joseph Fasano [<mailto:joesepe@msn.com>]

Sent: Friday, April 25, 2014 2:47 PM

To: undisclosed-recipients

Subject: A fatal wait: Veterans languish and die on a VA hospital's secret list

Importance: High

Hi Ms. Bradley a disturbing new revelation that was broadcasted on major media yesterday is symbolic of the overall broken VA system; particularly the VA Northport NY facility. In essence this news title can be applied to my situation since the director's criminal restrictions placed upon me and denial of fee basis requests for care gravely endangered and jeopardized my health, safety and welfare which is a clear violation of the laws that we discussed. So this criminal action has dire and sometimes fatal sequelae as was the case in the Phoenix VA and as is the case at the Northport VA. These veterans whose healthcare and benefits that died as a result of the wait is like the cruelty that I suffered at the hands of the VA Northport director. There is a social contract between the military and America whereby the military takes care of and protects America and in return America is charged with the tremendous and honorable responsibility of caring for its veterans upon completion of their military service. It appears that this social contract has been repeatedly violated by the foregoing since as a former Army officer having served with honor and distinction in elite Airborne and Special Operations units I had the tremendous responsibility, honor and privilege bestowed upon me to ensure the safety and well

the opposite approach to the assignment of duties and responsibilities in medical centers, where no two hospitals are alike. I believe that **it is appropriate to review the organizational structure and business rules of VHA to determine if there are changes that would make the delivery of care less prone to error and reinforce the priority that the delivery of health care should receive.**

Statement of John D. Daigh, Jr., M.D. Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before Committee on Veterans' Affairs United States House Of Representatives Hearing On "A Continued As

VA Orders Restructure of VHA's Office of Medical Inspector

WASHINGTON - In response to recent recommendations by the Office of Special Counsel (OSC), VA Acting Secretary Sloan Gibson announced that the Department's Office of Medical Inspector (OMI) will be restructured. "Given recent revelations by the Office of Special Counsel, it is clear that we need to restructure the Office of Medical Inspector to create a strong internal audit function which will ensure issues of care quality and patient safety remain at the forefront," Gibson said. The action followed Gibson's order for a 14-day comprehensive review of all aspects of the OMI after OSC sent a letter to President Barack Obama detailing the concerns. <http://www.usmedicine.com/late-breaking-news/va-orders-review-of-office-of-medical-inspector/>

White House Review Calls for Restructuring of VHA

WASHINGTON - The VHA needs to be "restructured and reformed" according to a scathing White House review. "The VHA leadership structure is marked by a lack of responsiveness and an inability to effectively manage or communicate to employees or veterans," noted the review, which focused on access to care at the VA. The review, which came several weeks after a VA inspector general's report confirmed problems regarding access to care, was presented to President Barack Obama. <http://www.usmedicine.com/agencies/department-of-veterans-affairs/white-house-review-calls-for-restructuring-of-vha/>

Six US-Signed Treaties and Declarations Recognizing a Right to Health Care

In addition to violating 38 CFR 17.107 when the VA Northport NY illegally restricted my legal entitlement and access to VA health care and benefits, a total of six treaties that the U.S. has entered into have been violated.

The VA violated the first two treaties in the below hyperlink when they illegally denied my access to healthcare with the illegal restrictions without any sort of reason in the absence of any wrong doing and in the absence of a clinical exam. Consider the following review points:

padded bonuses tied to this fraud. This was done to artificially suppress demand whilst simultaneously exceeding workload benchmarks in efforts to divert those obviated funds for other unapproved uses. Also to discourage vets from accessing these programs that they're entitled to. These intentional delays in care with this fraudulent shell game have resulted in vets dying, worsening illnesses & conditions, to seek care else where which is a form of denial of benefits, etc. Vets are misinformed by central intake regarding their eligibility status to discourage them from making appointments, accessing health-care, applying for benefits & submitting disability claims. Then vets are denied their benefits & healthcare by being turned down. Again this is done to suppress demand whilst falsely giving the impression of exceeding workload capacity in order to gobble up more resources and funding which is then laundered internally and diverted for other dubious reasons instead of going to vets in accordance with law regarding line item spending for tax dollars earmarked for specific purposes. Veterans are mislead with wrong information being told they don't meet eligibility criteria for AOC, RHP, etc. again to propagate this fraud which is another form of a de facto waiting list that vets are placed on while they die of their service connected conditions awaiting treatment and benefits that they or family will never receive. This is also true of the Endocrinology and Rheumatology clinics at the VA Northport (which the agency refused to investigate despite the OSC draft facts). They have the highest number of cancelled consults with the service chiefs deliberately discouraging appointments and consults using bully tactics to intimidate others from not submitting consults or referrals to their services. In some cases they have threatened to fire or actively tried to fire staff that were non compliant with their draconian demands. It's scary to think how many veterans died languishing for appointments. The mobile health clinics pose a danger to veterans, staff and the community with their noxious exhaust fumes and dirty unsanitary water. Just check the vehicle maintenance logs which are falsified and compare them to the mileage compared to the fake workload and it doesn't match up. The mobile health clinics are nothing more than very expensive advertising to distribute RHP flyers promoting the myth of a fake program that never performs as advertised. It has even been rumored that Michael Santillo (Program Specialist VERA) of the Performance Improvement office fudges the workload data to allow the poaching of numbers from the HSC to the RHP. The only way that VA Northport qualified for the RHP funding was to screen & collate all vets living in designated "rural" zip codes on the twin forks of Long Island (LI) & other miscellaneous towns commonly referred to as "out east." They exploited an archaic & outdated postal system since LI is entirely a NY metro area. I'd hardly consider multi million dollar wineries & vineyards "rural." Any farms that do exist are a relic of bygone days. Good luck trying to get a RHP appointment however if you live there as happened to a friend of mine Coast Guard petty officer Leonard Mastrogiacomo who also happens to be a detective for the NYPD IG office. He was repeatedly rebuffed & denied access to the RHP being told various tales ranging from going to the Riverhead CBOC to denial of care despite the fact that he resides in a designated rural zip code. However Community Relations outreach events & HSC vesting exams do NOT supplant for RHP workload. VA Northport receives substantial funding for each veteran that is "vested" into the system regardless

response to the agency's "investigative report" for both cases, alas; I fear that this is just agency retaliation against whistleblowers to cover up their scandals and wrong doing. So much for the empty pledges to reform the VA and how they conduct investigations. Mr. Gibson was quoted in open media sources in testimony before the House Committee on Veteran's Affairs on 7/16/2014 to "reform the agency" and "hold those accountable" of wrong doing including evidence tampering, obstruction of investigations and whistleblower retaliation. The VA Northport NY privacy office is meddling in records requests similar to a suit that claims agencies locked down documents. The agency is stonewalling records requests and negatively influencing their response to record requests. Accountable and transparent governance does not involve instructing agencies to discourage records requests by charging exorbitant and unreasonable fees in a discriminatory, retaliatory, punitive and hostile manner. This antagonistic message is effectively placing unnecessary tighter restrictions on information requests, as Messrs. McDonald (VA Secretary) and Gibson were vowing to run a more open VA in response to a scathing letter that the OSC chief Ms. Lerner sent to Mr. Obama regarding the agency's corrosive culture of whistleblower retaliation, stonewalling and bogus investigations. It appears that the VA Northport NY administration is weaponizing the FOIA process against me as a veteran and a patient to artificially suppress filings thus interfering and obstructing my participation in the aforementioned OSC investigations and other investigative protected activities. This is tantamount to veteran abuse and patient abuse. Ms. Mattila's veiled threats serve only to discourage me as a veteran and a patient. This is contrary to Messrs. McDonald's and Gibson's public pledges to reform the VA anathema to the VA's response to the OSC letter to Mr. Obama. Mr. McDonald vowed to transform the VA by "seeing things through the lens of the veteran." As a 100% total and permanent service connected disabled veteran I am very disturbed that I can continue to be treated so badly by the VA to the extent that I'm threatened with outrageous FOIA fees as a retaliatory response to scandals that I've exposed to the OSC. *According to the Office of Government Information Services (OGIS) if fees are charged, you may request a waiver of those fees if you can show that the records, when disclosed to you, will contribute significantly to the public's understanding of the operations or activities of the government which in the foregoing ongoing OSC investigations is fully demonstrated.* The agency's privacy officer has refused to provide crucial emails that I've requested and is flat out lying that many records don't exist when I know in fact that they do.

EMAILS RELATED TO CASE

ILLEGAL RESTRICTIONS TO HEALTHCARE

Description: correspondence between Mr. Richard Thomesen (NFFE local union president and VA administration):

From: Richard.Thomesen@va.gov

To: Philip.Moschitta@va.gov; Michael.Sabo@va.gov; Maria.Favale@va.gov;
Edward.Mack@va.gov

CC: Carl.Schramm@va.gov; bobredding@cableone.net; Robert.Redding@va.gov;
joesepe@msn.com

Date: Sat, 16 Nov 2013 13:02:58 -0500

Lorraine

Cc: Alexander, Sterling; Tank, Mandar; Carvalheira, Geri; Kitson, Richard; Favale, Maria; Butcher, Keith; Moschitta, Philip (SES)

Subject: Health Screening scheduling

Due to the temporary need to reallocate providers in the clinics, the Health Screening Clinic will operate with 1 provider per day. After much discussion and review of options, a plan for provider coverage has been established. We appreciate the staff's consideration regarding this change and any extra work necessary to re-arrange appointments to accommodate this plan. The goal remains the same, which is to offer vesting exams for Veterans as a scheduled appointment and as a walk-in option. This plan will be effective 7/5/2011 and is as follows:

Appointments for the Health Screening Clinic for Mon, Tues, Thurs. and Fri will be provided by NP Fasano

Appointments for the Health Screening Clinic for Wed will be provided by NP Judy Jones

This arrangement will start the week of 7/3

Appointments that have been made for NP Jones will need to be rescheduled for NP Fasano.

As I will be on AL 6/28 thru 7/11 please forward questions to Dr. Tank, Dr. Alexander or Ms. Favale.

Thank you.

JoAnne Anderson RN MSN FNPC

East End Health Care Coordinator

Northport VAMC

79 Middleville Road, Northport NY 11768

Ph: 631-261-4400 ext 4590

Mobile: 631-434-5506

Fax: 631-754-7933

It is an E&M level 3 or higher visit by a provider (MD, DO, NP, PA). Many visits to Primary Care, ER, Psychiatry with an E&M component, HBPC and Preventive Medicine qualify as a Level 3 visit.

Who can provide a vesting exam?

A clinician authorized by the Centers of Medicare and Medicaid (CMS) to provide E&M exams must administer VESTING CPT codes. Authorized clinicians include physicians (residents are physicians), physician assistants, clinical nurse specialists and nurse practitioners. The "person class" field in the VHA database identifies the VHA professional.

What are the elements of a Level 3 Established (99213) visit?

- History: 1-3 history of present illness elements, 1 Review of Systems related to problem.
- Exam: 2-7 Body Areas or Organ Systems
- Medical Decision Making: Low
- **2 out of 3** from the above elements

What are the elements of a Level 3 New Patient (99203) visit?

- History: 4 or more history of present illness elements, 2-9 Review of Systems
- Exam: 2-7 Body Areas or Organ Systems
- Medical Decision Making: Low
- **3 out of 3** from the above elements

Ann Marie Rapacki

Clinical Applications Coordinator

Bath VAMC

607-664-4787

VISTA e-mail address: RAPACKI.ANN_MARIE@V02.MED.VA.GOV

-----Original Message-----

From: Anderson, Joanne Catherine

Sent: Tuesday, December 06, 2011 4:17 PM

To: Brady, Eugene; Vasquez, Aida; Diaz, Scott; Marro, Deborah; Tabone, Lorraine; Fasano,

From: Fertil, Bertha
Sent: Tuesday, December 06, 2011 10:08 AM
To: Davis, Mara (VISN3)
Subject: RE: outreach call today - 2pm

From: Davis, Mara (VISN3)
Sent: Tuesday, December 06, 2011 8:10 AM
To: Fertil, Bertha
Subject: outreach call today - 2pm

Mara Davis

VISN 3 Deputy Network Director

Office: 718-741-4134

Cell: 646-772-3234

-----Original Message-----

From: Mitchell, Margaret
Sent: Thursday, December 08, 2011 11:29 AM
To: Fasano, Joseph
Subject: RE: outreach call today - 2pm

You had the highest level of New Enrollees and the highest amount of those VISN wide where vested. You can never get every new enrollee vested... you know there are ones that refuse, just don't want it. If they came through you they would be vested... if they just went to eye clinic and refused HS or Primary then they were seen but not vested... it's a constant challenge. I think when I had Debbie on it full time (not covering OEF OIF, she got more of these non-vested/Specialty patients). Joann does now even know what she is looking at with these numbers, or who comes from where or why. You are only one person and you are vesting plenty!

