Jason Ledford's Response to OSC File NO. DI-15-3337

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1. **Improper access by Mr. Richard Velasquez:** In the report it states on page 23 "The appropriateness of documenting these actions in the whistleblower's EHR may be questionable, the VA team determined that the accesses were for the purpose of health care operations."

   Response: At no time in 2012 did I see Mr. Velasquez for treatment, or for care associated with injury/illness I have. Therefore, I believe that the 2012 access by Mr. Velasquez were unlawful and improper.

2. **Improper access by Mr. Irving Chun:** In the conclusion section on page 25 it states, "Improper access for an unauthorized reason on December 16, 2011 at 12:25 p.m.

   Response: During the course of the investigation Mr. Chun approached me and apologized for entering my electronic health record. I accepted Mr. Chun's apology and wrote a letter of support to the acting director, Tonia Bagby, and asked for any adverse action against Mr. Chun regarding this access to be immediately vacated. Mr. Chun is a man of faith a true value to the Department of Veteran's Affairs.

3. **Improper Department of Defense Accesses:** In the report on page 30 it states, "...the VA team concludes it is more likely than not that these 10 accesses occurred as the result of an automated VA client system data call and were not made by an individual.

   Response: On numerous occasions after being rebuffed by leadership, I tried to find out about the Department of Defense accesses. The Privacy Officer at Tripler Army Medical Center stated, "I ran a SPAR on our system and at no time did anyone from the DOD access your medical records. More than likely, these access could have come from a VA person credentialed to use our computers. When the system to share information between the DOD and VA was created the DOD advised the VA against creating a single or blanket system password and to use dual authentication. The VA chose to ignore the DOD's advice. Therefore, with only one level of authentication/protection with the Joint Legacy Viewer there is a major security threat to all Veteran's Electronic Health Records." I believe that the security topic of electronic medical records needs to be revisited between the DOD and the VA. If Veteran's electronic medical records are in fact at a risk then this could be a potential matter of national security.

Synopsis:

My experience during this process and reading this report has been very impactful on me. Surprisingly, three things did not come up in the written report that need to be immediately addressed. First, the number of times, either through emails, EEO complaints, or requests that I attempted to solve these issues at the lowest level possible. I can think of at least 6 different occasions in which I approached the leadership with these issues only to be rebuffed, ignored

and retaliated against on numerous occasions. Sadly, this seems to be a trend in the VA system where individuals who bring forward an issue are persecuted for doing the right thing.

Next, the Traumatic Brain Injury program that I worked in suffered by being redesigned by Dr. Richard Stack. I believe this redesign was implemented because Dr. Richard Stack attempted to "get rid of me" by reducing my schedule and limiting interactions with others. This redesign resulted in ending the quality of care that patients received and instead only focused on conducting assessments and referrals. Basically, patients were evaluated and just passed off in the system. The impact of this redesign, I believe was at heavy cost. In the first 7 months after the redesign 6 patients committed suicide. At least 4 were, or had been seen, by the polytrauma team on numerous occasions (either by neurology, myself or speech language pathology). Sadly, this aspect to my knowledge has never been investigated.

Lastly, I had to endure discrimination on broad scale. Some of this discrimination came in the form of comments from people like Mr. Craig Oswald who stated to other employees, "Jay (Ledford) is a mental health patient and you shouldn't hang out with him." Specialty Care Nurse Manager, April Seghorn, stated, "What are you off your fucking meds?" I also had my schedule reduced, and did not receive a proper performance evaluation that reflected the accomplishments of the polytrauma team. All of these things weighed heavily on me and for health reasons choose to take another job. To add insult to injury there was an attempt from Ms. Meihlani Lee, Nurse Practitioner, who was in charge of the redesign of the polytrauma team to have me escorted from the building by the police without cause on my last day at VA Pacific Islands. Sadly, I was told since I left the agency that the retaliation cannot be addressed.

Recourse: To feel whole and finally lay this matter to rest, I am only asking for three things:

1. A written apology that includes the improper accesses of my medical records and the retaliation I suffered trying to bring this matter to light.

2. Full reinstatement at my current GS grade to VA Pacific Islands Health Care System. I want to continue to serve Veterans and Hawaii is my home. Sadly, due to the stress I suffered because of the acts against me I had to relocate to California.

3. Lastly, I ask that the patient suicides over the last 4 years that occurred at VA Pacific Islands Health Care System are fully reviewed by an external team with the intent of using the data gained by these investigations to redesign the system to ensure Veterans receive the highest quality of care.

Jason Heath Ledford

Jason H. Ledford, LCSW