Marge

-----Original Message-----

From: Fasano, Joseph
Sent: Thursday, December 08, 2011 8:28 AM
To: Mitchell, Margaret
Subject: FW: outreach call today - 2pm

Marge what does this mean?

Cell: 646-772-3234

From: Fertil, Bertha
Sent: Tuesday, December 06, 2011 10:08 AM
To: Davis, Mara (VISN3)
Subject: RE: outreach call today - 2pm

From: Davis, Mara (VISN3)
Sent: Tuesday, December 06, 2011 8:10 AM
To: Fertil, Bertha
Subject: outreach call today - 2pm

Mara Davis

VISN 3 Deputy Network Director

Office: 718-741-4134

Cell: 646-772-3234

VAOIG Report - Audit of VHA's Mobile Medical Units <http://www.va.gov/oig/pubs/VAOIG-13-03213-152.pdf>

From: Mack, Edward
Sent: Thursday, May 15, 2014 10:06 AM
To: redacted
Subject: Fw: VAOIG Report - Audit of VHA's Mobile Medical Units

From: Papineau, Tara
Sent: Thursday, May 15, 2014 09:58 AM Eastern Standard Time
To: V03 ELC; V03 PAOs; V03 Associate Directors; V03 Outreach Council
Subject: FW: VAOIG Report - Audit of VHA's Mobile Medical Units

Good Afternoon,

Please see the OIG report on Mobile Medical units.

Thanks,

consistently captured these data, it could compare MMU utilization and costs with other health care delivery approaches to ensure MMUs are providing efficient health care access to veterans in rural areas. These weaknesses occurred because VHA did not designate specific program responsibility for MMU management, define a clear purpose for its MMUs, or establish policies and guidance for effective and efficient MMU operations.

As a result of limited MMU data, we were unable to fully address the committee's concerns. However, it is apparent that VHA cannot demonstrate whether the almost \$29 million ORH spent, as well as unknown medical facility funding for MMUs, increased rural veterans' health care access and the extent to which MMUs can be mobilized to support its emergency preparedness mission. We recommended the Under Secretary for Health improve the oversight of MMUs by assessing their effect on rural veterans' health care access, establishing specific program responsibilities, policies, and guidance, including requirements to capture MMU data in DSS, and supporting emergency preparedness plans. The Under Secretary for Health concurred with our recommendations and provided an acceptable action plan. We will follow up on the implementation of the corrective actions.

Description: manipulation of health screening encounters for rural health program (MU = mobile unit)

From: Anderson, Joanne Catherine
Sent: Friday, September 16, 2011 2:27 PM
To: Fasano, Joseph
Cc: Brady, Eugene; Diaz, Scott
Subject: MU program

I just booked an Outreach event on Friday 11/4 in Elmont AL Post 1033 10am-4p.

They are requesting the Mobile Unit as well as the Eligibility Team.

Would you be willing to assist with the orientation of the new NP to working an Outreach Event on the Mobile Unit?

Could we block your appointments and perhaps you could work with the new Mobile Unit NP if she is ready?

If not, would you want to come out with us?

JoAnne

The noise level on both units (27' mobile unit and new dedicated mobile unit) is quite loud due to the generator to the extent that my ears are ringing the entire next day. The water from the sinks on the new mobile unit is awful and smells like dirty moldy old feet. Is there some sort of inspection (Bio Med, Joint Commission, OSHA, etc.) requirement to check the exhaust fumes and decibel levels? Thanks.

Joe

VA NORTHPORT RURAL HEALTH PROGRAM FAILED TO UPDATE ITS PATIENT ROSTERS IN LINE WITH NEW MANDATE OF 2012 THAT REDEFINED RURAL HEALTH AREAS AND UPDATED ZIP CODES

New Definition for Rural Areas to Improve VA Care Delivery

WASHINGTON - VHA is changing the method it uses to define urban, rural and highly rural land areas so that it can better identify and serve rural veterans, the agency has announced. The current method will be replaced by the Rural-Urban Commuting Areas system, which was developed by the Department of Agriculture and the Department of Health and Human Services and is popular with federal agencies. The new system, which will begin by the end of this month, takes into account population density and considers how closely a community is socio-economically linked to larger urban centers. <http://www.usmedicine.com/late-breaking-news/vha-announces-adoption-of-new-method-to-define-rural/>

Description: rural health program NP trained for vesting exams for health screening clinic since there are NO veterans in the rural health program. The vesting numbers are then poached to artificially prop up fictitious program that provides no real services. NP Tripoli used only for primary care backfill and health screening clinic.

From: Feldman, Joyce E.

Sent: Wednesday, October 26, 2011 2:00 PM

To: Anderson, Joanne Catherine; Fasano, Joseph

Cc: Ciulla, Joseph A.

Subject: RE: Orientation to Health Screening clinic

She will finish her orientation to PC this week. Starting 10/31, she will be in Patchogue on Mondays and Fridays.

The other days she is free for orientation.

Joyce Feldman, RN MSN

Cc: Ciulla, Joseph A.
Subject: RE: Orientation to Health Screening clinic

I will see if she can orient with NP Fasano on Tuesday 11/1 and Thursday 11/3.

JoAnne Anderson RN MSN FNPc
East End Health Care Coordinator
Northport VAMC
79 Middleville Road, Northport NY 11768
Ph: 631-261-4400 ext 4590
Mobile: 631-434-5506
Fax: 631-754-7933
Email: joannecatherine.anderson@va.gov

-----Original Message-----

From: Feldman, Joyce E.
Sent: Wednesday, October 26, 2011 2:00 PM
To: Anderson, Joanne Catherine; Fasano, Joseph
Cc: Ciulla, Joseph A.
Subject: RE: Orientation to Health Screening clinic

She will finish her orientation to PC this week. Starting 10/31, she will be in Patchogue on Mondays and Fridays.
The other days she is free for orientation.

Joyce Feldman, RN MSN

Nurse Manager, Primary Care

VAMC Northport NY 11768

631-261-4400 x 2051

cell: 631-831-5658

From: Anderson, Joanne Catherine
Sent: Wednesday, October 26, 2011 1:33 PM
To: Feldman, Joyce E.; Fasano, Joseph
Cc: Ciulla, Joseph A.
Subject: Orientation to Health Screening clinic

79 Middleville Road, Northport NY 11768

Ph: 631-261-4400 ext 4590

Mobile: 631-434-5506

Fax: 631-754-7933

Email: joannecatherine.anderson@va.gov

**MANIPULATION OF SCHEDULING FOR PRIMARY CARE CLINIC, AGENT
ORANGE CLINIC, ENDOCRINOLOGY CLINIC AND RHEUMATOLOGY CLINIC**

Audit: Northport VA appointment wait times higher than reported

<http://www.newsday.com/news/nation/audit-northport-va-appointment-wait-times-higher-than-reported-1.8390645>

June 9, 2014 by MARTIN C. EVANS / martin.evans@newsday.com

A nationwide audit released Monday by the Department of Veterans Affairs indicates that wait times for medical and psychiatric appointments at the Northport Veterans Affairs Medical Center are significantly longer than Northport's own figures would suggest, according to a Newsday analysis.

Data released Monday by the VA in Washington, D.C., said new patients seeking appointments for mental health issues at Northport wait an average of 25.23 days -- more than twice the 11.2 days reported by officials with the Veterans Affairs Medical Center in Northport.

Northport spokesman Joe Sledge said administrators were surprised by the findings and have sought input from Washington to reconcile the discrepancy.

"Our data is a little different," Sledge said.

New patients seeking specialty medical care at Northport wait an average of 39.87 days, according to the audit -- two weeks longer than the 22.75-day average wait computed by Northport officials.

To: McKenna, Edward
Subject: RE: cosigner

Thanks again Ed for your advocacy and support!

From: McKenna, Edward
Sent: Wednesday, July 13, 2011 10:27 AM
To: Fasano, Joseph
Subject: RE: cosigner

She removed your name.

From: Fasano, Joseph
Sent: Wednesday, July 13, 2011 10:19 AM
To: McKenna, Edward
Subject: RE: cosigner

Thanks.

From: McKenna, Edward
Sent: Wednesday, July 13, 2011 10:06 AM
To: Fasano, Joseph
Subject: RE: cosigner

I will speak to Joe

From: Fasano, Joseph
Sent: Wednesday, July 13, 2011 8:27 AM
To: McKenna, Edward
Subject: FW: cosigner
Importance: High

From: Fasano, Joseph
Sent: Tuesday, July 12, 2011 1:54 PM
To: Ciulla, Joseph A.
Cc: Thomesen, Richard
Subject: cosigner
Importance: High

Please be advised that Wendy Beiner is adding me as a cosigner to unnecessary clerical entries in the CPRS progress notes despite multiple attempts over the past 15 months to obtain compliance

Northport NY, 11768

Edward.McKenna@va.med.gov

631-261- 4400 ext 2771

From: Duryea, Margaret
Sent: Thursday, January 19, 2012 1:40 PM
To: Fasano, Joseph
Subject: RE: PC referral note co signer

Joe, if you would like to give me a call in the office this afternoon x 2188 before 4pm I would like to know the name of pt so I can look up exactly what was done.

Thanks

From: Fasano, Joseph
Sent: Thursday, January 19, 2012 1:06 PM
To: Ciulla, Joseph A.
Cc: McKenna, Edward; Thomesen, Richard; Walters, Richard J; Duryea, Margaret; Schramm, Carl
Subject: PC referral note co signer
Importance: High

Please be advised that Ms. Wendy Beiner (Primary Care secretary) is again inappropriately adding me as a co signer to clerical entries in CPRS progress notes despite multiple interventions by Joseph Ciulla and Ed McKenna to cease and desist with this inappropriate harassment in clear violation of VA policy and procedure regarding progress note entries. Your immediate intervention is once again requested to halt this abusive practice since it detracts from mission essential clinical applications that are reserved to communicate clinical information. Thank you in advance for your cooperation and support.

From: McKenna, Edward
Sent: Thursday, January 19, 2012 1:53 PM
To: Fasano, Joseph
Subject: RE: PC referral note co signer

Joe

I please call me on my cell I have to go to unit 31

To: IMCEAEX-_O=VA_OU=VISN+2003_cn=Recipients_cn=VHANOPCIULLJ@va.gov
CC: Edward.McKenna@va.gov; Richard.Thomesen@va.gov; Richard.Walters@va.gov;
Margaret.Duryea@va.gov; Carl.Schramm@va.gov

Date: Thu, 19 Jan 2012 13:06:26 -0500

Subject: PC referral note co signer

Please be advised that Ms. Wendy Beiner (Primary Care secretary) is again inappropriately adding me as a co signer to clerical entries in CPRS progress notes despite multiple interventions by Joseph Ciulla and Ed McKenna to cease and desist with this inappropriate harassment in clear violation of VA policy and procedure regarding progress note entries. Your immediate intervention is once again requested to halt this abusive practice since it detracts from mission essential clinical applications that are reserved to communicate clinical information. Thank you in advance for your cooperation and support.

--Forwarded Message Attachment--

From: Joseph.Fasano@va.gov

To: Edward.McKenna@va.gov

CC: IMCEAEX-_O=VA_OU=VISN+2003_cn=Recipients_cn=VHANOPCIULLJ@va.gov;
Richard.Thomesen@va.gov; Margaret.Duryea@va.gov; Richard.Walters@va.gov;
Carl.Schramm@va.gov

Date: Fri, 20 Jan 2012 08:27:10 -0500

Subject: RE: I got Wendy to remove your name. From note.

Thanks Ed – I hope that this is permanent. The greater issue, however, is that the referrals to Primary Care and Medical Herbicide (Agent Orange) clinics should follow the exact same CPRS electronic ordering process just like all other services (please see attached).

Joe

From: McKenna, Edward

Sent: Friday, January 20, 2012 8:15 AM

To: Fasano, Joseph

Subject: I got Wendy to remove your name. From note.

Joe

I got Wendy to remove your name. From note.

Edward J McKenna

Informatics Coordinator / VANOD Coordinator / Nurse Educator

Joe

I got Wendy to remove your name. From note.

Edward J McKenna

Informatics Coordinator / VANOD Coordinator / Nurse Educator

Northport VA Medical Center

79 Middleville Road

Northport NY, 11768

Edward.McKenna@va.med.gov

631-261- 4400 ext 2771

--Forwarded Message Attachment--

From: Joseph.Fasano@va.gov

To: Margaret.Duryea@va.gov

CC: Richard.Thomesen@va.gov

Date: Fri, 20 Jan 2012 11:18:15 -0500

Subject: RE: charting concerns

Thanks.

From: Duryea, Margaret

Sent: Friday, January 20, 2012 11:18 AM

To: Fasano, Joseph

Cc: Thomesen, Richard

Subject: charting concerns

Joe,

I sent a message to Joe Ciulla, Ed Mckenna and Carolyn plus I was able to talk to Joe on the phone this am.

They were already together talking about your concerns and how to correct the problem of inappropriate charting.

From: Thomesen, Richard
Sent: Wednesday, November 17, 2010 11:01 AM
To: Fasano, Joseph; Limb, Younghee J
Cc: Ciulla, Joseph A.
Subject: RE: primary care referrals

Joe (Ciulla) do you want to meet on this

From: Fasano, Joseph
Sent: Wednesday, November 17, 2010 8:37 AM
To: Limb, Younghee J
Cc: Ciulla, Joseph A.; Thomesen, Richard
Subject: FW: primary care referrals
Importance: High

From: Fasano, Joseph
Sent: Tuesday, November 16, 2010 9:27 AM
To: Mitchell, Marge
Subject: primary care referrals
Importance: High

Good morning Marge, enclosed please find memo as per our discussion. Thank you.

Joe

From: Thomesen, Richard
Sent: Friday, November 19, 2010 2:40 PM
To: Fasano, Joseph; Ciulla, Joseph A.; Mack, Edward; Murdock, Douglas; Limb, Younghee J; Tank, Mandar
Subject: FW: primary care referrals
Importance: High

Has this practice stopped?

From: Fasano, Joseph
Sent: Wednesday, November 17, 2010 8:37 AM
To: Limb, Younghee J
Cc: Ciulla, Joseph A.; Thomesen, Richard
Subject: FW: primary care referrals
Importance: High

To: V03 Directors; V03 Chief of Staff; V03 Chief Nurses
Cc: V03 Directors Secretaries; McInerney, Joan E.
Subject: consult process

Good afternoon,

Please review the attached memorandum from Mr. Schoenhard regarding consults.

Thank you,

Naronda Edwards
VISN 3 Secretary
130 West Kingsbridge Road
Bldg. 16
Bronx, NY 10468
(718) 741-4134
fax # 718-741-4141

Description: harassment related to Endocrinology referrals to discourage consults to this

service

From: Iqbal, Humaira
Sent: Friday, June 06, 2014 3:26 PM
To: McLaughlin, Timothy
Cc: redacted
Subject: FW: POOR PATIENT CARE

From: Iqbal, Humaira
Sent: Friday, June 06, 2014 3:26 PM
To: Newburger, Jennifer
Subject: POOR PATIENT CARE

Thanks for your time , as a follow up of my conversation with you , I will be stopping by your office and will be submitting poof .

Please take care of it , as this issue is a prime example of delay in care and poor patient care and I am committed to provide TIMELY ,QULITY CARE to my dear veteran patients , I consider myself as true advocate for my patients and will keep on advocating for them no matter how adverse the circumstances be !

To: McLaughlin, Timothy
Cc: redacted
Subject: for your eyes only official AFGE communique
Importance: High

Dr. Kapoor, as the AFGE local union president it has been brought to my attention that your behavior and comments directed at my Bargaining Unit Employees (BUE's) in attendance at a Medical Staff meeting on 10/15/14 were made in an angry, inflammatory, provocative, threatening, hostile and intimidating manner. The content of which seems to segue on the heels of a prior meeting whereby similar management adverse actions were taken to discourage and/or obstruct consults to Endocrinology. These heated angry statements were directed by you as the Endocrinology Service Chief to AFGE BUE's. Please clarify the following statements that were allegedly made: in response to requests to open more Endo clinic sessions weekly to increase veteran access to care you stated, "...in your dreams..." You further stated that you're, "...not responsible for patient care..." as the Endo Service Chief. It was reported that these declarations were made in a tone designed to discourage consults from Primary Care to Endo by publicly humiliating providers which seems to be harmful to veterans and a form of denial of access to care. In the wake of the many VA scandals daily reported by open media outlets particularly access to care issues these continued management actions are disturbing, a violation of the AFGE contract since AFGE was never notified of this meeting to properly represent BUE's where BUE's would be chastised and openly discredited and anathema to the Secretary's I-CARE initiatives to make the VA more "vet-centric." Please explain how this is part of the Secretary's open message regarding "sustainable accountability?" It is to my understanding that Endo has the highest number of canceled consults so in closing please clarify the following: How many clinic sessions per week does Endo offer to outpatients? Why so few sessions since many veterans are afflicted with Diabetes? What is your action plan beyond just discouraging consults to address these dire access issues that are harmful to veterans? This type of management behavior seems to be an infringement if not an outright restriction to physician practice privileges consistent with a change in work conditions. Henceforth, AFGE demands to be notified in advance of all future meetings involving AFGE BUE's.

From: McLaughlin, Timothy
Sent: Friday, October 17, 2014 4:11 PM
To: redacted; Fasano, Joseph
Subject: FW: AFGE Bargaining Unit Employees

From: McLaughlin, Timothy
Sent: Friday, October 17, 2014 4:10 PM
To: Kapoor, Anoop (chief Endocrinology)
Cc: Mack, Edward
Subject: AFGE Bargaining Unit Employees

From: McLaughlin, Timothy
Sent: Monday, October 20, 2014 10:12 AM
To: Fasano, Joseph
Subject: FW: AFGE Bargaining Unit Employees

From: Kapoor, Anoop
Sent: Monday, October 20, 2014 10:03 AM
To: McLaughlin, Timothy
Cc: Mack, Edward
Subject: RE: AFGE Bargaining Unit Employees

MR McLaughlin: All I can state is that these comments are taken out of context. The Endocrine service provides comprehensive services to all veterans in a timely fashion, despite baseless accusations made by some Pr Care Physicians who are angry at the management as they are doing quote "10 sessions of clinics per week". We have never denied access of care to any veteran, as we see them urgently, if required even when the clinic is not in session. Infact, Pr Care MD's see half the number of patients per week than their counter parts in practice and at Stony Brook University and want to shift their responsibilities to other services. You are welcome to meet with me anytime.

It is not the number of clinic sessions any specialty services provide-- it is the number of patients they see and what they do for patients and Veterans. I have a long service record at the VA (over 35 years) and have received many complimentary letters from dear Veterans. We can accommodate all the veterans in the number of sessions we have. Once we meet, I can share with you detailed information and clarifications about accusations made in your message. I have the data.

Thanks.

Anoop Kapoor, MD

Chief Endocrinology, Metabolism & Diabetes

Northport VAMC, NY

Associate Professor Of Clinical Medicine,

SUNY at Stonybrook, NY

From: McLaughlin, Timothy
Sent: Friday, October 17, 2014 4:10 PM

whole vs. some anecdotal rare instances of customer satisfaction. The PCP's are very frustrated with the caustic response of your Endo service in providing care to veterans.

*Limited access to care = harm to veterans.

*It appears perhaps that veterans are being accommodated superficially and artificially since there's a manipulation of the data and numbers to neatly fit performance measures by discouraging the consults on the front end.

In closing please address the AFGE concerns from the original draft memo sent on 10/17/2014.

From: Fasano, Joseph
Sent: Monday, October 20, 2014 10:32 AM
To: McLaughlin, Timothy
Subject: RE: AFGE Bargaining Unit Employees
Importance: High

Focus on:

*he's making disparaging remarks about your BUEs without any data, *"Infact, Pr Care MD's see half the number of patients per week than their counter parts in practice and at Stony Brook University and want to shift their responsibilities to other services"*

*the issue is about access and denial of access to care and facilitating that access to care via the PCP. This is very bad internal customer service ultimately harming the veterans since the veteran relies almost exclusively on their PCP. The veteran thus becomes a helpless pawn and victim of a broken system that cares more about their own fudged metrics than meeting veteran needs.

*challenge his false claims comparing his service to other Endo services in the VISN, the country and the private sector.

*he's blaming the BUE for his own failures, inadequacies and shortcomings.

*consider forwarding your original memo to the powers that be.

*limited access to care = harm to veterans

*of course he can accommodate all the vets since he's manipulating the data and #s to neatly fit his performance measures by discouraging the consults.

Northport VAMC, NY

Associate Professor Of Clinical Medicine,

SUNY at Stonybrook, NY

From: McLaughlin, Timothy
Sent: Friday, October 17, 2014 4:10 PM
To: Kapoor, Anoop
Cc: Mack, Edward
Subject: AFGE Bargaining Unit Employees

Please see attached.

From: McLaughlin, Timothy
Sent: Tuesday, October 21, 2014 9:49 AM
To: redacted; Fasano, Joseph
Subject: FW: AFGE Bargaining Unit Employees

From: Kapoor, Anoop
Sent: Tuesday, October 21, 2014 7:58 AM
To: McLaughlin, Timothy
Cc: Mack, Edward
Subject: RE: AFGE Bargaining Unit Employees

Mr McLaughlin: I respectfully beg to differ with all your allegations. Kindly provide specific examples of patients that I can address. I have a list –in the previous 6 months we answered all consults , including for Diabetes, in a timely manner in full compliance with VISn3 and VA-DOD guidelines.

This issue has been discussed and address several times in the past with all chiefs including Dr Mack.

Besides, I feel persecuted by your comments and would like to seek my own BUE representation.

I am not the supervisor for the primary care MD's. (or a manager to the best of my information and belief)

If you really want to help the veterans get the best primary care I strongly urge you to meet with me personally. I will be available in between my teachings to residents today(10AM) . Also,

From: McLaughlin, Timothy
Sent: Saturday, November 01, 2014 7:15 AM
To: redacted; Fasano, Joseph
Subject: FW: BN-CA-14-0440 - VHA Handbook provisions on health record documentation

???

From: Greene, Gerard [<mailto:GGreene@flra.gov>]
Sent: Friday, October 31, 2014 2:15 PM
To: McLaughlin, Timothy
Subject: [EXTERNAL] BN-CA-14-0440 - VHA Handbook provisions on health record documentation

Mr. McLaughlin,

Attached is copy of excerpts from the Sept 19, 2012, edition of the VHA Handbook 1907.01, Health Information Management and Health Records, which the VA has provided as relevant to the charge in Case No. BN-CA-14-0440 as they prescribe standards for health record documentation. This edition was in effect in June 2014, when the alleged unfair labor practices occurred. It has since been replaced by an edition dated July 22, 2014, and I have attached excerpts from that document on the same provisions for comparison purposes only.

In regard to the 2012 edition, the attachment contains the title page, the table of contents, and parts of Paragraph 26 Documentation, pp 31 – 33 and pp 43 – 44 which the VA cites as relevant.

The second attachment contains comparable excerpts from the current edition namely, the title page, the table contents and parts of Paragraph 28 Documentation, pp 36 -37 and pp 47 – 48.

After you have looked at these, please give me a call on Monday, November 3, at 617 565 5100 x 3012.

Gerard M. Greene

Dispute Resolution Specialist

FLRA Boston Region

From: Kapoor, Anoop
Sent: Monday, December 15, 2014 9:34 AM
To: redacted

AFGE LOCAL 1843 AFFILIATED WITH NEW YORK STATE AFL-CIO v»: MEDICAL CENTER NORTHPORT, NEW YORK 11768 (631) 261-4400 EXT.2187 (631) 757-9606.
AFGE

- - Dr. Kapoor October 17, 2014

Dr. Kapoor, as the AFGE local union president it has been brought to my attention that your behavior and comments directed at my Bargaining Unit Employees (BUE's) in attendance at a Medical Staff meeting on 10/15/14 were made in an angry, inflammatory, provocative, threatening, hostile and intimidating manner. The content of which seems to segue on the heels of a prior meeting whereby similar management adverse actions were taken to discourage and/or obstruct consults to Endocrinology. These heated angry statements were directed by you as the Endocrinology Service Chief to AFGE BUE's. Please clarify the following statements that were allegedly made: in response to requests to open more Endo clinic sessions weekly to increase veteran access to care you stated, " ...in your dreams ..." You further stated that you're, "...not responsible for patient care ..." as the Endo Service Chief. It was reported that these declarations were made in a tone designed to discourage consults from Primary Care to Endo by publicly humiliating providers which seems to be harmful to veterans and a form of denial of access to care. In the wake of the many VA scandals daily reported by open media outlets particularly access to care issues these continued management actions are disturbing, a violation of the AFGE contract since AFGE was never notified of this meeting to properly represent BUE's where BUE's would be chastised and openly discredited and anathema to the Secretary's I-CARE initiatives to make the VA more "vet-centric." Please explain how this is part of the Secretary's open message regarding "sustainable accountability?" It is to my understanding that Endo has the highest number of canceled consults so in closing please clarify the following: How many clinic sessions per week does Endo offer to outpatients? Why so few sessions since many veterans are afflicted with Diabetes? What is your action plan beyond just discouraging consults to address these dire access issues that are harmful to veterans? This type of management behavior seems to be an infringement if not an outright restriction to physician practice privileges consistent with a change in work conditions. Henceforth, AFGE demands to be notified in advance of all future meetings involving AFGE Local 1843 Bargaining Unit Employee's. Local 1843 President

From: Fasano, Joseph

Sent: Monday, October 20, 2014 10:32 AM

To: McLaughlin, Timothy

Subject: RE: AFGE Bargaining Unit Employees

Importance: High

Focus on:

MR McLaughlin: All I can state is that these comments are taken out of context. The Endocrine service provides comprehensive services to all veterans in a timely fashion, despite baseless accusations made by some Primary Care Physicians who are angry at the management as they are doing quote "10 sessions of clinics per week". We have never denied access of care to any veteran, as we see them urgently, if required even when the clinic is not in session. Infact, Primary Care MD's see half the number of patients per week than their counterparts in practice and at Stony Brook University and want to shift their responsibilities to other services. You are welcome to meet with me anytime.

It is not the number of clinic sessions any specialty services provide-- it is the number of patients they see and what they do for patients and Veterans. I have a long service record at the VA (over 35 years) and have received many complimentary letters from dear Veterans. We can accommodate all the veterans in the number of sessions we have. Once we meet, I can share with you detailed information and clarifications about accusations made in your message. I have the data.

Thanks.

Anoop Kapoor, MD

Chief Endocrinology, Metabolism & Diabetes

Northport VAMC, NY

Associate Professor Of Clinical Medicine,

SUNY at Stonybrook, NY

From: McLaughlin, Timothy

Sent: Monday, October 20, 2014 1:55 PM

To: Fasano, Joseph

Subject: FW: AFGE Bargaining Unit Employees

From: McLaughlin, Timothy (AFGE local president)

Sent: Monday, October 20, 2014 1:54 PM

To: Kapoor, Anoop (Endocrinology Service Chief)

Cc: Mack, Edward (Chief of Staff)

Subject: RE: AFGE Bargaining Unit Employees

Please see attached

From: Kapoor, Anoop
Sent: Tuesday, October 21, 2014 7:58 AM
To: McLaughlin, Timothy
Cc: Mack, Edward
Subject: RE: AFGE Bargaining Unit Employees

Mr McLaughlin: I respectfully beg to differ with all your allegations. Kindly provide specific examples of patients that I can address. I have a list –in the previous 6 months we answered all consults , including for Diabetes, in a timely manner in full compliance with VISn3 and VA-DOD guidelines.

This issue has been discussed and address several times in the past with all chiefs including Dr Mack.

Besides, I feel persecuted by your comments and would like to seek my own BUE representation.

I am not the supervisor for the primary care MD's. (or a manager to the best of my information and belief)

If you really want to help the veterans get the best primary care I strongly urge you to meet with me personally. I will be available in between my teachings to residents today(10AM) . Also, I would strongly recommend you to talk to other service chiefs esp. of Surgery, PM and R and & Neurology about the Pr Care Service at Northport.

With warm Regards--Anoop

My cell is 774 2815

Anoop Kapoor, MD

Chief Endocrinology, Metabolism & Diabetes

Northport VAMC, NY

Associate Professor Of Clinical Medicine,

SUNY at Stonybrook, NY

From: Fasano, Joseph
Sent: Tuesday, October 21, 2014 10:07 AM

Email: joannecatherine.anderson@va.gov

From: Sievers, Kristin

Sent: Monday, August 15, 2011 12:16 PM

To: Anderson, Joanne Catherine; Werns, Elizabeth Ann; Diaz, Scott; Brady, Eugene; Vasquez, Aida; Fasano, Joseph; VHANOP Eligibility

Subject: RE: Agent Orange

Myself and the team are available. Please let us know once you confirm this meeting.

From: Anderson, Joanne Catherine

Sent: Monday, August 15, 2011 9:12 AM

To: Werns, Elizabeth Ann; Sievers, Kristin; Diaz, Scott; Brady, Eugene; Sievers, Kristin; Vasquez, Aida; Fasano, Joseph

Subject: Agent Orange

Just wondering if we could meet to review the Agent Orange process for new veteran enrollees.

As acting Outreach Supervisor I want to ensure that my staff is adhering to any processes that are in place.

Please let me know if Tuesday 8/16 at 1pm , Bldg 200 works for all of you!

Thank you.

JoAnne Anderson RN MSN FNPC

East End Health Care Coordinator

Northport VAMC

79 Middleville Road, Northport NY 11768

Ph: 631-261-4400 ext 4590

Mobile: 631-434-5506

Fax: 631-754-7933

Email: joannecatherine.anderson@va.gov

Wendy Beiner

PCMM Coordinator

Northport NY

From: Tank, Mandar

Sent: Wednesday, April 30, 2014 11:06 AM

To: Cruise, Gerald [Northport]; Tansiongco, Shirley; Castagnino, Richard; Limsuvanrot, Lily; Sklar, Michael; VHANOP PC Primary Care Providers

Subject: RE: compile complaints

Please refrain from using personal opinions in official e-mail. It does not look professional. This SOP was made by a subcommittee made up of your peers -- if there is a issue with this bring it to your representative at the PACT steering committee (Dr. Zias, Dr. Cruise, Dr. Anyaogu, Dr. Bernas, Mike Sklar) to present the issues to the steering committee for discussion.

From: Cruise, Gerald [Northport]

Sent: Monday, April 07, 2014 2:36 PM

To: Tansiongco, Shirley; Castagnino, Richard; Limsuvanrot, Lily; Sklar, Michael; VHANOP PC Primary Care Providers

Subject: RE: compile complaints

I think this should be brought up in a provider's meeting. There seem to be numerous cases where the SOP is not being followed.

From: Tansiongco, Shirley

Sent: Monday, April 07, 2014 2:35 PM

To: Cruise, Gerald [Northport]; Castagnino, Richard; Limsuvanrot, Lily; Sklar, Michael; VHANOP PC Primary Care Providers

Subject: RE: compile complaints

I have a new patient scheduled at 3pm.

From: Cruise, Gerald [Northport]

Sent: Monday, April 07, 2014 2:34 PM

To: Tansiongco, Shirley; Castagnino, Richard; Limsuvanrot, Lily; Sklar, Michael; VHANOP PC Primary Care Providers

Subject: RE: compile complaints

New patients in the afternoon should be scheduled in the 1:00 slot.

abused nurses and even threatened to kill Bower and a hospital administrator. Bower cited medical noncompliance and violent threats as grounds for terminating care. The Fifth Circuit Court of Appeals, in New Orleans, agreed with him, ruling that doctors can refuse to treat violent or intransigent patients as long as they give proper notice so that the patient can find alternative care. Forcing doctors to treat such patients, the court said, would violate the 13th Amendment, which prohibits involuntary servitude.

<http://www.nytimes.com/2003/03/16/magazine/when-doctor-s-slam-the-door.html>

From: Sklar, Michael
Sent: Thursday, March 27, 2014 11:58 AM
To: Limsuvanrot, Lily; VHANOP PC Primary Care Providers
Subject: RE: compile complaints

Frankly, any comparison of our JOB here as compared to slavery is pretty offensive. Mike

From: Limsuvanrot, Lily
Sent: Thursday, March 27, 2014 11:10 AM
To: VHANOP PC Primary Care Providers
Subject: compile complaints

My dear fellow frogs (reference- to the frog that sits in slowly heated water is less likely to escape as water reaches boil vs. one dropped in suddenly into boiling water-which one is more likely to escape/survive?)

Obviously- most people have been having issues with the new pt scheduling- I have received an email from the Union stating that I can go down and talk to them and I have seen the emails from our supervisors stating that we should go and talk to them when there is an issue and then there's Wendy's response.

Perhaps I am optimistic in my request to see if we can meet or communicate via email to compile the complaints so that it can be presented to someone that may be able to help us? Whether that is via Union rep or our supervisors so that it can be brought up (YET AGAIN) during a meeting at least we can try. Remember Slavery was abolished in the 13th amendment....

Your fellow frog/chained to Primary care desk...Lily

POLICIES AND REGULATIONS

Separation of Duties/Continuous Readiness Information Security Program

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).

VA Policy References:

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

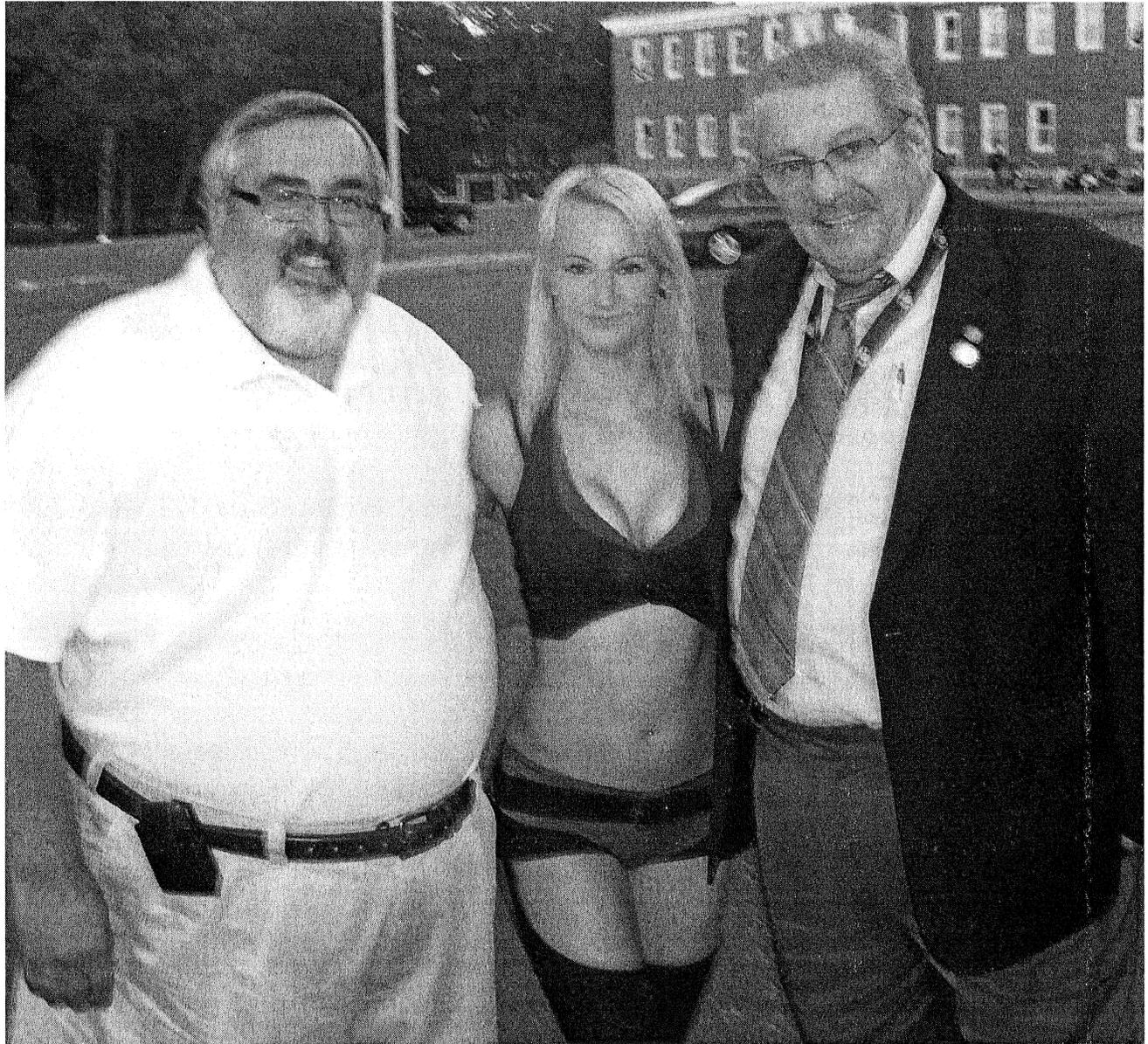
References: Business Rules Related to VistA Fee Application Software Access and SOD Control, Volume 2013; Issue 05; Oct 12, 2012.

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 Helgensen (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 CIRTIS incident record by using a CIRTIS subject category called Privacy, Security and HIPAA Issues; CRISP Fee.**

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



Plastered all over VA computer systems, e-mail, social media, etc.

A very disturbing event occurred at the Veterans Health Administration Medical Center in Northport New York on 8/29/2012 involving sexual harassment and discrimination on par with the infamous 1991 Navy Tail hook scandal. A scantily clad female stripper named Sasha Gaulin (www.firegypsy.com) was hired to perform an erotic and sexually provocative fire dance (which is listed on her website under the tab "Upcoming Shows" titled Northport VA Event Fire Performance). The idea and approval was conceived, initiated and 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 and 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 and

(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 and an unauthorized commitment since Mr. Moschitta approved the ratification which is the process whereby designated officials convert and 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. and must be for services which VA has authority to contract and/or to expend appropriated funds not in violation of public law i.e. for strippers, booze, food, blondes, etc. Mr. Moschitta as the Ratification Official was ultimately culpable and responsible. A report should've been sent to the VA Business Oversight Board at Central Office. Mr. Moschitta violated VISN 3 Network Policy #10N3-90-003, VHA Handbook 7401.7 and VA Directive 7401.7.

This also violates a United Nations treaty that the U.S. has signed called The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is the world's primary legal document on women's equality. It reflects the consensus of the international community on the specific protections and actions states are obliged to take to ensure equality between men and women. CEDAW's provisions cover all aspects of women's right to equality, including areas where women living in the U.S. still face serious challenges, such as equal pay for equal work, domestic violence, access to health care, parental leave and discrimination linked to parenting responsibilities. Perhaps more importantly, CEDAW provides a clear definition of discrimination and equality and spells out state obligations with regard to guaranteeing women's enjoyment of their human rights on an equal footing with men. Key points:

- CEDAW contains important provisions to ensure women's ability to participate in the workplace on a basis of equality.
- Through ratification, the U.S. will commit to periodically review its record on these crucial areas by the CEDAW committee of independent experts and to revise the laws, policies and programs that may impede real equality for women in the U.S. The experience of other countries has shown that the democratic dialogue ensuing from these procedural commitments is very beneficial, leading, for example, to the creation of national equality action plans, renewed and nuanced public debate on equality issues and constructive engagement from all parts of society in achieving women's equality.

(CEDAW). The "women's bill of rights" is a cornerstone of all UN Women programmes. More than 185 countries are parties to the Convention. - See more at: <http://www.unwomen.org/en/about-us/guiding-documents#sthash.78nBIPbs.dpuf>

Many are dismayed and disenfranchised that Mr. Moschitta NEVER offered any public apology for his offense to those victimized by his 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 broadcast message only instigated senior management's zeal for their mean spirited behavior

such as oxygen. The insurance costs and 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 civilian 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.

In 2012, Mr. Moschitta yelled/cursed at, threatened and forcibly detained Ms. Rosie Chatham (Chief Nursing Service) against her will whilst blocking her egress to safety, yet Mr. Moschitta was never disciplined, investigated, suspended and/or limited from accessing the agency facility.

The honeymoon period is over for “Bob” the VA Secretary. Since taking office he’s accomplished nothing beyond mere insincere disingenuous misleading feel good optimism to Congress, veterans and the American public with all of his phony empty rhetoric. His stupid comments published in Op-Ed pieces and an Oscar worthy performance on 60 Minutes fail to address the dire circumstances veterans face because of his Born on the Fourth of July VA failures only mentioning remotely past accomplishments; in other words “Bob” go back to making soap because not even P and G could make enough cleaning products and disinfectants to clean house at the VA Northport NY.

How do you expect to change the VA when you’re relying upon the same corrupt incompetent morons like Phil (Moschitta) at the SES level that caused, perpetuated and covered up the scandals? Instead of all that money going to veterans for treatments and benefits he wastes it like Monopoly play money choosing instead to frivolously use it to persecute the same folks tasked with treating veterans. That’s my money intended for my healthcare needs that your underling is wasting to screw over disabled veteran employees like me.

Most of us veterans just want to get on with our lives peacefully and quietly. Most of our disabilities are not obvious yet we suffer the cruelty inflicted upon us by the same VA system that’s supposed to help us. Instead of being a safe refuge the VA is a disgrace with many of your administrators taunting and jeering at us like some circus freaks mocking our crippling conditions in humiliating ways. Don’t think we’re too stupid to hear their disrespectful snickering remarks about our tax free disability payments, entitlements, etc. Or their condescending patronizing tone. The outright forms of discrimination and harassment shocks the conscious but it’s the subtle insidious forms that are worse to deal with. Worse yet their degenerate keystone security guards (cops) bully crippled veterans instigating them to provoke a response.

that pay the heavy price for maintaining and supporting evil hate mongers such as Messrs. Sabo, Moschitta and Sledge with their anti-disabled veteran crusade masquerading as YourVA.

I demand that your office conduct a full investigation and independent Congressional probe into this disturbing incident as an overall systemic pattern of fraud, waste, abuse, mismanagement, intimidation and discrimination promulgated and fostered by Mr. Moschitta and Mr. Sabo VISN 3 director who was very well informed who cowardly acquiesced despite desperate pleas to publicly apologize and to remove Mr. Moschitta. This has created a very toxic and hostile work environment at the VA Northport despite a 2011 GAO report slamming the VAs negligence and failure to report sexual attacks at VA facilities. This is ultimately very harmful to veterans and is a form of veteran abuse. Perhaps if the director focused more on delivering timely care to veterans instead of hiring strippers the VA would be a better place for veterans. Ms. Maria Favale associate VA Northport director should also be terminated since she was also photographed prancing around with this same stripper. This fraternity stunt gone wild objectifies & humiliates women which is conduct unbecoming of a public official reflecting poorly upon the VA and its values, the military, veterans, women, children and America. This is anathema towards the VA I-CARE initiatives and 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?

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

* 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)

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

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

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

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;

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?

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.

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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

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
Office of Inspector General**

**Audit of Alleged
Manipulation of Waiting Times in
Veterans Integrated Service Network 3**

Report No. 07-03505-129

VA Office of Inspector General
Washington, DC 20420

May 19, 2008



AN OVERSIGHT REPORT FROM SEN. TOM COBURN, M.D.

DEATH, DELAY & DISMAY AT THE VA

FRIENDLY FIRE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WSJ Blogs - Explaining the VA's Size and Scope, in Five Charts - Washington Wire

http://blogs.wsj.com/washwire/2014/05/29/explaining-the-vas-size-and-scope-in-five-charts/?mod=wsj_valettop_email

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

BY RICHARD A. OPPEL JR.

The head of an independent agency within the executive branch criticized the Department of Veterans Affairs for not digging deeper into widespread allegations. <http://nyti.ms/V5Dyb5>

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

<http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/>

WSJ.com - Treat veterans with respect, not pity

http://online.wsj.com/news/article_email/SB1000142405270230398000457957642304520721-0-1MvQjAxMTA0MDIwNTEyNDUyWj

NYTimes.com: Thank You for Being Expendable

BY COLBY BUZZELL

The scandal over the care of veterans is really an old story. <http://nyti.ms/1hoSXR5>

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

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

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

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

This must change.

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

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

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

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

[NYTimes.com: Why I Blew the Whistle on the V.A.](http://nyti.ms/1ooW4I)

BY SAM FOOTE

Veterans must get the medical care they need. <http://nyti.ms/1ooW4I>

A federal investigative agency says it is examining 67 claims of retaliation by supervisors at the VA against employees who filed whistleblower complaints. The independent Office of Special Counsel said 30 of the complaints about retaliation have passed the initial review stage and are being further investigated for corrective action and possible discipline against VA supervisors and other executives.

Monday's private report details the case of Stuart Kallio, an inpatient pharmacy technician supervisor at the Palo Alto VA Health Care System who complained to superiors about what he described as incompetent, uncaring management and inefficiencies in delivering medicine to patients.

The pharmacy service had steadily deteriorated to the point that it was "in a perpetual state of failure, failing to provide timely, quality care to veterans," Kallio said in a Feb. 26 email to supervisors. He addressed his criticisms up the chain of command as far as Elizabeth Joyce Freeman, director of the Palo Alto VA Health Care System.

On April 7, the chief of the pharmacy service sent Kallio a letter threatening to suspend him for sending emails "that contained disrespectful and inappropriate statements about your service chief" and others at the hospital, including leadership of the Palo Alto VA, the POGO report said. Kallio defended himself in a letter to superiors detailing hospital records that showed patients suffering from "missed doses, late doses, wrong doses" of medication. He was suspended for two weeks in June.

On June 20, the day before his suspension was to end, Freeman placed Kallio on paid leave pending an investigation. Another VA official ordered Kallio not to discuss the case outside the VA, the report said.

This month, Freeman became interim director of the VA's troubled Southwest Health Care Network based in Arizona. The former director there retired after reports this spring that dozens of patients have died while awaiting treatment at the Phoenix VA hospital.

POGO's Brian said an order attempting to gag Kallio, coupled with expansion of Freeman's responsibilities, "seem directly at odds" with a message Acting VA Secretary Gibson has repeated in recent weeks emphasizing the importance of whistleblower protection.

A spokesman for Gibson said Monday that the VA thanks POGO "for bringing these important claims to light." The spokesman, Drew Brookie, encouraged the group to provide relevant information to the VA's Office of Inspector General and Office of Special Counsel "so there can be appropriate follow-up."

The VA's acting inspector general, Richard Griffin, has issued a subpoena demanding that POGO turn over a list of whistleblowers who filed complaints through its website, which is operated jointly with the Iraq and Afghanistan Veterans of America. The groups have refused, saying release of the name would violate the promise they made to whistleblowers.

"The scheme was deliberately put in place to avoid the VA's own internal rules," said Foote in Phoenix. "They developed the secret waiting list," said Foote, a respected local physician.

The VA requires its hospitals to provide care to patients in a timely manner, typically within 14 to 30 days, Foote said.

According to Foote, the elaborate scheme in Phoenix involved shredding evidence to hide the long list of veterans waiting for appointments and care. Officials at the VA, Foote says, instructed their staff to not actually make doctor's appointments for veterans within the computer system.

Instead, Foote says, when a veteran comes in seeking an appointment, "they enter information into the computer and do a screen capture hard copy printout. They then do not save what was put into the computer so there's no record that you were ever here," he said.

According to Foote, the information was gathered on the secret electronic list and then the information that would show when veterans first began waiting for an appointment was actually destroyed.

"That hard copy, if you will, that has the patient demographic information is then taken and placed onto a secret electronic waiting list, and then the data that is on that paper is shredded," Foote said.

"So the only record that you have ever been there requesting care was on that secret list," he said. "And they wouldn't take you off that secret list until you had an appointment time that was less than 14 days so it would give the appearance that they were improving greatly the waiting times, when in fact they were not."

Foote estimates right now the number of veterans waiting on the "secret list" to see a primary care physician is somewhere between 1,400 and 1,600.

Doctor: It's a 'frustrated' staff

"I feel very sorry for the people who work at the Phoenix VA," said Foote. "They're all frustrated. They're all upset. They all wish they could leave 'cause they know what they're doing is wrong."

No one called from the VA with a primary care appointment. Sally says she and her father-in-law called "numerous times" in an effort to try to get an urgent appointment for him. She says the response they got was less than helpful.

"Well, you know, we have other patients that are critical as well," Sally says she was told. "It's a seven-month waiting list. And you're gonna have to have patience."

Sally says she kept calling, day after day, from late September to October. She kept up the calls through November. But then she no longer had reason to call.

Thomas Breen died on November 30. The death certificate shows that he died from Stage 4 bladder cancer. Months after the initial visit, Sally says she finally did get a call.

"They called me December 6. He's dead already."

Sally says the VA official told her, "We finally have that appointment. We have a primary for him." I said, 'Really, you're a little too late, sweetheart.' "

Sally says her father-in-law realized toward the end he was not getting the care he needed.

"At the end is when he suffered. He screamed. He cried. And that's somethin' I'd never seen him do before, was cry. Never. Never. He cried in the kitchen right here. 'Don't let me die.' "

Teddy added his father said: "Why is this happening to me? Why won't anybody help me?"

Teddy added: "They didn't do the right thing." Sally said: "No. They neglected Pop."

First hidden -- and then removed

Foote says Breen is a perfect example of a veteran who needed an urgent appointment with a primary doctor and who was instead put on the secret waiting list -- where he remained hidden.

Foote adds that when veterans waiting on the secret list die, they are simply removed.

"They could just remove you from that list, and there's no record that you ever came to the VA and presented for care. ... It's pretty sad."

Foote said that the number of dead veterans who died waiting for care is at least 40.

It stated, in part: "We have conducted robust internal reviews since these allegations surfaced and welcome the results from the Office of Inspector General's review. We take these allegations seriously."

[Read the full statement here](#)

The VA statement to CNN added: "To ensure new Veterans waiting for appointments are managed appropriately, we maintain an Electronic Wait List (EWL) in accordance with the national VHA Scheduling Directive. The ability of new and established patients to get more timely care has showed significant improvement in the last two years which is attributable to increased budget, staffing, efficiency and infrastructure."

Foote says Helman's response in the first statement is stunning, explaining the entire secret list and the reason for its existence was planned and created by top management at the Phoenix VA, specifically to avoid detection of the long wait times by veterans there.

"This was a plan that involved the Pentad, which includes the director, the associate director, the assistant director, the chief of nursing, along with the medical chief of staff -- in collaboration with the chief of H.A.S."

Washington is paying attention

The Phoenix VA's "off the books" waiting list has now gotten the attention of the U.S. House Veterans Affairs Committee in Washington, whose chairman has been investigating delays in care at veterans hospitals across the country.

According to Rep. Jeff Miller, chairman of the House Committee on Veterans' Affairs, what was happening in Phoenix is even worse than veterans dying while waiting for care.

Even as CNN was working to report this story, the Florida Republican demanded the VA preserve all records in anticipation of a congressional investigation.

In a hearing on April 9, Miller learned even the undersecretary of health for the VA wasn't being told the truth about the secret list:

"It appears as though there could be as many as 40 veterans whose deaths could be related to delays in care. Were you made aware of these unofficial lists in any part of your look back?" asked Miller.

<http://www.foxnews.com/politics/2014/05/05/probe-finds-records-falsified-at-colorado-va-facility/>

Does the VA Have More Secret, Deadly Wait Lists? - The Daily Beast

<http://thebea.st/SET4JG>

Does the VA Have More Secret, Deadly Wait Lists?

A single, secret wait list contributed to the deaths of dozens of veterans in a single VA hospital. Insiders say there could be many, many more such lists.

GOP leaders, whistle-blower join in calls to privatize veterans' care

Published May 25, 2014

FoxNews.com

Calls to move veterans' health care into the hands of private hospitals, amid allegations of widespread problems in Veterans Affairs facilities, gained momentum this weekend with House Speaker John Boehner and a Department of Veterans Affairs whistle-blower backing such a plan.

"It's absolutely a good idea," Dr. Margaret Moxness, who exposed long waits at a VA facility in West Virginia, told "Fox News Sunday." "This should have happened years ago."

Derek Bennett, of the advocacy group Iraq and Afghanistan Veterans of America, also said on the show that he supports the idea.

Boehner said Saturday that he supported the idea of "privatizing" the department two decades ago, and that he has a renewed interest amid allegations that government employees kept secret records to conceal veterans' long waits for medical treatment and that as many as 40 died while waiting.

"I still like the idea, and especially now," he told The Columbia Dispatch newspaper, while making clear that getting veterans prompt care comes before making such a sweeping change.

The Obama administration announced Saturday that more veterans will be allowed to be treated in private hospitals in situations where the federal government cannot expand care in VA facilities.

Officials also are investigating claims that VA employees have falsified appointment records to cover up delays in care. An initial review of 17 people who died while awaiting appointments in Phoenix found that none of their deaths appeared to have been caused by delays in treatment.

The Associated Press contributed to this story.

American tax dollars paying for poor service, bad outcomes in VA hospitals

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

Over the years, I've become aware of numerous stories highlighting the many instances of poor care given to our veterans within the veterans affairs (VA) hospital system. And in my opinion, the Obama administration has only made things worse within the VA hospitals, because of its lack of accountability and poor transparency over the past 5 1/2 years. Ironically, President Obama was elected on the principles of transparency and accountability. Yet, the records clearly show this has been one of the least transparent administrations ever. If not for the outcry coming from the families of veterans, journalists and congressional legislators, many of the horror stories coming out of VA hospitals may never have seen the light of day. In 2012, malpractice payments to U.S. veterans reached a 12-year high. That year, \$91.7 million was paid out to patients who were allegedly injured during the course of their medical treatment in VA hospitals, according to records obtained by [Bloomberg News](#) through a Freedom of Information Act request. And according to data obtained by the [Center for Investigative Reporting](#), in the 12 years since September 11, 2001, more than \$200 million in wrongful death payments have been made by the Department of Veterans Affairs. Of course, there are thousands of well qualified health workers in the VA health system – including doctors, nurses and technicians. However, there are also physicians and health care providers who appear to be failing to meet their professional responsibilities in providing good care. And because VA hospital workers are government employees, it is extremely difficult to discipline, monitor or fire these people. In fact, if a patient wants to sue for medical malpractice at a VA hospital, they must sue the federal government, not the individual physician or health care worker. Suing the federal government is not an easy task. Many lawyers who deal with regular malpractice are not knowledgeable about federal malpractice rules. And it gets worse: The American taxpayer is being forced to pay for the medical negligence being incurred upon our veterans by these government health professionals. VA records showed that taxpayers have spent at least \$700 million to resolve claims filed against the VA since 2001. Perhaps one of the saddest aspects of this story is that over the past 12 years, thousands of new veterans have needed to rely on health services provided by the federal government after returning from wars in Afghanistan and Iraq. Many of these patients are young. They need good outcomes. This generation of veterans has paid a hard price in fighting for our freedom – often well beyond the call of duty. Why has providing for these veterans, along with ensuring that instances of malpractice or wrongful death within the VA system are properly addressed, not been a priority for the Obama administration?

veterans to lose faith in the system," Tarantino said in a statement. "VA has a long way to go to earn back the trust and confidence of the millions of veterans shaken by this controversy."

The no-frills whistle-blower website suggests that potential users use a secure browser to submit any allegations.

"You should never use a government or contractor phone, fax or computer to contact POGO," the website reads. "POGO may be able to further research your concerns, bring public attention to any wrongdoing, and alert senior policymakers, who can bring about change. We've been a watchdog since 1981."

Shinseki and other witnesses are testifying Thursday about allegations that the Phoenix hospital maintained a secret waiting list to hide lengthy delays for sick veterans. A former clinic director says up to 40 veterans may have died while awaiting treatment at the Phoenix facility.

"If allegations about manipulation of appointment scheduling are true, they are completely unacceptable -- to veterans, to me and to our dedicated VA employees," Shinseki said.

The hearing before the Senate Veterans Affairs Committee comes as President Obama has assigned White House Deputy Chief of Staff Rob Nabors to work on a review focused on policies for patient safety rules and the scheduling of patient appointments. The move, announced late Wednesday, signals Obama's growing concern over problems at the VA. Problems similar to those that surfaced in Phoenix have since been reported in other states.

The American Legion and some congressional Republicans have called for Shinseki to resign, a move he and the White House have resisted. The VA's inspector general is investigating the Phoenix claims, and Shinseki has ordered an audit of VA facilities nationwide to see how they provide access to care.

A White House official said Shinseki requested more help with the review, leading Obama's chief of staff, Denis McDonough, to tap Nabors for the assignment. Shinseki said he welcomes Nabors' help in making sure veterans receive high-caliber health care in a timely fashion.

"While we get to the bottom of what happened in Phoenix, it's clear the VA needs to do more to ensure quality care for our veterans," Obama said in a statement.

The chairman of the Senate committee said there were "serious problems" at the VA, but lawmakers must avoid a rush to judgment.

"I don't want to see the VA system undermined," Sen. Bernie Sanders, I-Vt., told The Associated Press. "I want to see it improved. I want these problems addressed."

VA spends close to \$500M on conference room, office makeovers under Obama

The records also show hundreds of thousands in taxpayer dollars were spent on work that had little to do with health care. The hospital's 2013 gardening budget was more than \$180,000. The hospital's interior design bills over the past three years surpassed \$211,000.

The figures have raised concern, as the Phoenix VA faces accusations that up to 40 veterans may have died while waiting for critical care. VA Secretary Eric Shinseki is testifying Thursday on Capitol Hill on the scandal.

"Our nation's veterans need access to health care and doctors, not interior decorators and designers," Sen. Tom Coburn, R-Okla., said in a statement. "I'm proud of the work ordinary citizens and groups like Open the Books are doing to hold the VA accountable."

Total compensation, records show, topped \$700 million over the past three years and exceeded \$240 million in 2013 alone. Salaries make up about half the Phoenix VA's annual budget, with doctors and nurses making up just a quarter of the Phoenix VA staff. The Phoenix VA currently treats 78,000 veterans, putting the Phoenix VA's doctor-to-patient ratio at 1-to-345.

Staff salaries, according to the records, reach as high as \$357,528 for doctor executives and \$147,724 for nurse staff. The average Arizona doctor makes just over half of what the top-paid Phoenix VA doctors make, according to federal stats.

One Phoenix VA chaplain was paid more than \$100,000 in 2013.

Phoenix VA Director Sharon Helman, now on leave, received the highest bonus compensation in 2013, with \$9,345.

"Taxpayers paid out tens of millions in salaries to an elite corps of doctors and health care experts," said Adam Andrzejewski, founder of federal spending database OpenTheBooks.com. "None of them blew the whistle. These experts were either incompetent or made too fat on the taxpayer gravy train."

Records from the Phoenix VA's non-medical departments reveal that bonuses were paid out across the hospital's branches. The hospital's one Quality Assurance unit worker earned roughly \$90,000 a year for 2011 and 2012, without bonuses.

As complaints about care quality and alleged cover-ups mounted, the Phoenix VA did not expand its Quality Assurance unit beyond its one employee.

Rep. David Schweikert, R-Ariz., says his office received complaints on the Phoenix VA hospital system for over a year, and that he turned these concerns over to House investigators. However, it was not until whistle-blower and former Phoenix VA staff member Dr. Sam Foote lodged his complaints with lawmakers and the inspector general that inquiries began into deaths potentially tied to delayed treatment and some 1,600 military veteran patients waiting months for care.

<http://www.usmedicine.com/agencies/department-of-veterans-affairs/va-care-delays-implicated-in-veteran-fatalities-lawmakers-express-anger/>

VA Faces Systemwide Problems with Patient Scheduling

By Bob Brewin

May 15, 2014

The Veterans Affairs Department faces systemic problems going back more than a decade when it comes to scheduling timely medical appointments for patients, lawmakers on both sides of the aisle charged at a Senate Veterans Affairs Committee hearing today.

The hearing was spurred by news reports that the Phoenix VA Health Care System maintained a “secret” waitlist of 1,400 to 1,600 veterans forced to wait months for treatment. According to reports, 40 veterans on the list died while awaiting care. Since then VA whistleblowers have charged that personnel at VA facilities in Colorado, Florida, Texas and Wyoming have “gamed” the system and “cooked the books” to hide patient wait times.

Sen. Patty Murray, D-Wash., said the Government Accountability Office reported in 2001 that “long wait times persist” even though VA had set a goal for patients to see a clinician within 30 days. Similar critical reports by GAO or the department’s inspector general followed in 2005 and 2012. Sen. Richard Burr, R-N.C., the committee’s ranking member, said “manipulation of patient wait times” included making appointments in what he called “ghost clinics” without staff.

Sen. Johnny *Isakson*, R-Ga., cited an August 2010 internal VA memo from William Schoenhard, then undersecretary for health administrative operations, where he said “It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as ‘gaming strategies’ . . . This is not patient centered care.”

In the memo, first obtained and published by VA Watchdog.org in 2010, Schoenhard said patient schedulers had crafted dozens of strategies to manipulate the system and “additional new or modified gaming strategies may have emerged, so do not consider this list a full description of

BY RICHARD A. OPPEL JR.

The V.A.'s acting inspector general told a Senate committee that federal prosecutors are looking to determine whether criminal violations occurred at a medical center in Phoenix accused of falsifying data or creating secret waiting lists. <http://nyti.ms/1grzhIb>

Exclusive: VA Scandal Hits New Hospital

Veterans with serious heart conditions, gangrene, and even brain tumors waited months for care at the Albuquerque VA hospital, a whistleblowing doctor tells The Daily Beast.

Add Albuquerque, New Mexico's to the growing list of VA hospitals accused of keeping secret waiting lists to hide delays for veterans seeking medical care. And it may already be too late to get to the truth and find out what harm, if any, was done to veterans there—VA officials are already destroying records to cover their tracks, a whistleblower inside the hospital tells The Daily Beast.

Last month, word broke that the Department of Veterans Affairs hospital in Phoenix kept a secret waiting list that allegedly led to dozens of preventable deaths. The VA's inspector general was brought in to investigate the charges and hasn't yet found any deaths in Phoenix linked to wait times, but his investigation is ongoing. Since then five other facilities have come under fire, leading to calls for VA Secretary Eric Shinseki to step down. And now there's Albuquerque's. The evidence for this new secret list may be hard to track down, however.

“The ‘secret wait list’ for patient appointments is being either moved or was destroyed after what happened in Phoenix,” according to a doctor who works at the Albuquerque VA hospital and spoke exclusively with The Daily Beast. “Right now,” the doctor said, “there is an eight-month waiting list for patients to get ultrasounds of their hearts. Some patients have died before they got their studies. It is unknown why they died, some for cardiac reasons, some for other reasons.”

There's no proof yet that veterans died while waiting for treatment, like what allegedly happened in Phoenix. But the doctor says it's quite possible that some veterans would still be alive if they hadn't been pushed through a record-keeping trap door that buried their requests for medical care.

On March 19, 2014, for example, a patient with a deteriorating heart condition requested to see a doctor. The patient was finally seen only days ago, on May 16, when they were admitted to the hospital for decompensated heart failure. “A near miss” as the VA doctor familiar with the case described it. “He could have died before being seen.”

The Albuquerque VA did not respond to requests for comment but Ozzie Garza, director of the VA Regional Office of Public Affairs, provided this statement to The Daily Beast: “We are not

One veteran's heart troubles were serious enough that a physician requested they be seen in the next available slot on January 8, 2014. Over three months later, the patient was seen in late April.

A patient whose initial blood test on December 8, 2013 suggested he might have a brain tumor waited until April 28 2014 before he was seen again. Another veteran, diagnosed with gangrene, was referred for surgery so doctors could try to salvage his limb or amputate it if necessary—it's 36 days after he was initially supposed to see the surgeons and he's still waiting now.

A second source inside the Albuquerque VA, a medical technician, said the facility provided high quality care. But the technician acknowledged it could take a long time before veterans get in the door to receive it.

The list of patients waiting for tests grew so long in one department that the technician became disheartened and stopped checking it around Christmas of last year. "I honestly stopped doing that because it just overwhelmed me personally," the technician said.

The VA's Office of Inspector General began investigating the Albuquerque medical center last year, according *The Albuquerque Journal*, after employees there reported that appointments were being manipulated to conceal patients' actual wait times. That would mean that the inspector general, and the VA itself, knew about allegations of corruption there long before the Phoenix story broke in April.

Rep. Jeff Miller, chairman of the House Committee on Veterans' Affairs, has been beating the drum about wait times and advocating reform since before the latest crisis put the VA back in the spotlight. "VA's delays in care problem is real and has already been linked to the recent deaths of at least 23 veterans," Miller told *The Daily Beast*.

Yet it wasn't until the latest VA scandal broke nationally—months after the inspector general first investigated claims that are strikingly similar to what was later reported in Phoenix—that Albuquerque's came back into focus. The status of the initial investigation still hasn't been made public.

Last week, New Mexico Senator Tom Udall requested a new investigation into his state's VA hospitals. Udall called for the audit after his office received dozens of complaints from veterans about long wait times at the VA, and reports that Albuquerque's schedulers were forging appointment records.

New Mexico is now the seventh state where allegations have emerged about VA medical facilities cooking the books. As new incidents continue to display the same features uncovered in past cases, the details are revealing a common language of bureaucratic corruption communicated across state lines between different VA facilities.

his own feelings. The second echo of Shinseki came when McDonough said the president had sent staff to look into the VA investigation and “find out if this is a series of isolated cases or whether this is a systemic issue.”

The VA’s own investigation is ongoing and will continue to attract attention as more revelations, like the claims about the Albuquerque VA, keep coming out. It remains to be seen how leaders who are “madder than hell” will react to the evidence they find and what, if anything, they will order done about the situation.

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

A doctor tells the truth about the VA health care system

By **Dr. Marc Siegel**

Published May 27, 2014

FoxNews.com

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

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

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

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

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

counseling, surgery, hospitalization, and nursing-home care." Another less recognized but very valuable service to our country includes the provision of a fertile training ground for physicians, including the cardiologists of tomorrow.

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

To a young physician who was in love with the idea of the practice of medicine since kindergarten, it was a veritable Disney World of medical procedures, odd diagnoses, and clinical scenarios. Toward the end of my residency and then into my fellowship, my time there evolved into an intense love-hate relationship. I loved the autonomy, the opportunity to learn procedures, and the great responsibilities given to young trainees. I literally skipped out of the cath lab after my first day, having been handed the manifold for the first time and "allowed" to inject my first coronary artery. But as much as I loved my training experiences there, I loathed even more the red tape and the "because-I-said-so" rules that made no sense from the standpoint of service, such as the limited number of caths we could book on a daily basis.

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

My first serious disappointment involved the inability to get a patient with severe coronary artery disease to another facility in another state for more definitive care. I was an intern on the cardiology service. His family would call us weekly through an overhead page to ask whether we were making any headway. In turn, I made weekly phone calls to every entity I could think of to try to get that patient his procedure. My resident told me one day very matter-of-factly "not to bother," because he had died. I've never forgotten the sting of unnecessary death at the hands of inefficiency. Even as I write this note, my mind flashes back to a sea of white tile floors, shiny

"There is the phone, doctor," pointing to the lobby desk. "I suggest you pick it up and make your call, because I'm going and I'm taking these images with me."

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

After I entered private practice, I continued to occasionally wrangle with the VA system. There were stupid rules that some hospitals couldn't accept a patient "after 5 PM on a Friday." Others accepted "no transfers on the weekend," and worst of all, a patient died because there were no beds available at a VA facility. Even though the surgery program with which the VA dealt accepted this patient as a bypass candidate, I could not get the VA hospital officials to confirm they would cover the bill. The bone of contention was that if I sent him directly from my community hospital to the bypass-surgery hospital they would *not* guarantee anything. They would cover the procedure only if I transferred him to their hospital and then to the bypass-capable facility, but their hospital had no beds. After numerous phone calls on behalf of his family and myself, the best the VA would do was to say, "Well, it will probably be covered, but there is no mechanism to address this, so just let him undergo the surgery and we will address it then." After a week of wrangling, he was so disgusted that he left our facility AMA and died soon afterward, ignoring my advice just to drive to their ER. He said he'd rather die than take the chance of sticking his family with a \$70K bill, so that's exactly what he did.

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

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

It is said that the fabric of a society can be judged by how well it treats the sick and the frail. We should also judge our integrity as a nation by how well we care for those who have been willing

<http://www.foxnews.com/politics/2014/08/05/as-investigation-continues-va-has-told-congress-more-than-few-whoppers/?intcmp=latestnews>

Gingrich: Why can't VA be customer-friendly and digitally competent?

By Newt Gingrich and Ali Meshkin
updated 10:32 AM EDT, Fri May 23, 2014

(CNN) -- When the American Legion calls for Secretary of Veterans Affairs Gen. Eric Shinseki to resign, you know something is profoundly wrong.

In a statement entitled "Shinseki Must Go," Daniel Dellinger, national commander of the American Legion, said, "His record as the head of the Department of Veterans Affairs ... tells a story of bureaucratic incompetence and failed leadership."

"The disturbing reports coming from the Phoenix VA Medical Center are just one of what appears to be a pattern of scandals that have infected the entire system," Dellinger continued. "It has been more than 20 years since the American Legion has called for the resignation of a public official. It's not something we do lightly. We do this because of people who have been failed by the system."

Note the key charge: "A pattern of scandals that have infected the entire system."

This is an historic opportunity for Congress to look beyond personality and scapegoating and to take seriously the potential for a "breakout" that would replace the current breakdown with a new Veterans Administration capable of serving today's veterans with modern technologies and standards.

Congress should start by looking at institutions that handle people and information effectively, accurately and with great accountability.

The next time you make an airline or hotel reservation, ask why the Veterans Administration can't be that customer-friendly.

The next time you use your smartphone, ask why there isn't a "veterans app" that makes it easier for our veterans to keep track of their VA appointments, records, diagnoses, etc.

The next time you use an ATM machine to get cash in less than 11 seconds, ask why it can take 175 days to transfer a veteran from the Defense Department to the Veterans Administration.

In contrast to the modern systems we deal with on a daily basis, the VA bureaucracy is a disaster.

The VA doesn't need to employ criminals to lose large sums of money, however. It's capable of losing taxpayer funds all on its own through sheer incompetence.

As of February, there were 400,000 disability claims considered "backlogged." That is, they've been in processing for more than 125 days. As one veteran of combat in Afghanistan told us, "Appointments are so far back it's ridiculous and claims are even further behind. ... You can definitely get an appointment -- it's just going to be three to six months down the road."

To fix this mess, the VA created a new program, the Veterans Benefits Management System. But as the Washington Examiner describes a new report by the department's Inspector General, "Poor planning, slow software and cost overruns raise the spectre that the \$500 million electronic document system being deployed by the Department of Veterans Affairs will not break the months-long delays to process disability compensation claims."

The computer system started out flawed as millions of dollars were spent to scan files "without a clear plan," the result being that users had to "wade through hundreds of pages of electronic documents, sometimes for hours, to find the information they needed." And it still takes employees longer to create a claim in the new system, which reportedly crashes on a regular basis, than it did in the old one.

We probably should not be surprised at this money being spent to build systems that work just as poorly as the ones they replace. The VA and Defense Department have spent \$1.3 billion over the past four years attempting unsuccessfully to develop a single system for electronic health records.

This record of corruption and incompetence is nothing to be proud of, and certainly nothing to reward. In fact, it's intolerable.

Senior VA officials, however, are not only keeping their jobs but are receiving bonuses.

From 2007 to 2011, the bureaucrats in charge of the VA distributed nearly \$17 million in "extra compensation" to senior officials at a time when hundreds of thousands of veterans' claims were backlogged. At a facility in Pittsburgh, employees were given bonuses despite the fact that 29 veterans contracted Legionnaires' disease, five of whom died.

With 13 years of continuous war behind us and an aging population of veterans from previous wars, the workload at the VA is only going to increase. This is not a temporary problem, and our veterans are not just going to disappear. In fact, as time goes on, there will likely be more of a demand for care since issues such as PTSD sometimes do not manifest themselves until years later.

In a big bureaucracy, people are promised comfortable jobs; it's difficult to fire them, and they are typically not held to any real performance standards. This breeds an environment favoring incompetence and corruption.

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

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

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

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

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

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

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

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

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

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

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

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

Shinseki acknowledged that the VA destroyed the list, but he said federal law and VA policy require the agency to take such action with records that are “no longer needed for reference purposes.”

Wednesday’s hearing comes one day after Sen. Pat Toomey (D-Pa.) announced plans to introduce a bill that would allow patients at VA hospitals to sue VA employees who falsify or destroy health records. The measure would also allow the VA to fire employees who engage in such activities.

Miller has also promised legislation related to the scheduling controversy. He said last week that he would introduce a bill that would allow veterans to receive care at private-sector clinics if they wait more than 30 days for appointments. The VA would pick up the costs of treatment under that proposal.

The three VA officials scheduled to testify Wednesday are: Assistant Deputy Under Secretary for Clinical Operations Thomas Lynch; Assistant Secretary for Congressional and Legislative Affairs Joan Mooney and Congressional Relations Officer Michael Huff.

Democrats and Republicans on the committee expressed frustration with the VA for not making the officials available to testify at a hearing last week. The panel has approved a motion to subpoena the employees if they do not appear Wednesday.

MORE: House panel readies subpoena for VA officials

The VA complained that the committee provided only 15 hours notice before the hearing. But the department has agreed to have the officials testify Wednesday, according to committee staff.

The hearing begins at 7:30 p.m.

VA Audit Confirms Thousands of Veterans Await Care Appointments

WASHINGTON - A VA internal audit found that more than 57,000 new veterans have been waiting for more than 90 days or more for an appointment and that another 64,000 veterans who requested an appointment during the enrollment process during the past 10 years have not yet

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

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

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

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

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

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

The Associated Press contributed to this report

Despite scrutiny, whistleblowers say problems persist at VA

By [Heath Druzin](#)

Stars and Stripes

Published: October 6, 2014

Employees of the beleaguered Phoenix VA health care system say many of the problems that led to a nationwide scandal still plague the system five months after revelations of patients dying on secret wait lists, falsified data and a toxic culture.

"As far as the administrative culture, I haven't seen any change at all," said Phoenix VA doctor Katherine Mitchell, who was reassigned after reporting problems with emergency care at the hospital. "Certainly, my chain of command hasn't been changed."

“Secretary Shinseki began the process of removing senior leaders at the Phoenix VA Medical Center. I agree with that decision,” McDonald said. “There continue to be investigations in Phoenix, and once those are complete, we will be able to hold employees who have violated our values accountable and we will do so to the letter of the law. But from my travels to more than 30 VA sites over the last 60 days, I see that the overwhelming majority of them are doing their best every day to serve Veterans. I saw that in Phoenix and I’ve seen that across the country.”

Messages left with Helman’s attorney and at Deering’s office were not returned. A woman who answered the phone in Deering’s office said, “Well, we get a lot of criticism, so we’re kind of numb to it.”

A spokesman for the Phoenix VA said he had to run media requests through the VA’s national communication office.

The scandal broke in May, with revelations that the Phoenix VA had created a secret list in order to make patient wait times seem shorter, numbers that were tied to some officials’ bonuses. Patients were languishing for months and, according to a VA inspector general’s report, 293 died while awaiting care. Helman, Deering and other leaders have also been accused of creating a hostile workplace environment in which employees were punished for speaking out.

For Pedene, that retaliation came in the form of losing the job she loved and had served in for nearly two decades. After she spoke out about financial improprieties, she was transferred to a clerical job, yet continued to collect the salary of a senior government employee.

“It hurts my heart to talk about it,” Pedene said.

Mitchell was reassigned from her job as emergency room director after she reported serious problems at the ER, including improper triage protocol. She said many employees are still afraid to speak out or even be associated with those who have because the leadership has not changed.

“There were some employees that requested that I not send them emails and not speak with them in the hallway because they worried management might think I was getting information from them,” she said. “They didn’t trust their manager not to retaliate against them.”

As more whistleblowers have come forward, the scandal has extended far beyond Phoenix, showing a deeply troubled department and a national crisis in veterans care just as the system is absorbing hundreds of thousands of Iraq and Afghanistan veterans, some with serious injuries and long-term ailments such as post-traumatic stress disorder.

One of the most vocal critics has been Samuel Foote, the pugnacious, longtime Phoenix VA physician with glasses and long gray sideburns who has become the face of the VA whistleblower movement. In an interview with Stars and Stripes, Foote, who testified on Capitol

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

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

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

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

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

A year earlier, William Schoenhard, then a VA deputy undersecretary, described and prohibited various "gaming strategies" used nationwide to falsify wait-time data. His directive made top regional administrators responsible for ensuring the integrity of medical appointment systems, and required annual reviews.

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

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

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

Yet, as late as last December, Helman continued to paint a rosy picture for outsiders. In a letter to Sen. John McCain, R-Ariz., Helman discounted allegations of a Phoenix whistle-blower who

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

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

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

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

VA employees often recorded walk-in patients as scheduled visits to make it appear veterans were seen without any wait at all when, in fact, they showed up uninvited because they could not schedule appointments. In Phoenix, 77 percent of the walk-in patients were improperly listed as scheduled appointments. At Prescott's VA medical center, 85 percent of the clinics engaged in the deceptive practice, which apparently skewed wait-time data. It also allowed veterans to collect round-trip travel expenses for their clinic visits, rather than one-way benefits authorized for walk-in patients under the VA claims system.

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

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

Some VA facilities misrepresented wait times by incorrectly recording the date patients were seen by physicians as the desired appointment date. At the VA medical center in Prescott, administrators claimed four of five patients were seen on the date they wanted an appointment. Although auditors could not determine the data accuracy without analyzing each appointment,

BREAKING NEWS Wednesday, May 28, 2014 2:08 PM EDT

V.A. Watchdog Finds Failures in Care at Phoenix Hospital

The inspector general for the Department of Veterans Affairs reported on Wednesday that at least 1,700 veterans at the agency's medical center in Phoenix were not registered on the proper waiting list to see doctors, creating a serious condition that means veterans "continue to be at risk of being forgotten or lost" in the convoluted scheduling process.

All the while, the hospital falsely reported waiting times that suggested delays were minimal, the report said.

"While our work is not complete, we have substantiated that significant delays in access to care negatively impacted the quality of care at this medical facility," Richard J. Griffin, the acting inspector general for the department, said in an interim report on his investigation into the Phoenix medical center.

READ MORE »

http://www.nytimes.com/2014/05/29/us/va-report-confirms-improper-waiting-lists-at-phoenix-center.html?emc=edit_na_20140528

The true VA scandal is shared across the federal government

By Editorial Board.

AT THE Department of Veterans Affairs, the federal government's largest employer (the Army ranks second), only 56.9 percent of employees believe they can disclose a suspected violation of law or regulation without fear of reprisal. Even fewer — 46.1 percent — feel "a high level of respect" for their senior leaders. Fewer still — 37 percent — are satisfied with the policies and practices of those leaders.

Quite an indictment, you may say, one that confirms congressional demands for the summary firing of Eric K. Shinseki, the Cabinet secretary in charge of the VA. But the numbers for the

Read more about this issue:

[Eugene Robinson: Heads need to roll at the VA](#)

[Dana Milbank: VA Secretary Eric Shinseki needs to go](#)

[Poor care at VA hospitals cost 1,000 veterans their lives, report says - Washington Times](#)

<http://www.washingtontimes.com/news/2014/jun/24/poor-care-va-hospitals-cost-1000-veterans-their-li/>

[VA nurse alleges agency turned on her after she reported abuses | Fox News](#)

<http://www.foxnews.com/us/2014/06/25/va-nurse-alleges-agency-turned-on-her-after-reporter-patient-abuse/?intcmp=latestnews>

[VA Physicians Testify about Harsh Retaliation for Blowing Whistles on Care Issues](#)

WASHINGTON - Retaliation against physicians and other employees who voice complaints is unacceptable and will not be tolerated in the agency, a senior VA official emphasized to lawmakers at a House hearing last month. James Tuchschildt, MD, VA acting principal deputy under secretary for health, offered a broad apology following testimony by physician whistleblowers who recounted how retaliation against those who speak up about problems at VA is "alive and well." <http://www.usmedicine.com/agencies/departments-of-veterans-affairs/va-physicians-testify-about-harsh-retaliation-for-blowing-whistles-on-care-issues/>

[VA apologizes for error in patient-death report](#)

Published August 08, 2014

[Associated Press](#)

The Department of Veterans Affairs has apologized for what it called an "inadvertent" mistake that underreported the number of deaths linked to delays in cancer treatment at VA medical facilities.

"VA inadvertently caused confusion in its communication" of a review of cases involving patient harm or deaths linked to delays in treatment for gastrointestinal cancers, the agency said in a statement obtained by The Associated Press.

The VA apologized for the error and said, "There was no intent to mislead anyone with respect to the scope or findings of these reviews."

By Ellison Barber

Published August 28, 2014

Washington Free Beacon

A whistleblower who helped bring attention to extended wait times for veterans at VA hospitals says that a report by the Department of Veteran Affairs inspector general is misleading and intended to “exonerate” the VA of wrongdoing.

While the IG report found that at least 40 vets died while on electronic wait lists (EWL) and numerous veterans were forced to wait for extended periods of time for treatment, the report’s authors were “unable to conclusively assert” that electronic wait list (EWL) times caused the deaths.

The report also claims that whistleblowers did not provide them with a list of the forty patients who allegedly died while awaiting care. Instead, the investigators “conducted a broader review of 3,409 patients identified from multiple sources.”

Utilizing electronic records from the Phoenix VA, the report continues, “we were able to identify 40 patients who died while on the EWL during the period April 2013 through April 2014.”

Out of the 3,409 patients reviewed, investigators found “28 instances of clinically significant delays in care associated with access to care or patient scheduling.”

Department of Veterans Affairs training guide depicts upset veterans as Oscar the Grouch

<http://nydn.us/1zUctoa>

An 18-page slide show titled 'What to Say to Oscar the Grouch - Dealing with Veterans During Town Hall Claims Clinics' was reportedly presented last week to VA employees in preparation for upcoming town-hall events in Philadelphia.

BY MICHAEL SORRENTINO

NEW YORK DAILY NEWS

Friday, August 29, 2014, 8:10 PM

The Department of Veterans Affairs likened dissatisfied veterans to Oscar the Grouch, according to an internal training guide obtained by the [Philadelphia Inquirer](#).

Managers at more than a dozen Veterans Affairs medical facilities lied to investigators about scheduling practices and other issues, the department's inspector general said Tuesday.

Richard Griffin, the VA's acting inspector general, said his office is investigating allegations of wrongdoing at 93 VA sites across the country, including 12 reports that have been completed and submitted to the VA for review.

"The rest are very much active," Griffin told the Senate Veterans Affairs Committee on Tuesday.

Griffin's office has been investigating VA hospitals and clinics across the country following reports of widespread delays that forced veterans in need of medical care to wait months for appointments. Investigators have said efforts to cover up or hide the delays were systemic throughout the agency's network of nearly 1,000 hospitals and clinics.

While incomplete, Griffin provided the panel with a snapshot of the results so far.

Managers at 13 facilities lied to investigators about scheduling problems and other issues, he said, and officials at 42 of the 93 sites engaged in manipulation of scheduling, including 19 sites where appointments were cancelled and then rescheduled for the same day to meet on-time performance goals.

Sixteen facilities used paper waiting lists for patients instead of an electronic waiting list as required, Griffin said.

Griffin was testifying on an investigative report by his office on delays in patient care at the troubled Phoenix veterans' hospital, where a whistleblower first exposed long delays and falsified waiting lists. A resulting scandal led to the ouster of former VA Secretary Eric Shinseki last spring.

The Aug. 26 report said workers at a Phoenix VA hospital falsified waiting lists while their supervisors looked the other way or even directed it, resulting in chronic delays for veterans seeking care. The inspector general's office identified 40 patients who died while awaiting appointments in Phoenix, but the report said officials could not "conclusively assert that the absence of timely quality care caused the deaths of these veterans."

Investigators identified 28 patients who experienced "clinically significant delays in care" that negatively affected the patients, Griffin said. Of those patients, six died, he said. In addition, the report identified 17 patients who received poor care that was not related to delays or scheduling problems, Griffin said. Of those patients, 14 died.

Three high-ranking officials at the Phoenix facility have been placed on leave while they appeal a department decision to fire them.

Lawmaker, VA IG Clash Over Death Report at Hearing | Fox News

<http://www.military.com/daily-news/2014/09/18/lawmaker-va-ig-clash-over-death-report-at-hearing.html#.VBsTe7ujwb4.email>

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

1. Fire all top VA admin officials STAT!
2. Fire all executive VA officials at all of the under performing medical centers STAT!
3. Fire all executive VA officials at all medical centers involved in scandals STAT!
4. Force VA to pay back all monies that have not been spent directly on veteran care, benefits, etc. including but not limited to monies spent on under deserved bonuses, office furniture, interior decorating/design, surpluses, etc.
5. Remove as many bureaucratic layers as possible making the VA as flat a leadership system as possible.
6. The ratio of providers and clinical staff must be boosted whilst reducing the bloated bureaucracy of paper weight positions (the size of the VA workforce and budget dwarfs the US Marine Corps).
7. All new hires hence forth must be veterans.
8. A requirement for all VA executive positions and senior officials MUST be veterans.

9. All VA medical centers must be aligned with an affiliate/associate active duty counter part medical center similar to the way the Army realigned all of their medical centers with their Corps to synchronize the medical mission with the war fighting capabilities.
10. The above would reduce redundancy.
11. Every veteran that is eligible for health care at the VA must receive a voucher card that gives that veteran the option of either receiving health care at the worst place possible i.e. the VA or selecting the best health care in the private sector that their VA entitlements allow. This would