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The Special Counsel

February 11, 2013

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

Re: OSC File Nos. DI-11-2679 and DI-11-2798

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by whistleblowers at the Department of Veterans Affairs (VA) Boston Healthcare System (VABHS), Brockton Division (Brockton), Business Office, Brockton, Massachusetts. I received these allegations from Ms. Mary Dunn and Ms. Elizabeth Cruz. Ms. Dunn is a Patient Services Supervisor at Brockton. Ms. Cruz is a Patient Services Assistant and Ms. Dunn's subordinate. Ms. Cruz is also a veteran who receives medical treatment at Brockton. The whistleblowers alleged that three Brockton administrative employees improperly accessed Ms. Cruz's full medical records on several occasions, in violation of agency policy.

The VA report does not substantiate the whistleblowers' allegations regarding improper access to Ms. Cruz's medical records. However, the report fails to provide responsive, adequate explanations for the repeated access that did occur. The agency's conclusions are not supported by the facts, and thus, do not appear to be reasonable.

Ms. Dunn and Ms. Cruz alleged that Brockton employees Dawn Burns, Karen Ameri, and Junelle Valdez had accessed Ms. Cruz's medical records in violation of Veterans Health Administration (VHA) Handbook 1605.2, Appendix A, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information*, which limits the access of particular employees to patients' full medical records. Ms. Dunn stated that she was provided a summary of the agency's Privacy Officer's interviews with the individuals, which were conducted after Ms. Cruz first reported her concerns. According to Ms. Dunn, the Privacy Officer determined that violations had occurred. Ms. Dunn attempted to begin the disciplinary process against Ms. Burns, Ms. Ameri, and Ms. Valdez, but alleged that management failed to assist her with taking appropriate action and ordered her to discontinue her involvement.

The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The whistleblowers' allegations were referred to the Honorable Eric K. Shinseki, Secretary, VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary referred the matter to the Under Secretary for Health for review, and an Administrative Investigation Board (AIB) was convened to carry out the investigation. On January 9, 2012, the Secretary submitted the agency's report to this office. I received a supplemental report in this matter on February 10, 2012. Pursuant to 5 U.S.C. § 1213(e)(1), Ms. Dunn and Ms. Cruz were offered the opportunity to comment on the findings of the Secretary's office. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and comments to you.

I. Mandatory Guidelines

VHA Handbook 1605.2 provides mandatory guidelines for the use and disclosure of patients' individually-identifiable health information. Handbook 1605.2 explains that VHA constitutes a covered entity as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. As such, VHA is required to implement the "minimum necessary standard." This standard requires covered entities to establish policies to limit the use or disclosure of protected health information to the minimum amount necessary.

To accomplish the goal of limiting the use of protected health information, VHA divides employees into functional categories, each with an appropriate level of minimum access. VHA Handbook 1605.2, Appendix A, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information*. Individuals in administrative support positions, as outlined in Appendix A, have limited access to medical records when necessary to complete an assignment. VHA Handbook 1605.2, para. 6, specifically states that all VHA personnel must use protected health information to the minimum amount necessary to perform their specific job function, and must not access information that exceeds the limits of their functional category. Paragraph 6 further notes that, even if an employee's position allows for greater access, the employee should only access the information necessary to perform their official function. Thus, the whistleblowers alleged that Ms. Burns, Ms. Ameri, and Ms. Valdez exceeded their authority as administrative employees to view Ms. Cruz's medical records, in violation of agency policy.

II. The Whistleblowers' Allegations

Ms. Cruz disclosed that in 2009, one of her co-workers made a joke about Ms. Cruz having bi-polar disorder. Ms. Cruz became concerned that her co-workers were accessing her medical records in order to see if she was seeking psychological or psychiatric treatment. She requested a log of the individuals who viewed her medical records, but never received it. Ms. Cruz stated that in February 2011, she began to seek counseling at Brockton for concerns related to her son's

cerebral palsy, and again requested a log of those individuals who had accessed her medical records between 2009 and 2011. Ms. Cruz received a copy of this log from Jeff Parillo, VA Privacy Officer, in February 2011. According to Mr. Parillo's report, three individuals within Brockton accessed Ms. Cruz's records between 2009 and 2011 without an apparent reason to do so. These individuals were Dawn Burns, Administrator on Duty; Karen Ameri, Patient Services Assistant; and Junelle Valdez, Patient Services Assistant.

Ms. Dunn disclosed that, as Ms. Cruz's supervisor, she also received Mr. Parillo's report with notes from his interviews with these three individuals. According to this report, which Ms. Dunn provided to OSC, Ms. Burns asserted that on September 22, 2009, she may have accessed Ms. Cruz's records in order to include Ms. Cruz's diagnosis information on a daily log for the Director. Ms. Burns asserted that all patients who visited Urgent Care the previous day were included on this log. However, Mr. Parillo noted in his email that he was unable to find such a log for this date. According to Mr. Parillo, Ms. Valdez similarly stated that on December 11, 2009, she had accessed Ms. Cruz's records for the same daily log for the Director. Mr. Parillo was again unable to find a log for this date.

Ms. Cruz also stated that when she worked in Urgent Care, she was trained by Ms. Valdez. Ms. Cruz alleged that Ms. Valdez never instructed her to access patient medical records to complete the Director's log. Rather, the information for the Director's log was gleaned from a sheet retrieved from the Nurse's Station.

Ms. Ameri stated that she viewed Ms. Cruz's records on July 17, 2009, in conjunction with Ms. Cruz's visit to Urgent Care on that day. When questioned as to why she would need to access Ms. Cruz's full records to check her in to Urgent Care, Ms. Ameri speculated that she was probably printing medication reconciliation information according to policy. Ms. Cruz and Ms. Dunn both asserted that no such policy exists.

In addition, Ms. Cruz disclosed that she did not visit Urgent Care on September 22, 2009, and December 11, 2009, when Ms. Burns and Ms. Valdez accessed her records. She noted that she did visit Urgent Care on December 15, 2009, July 14, 2009, and July 29, 2010; however, there is no record of Ms. Burns, Ms. Valdez, or Ms. Ameri accessing her medical records on those dates. Ms. Cruz alleged that if Ms. Burns' and Ms. Ameri's explanations for accessing her records were accurate, there would be a record of such access, but no such access was discovered.

Ms. Dunn explained that as Privacy Officer, Mr. Parillo is not authorized to make a determination based upon his findings or to take any corrective action. Such action must be taken by the employee's supervisor, here, Ms. Dunn, who lacked prior experience with violations of this nature. Thus, she sought guidance from her chain of command, forwarding Mr. Parillo's report to her immediate supervisor, Delena Jones, as well as to Ms. Jones' supervisor Paul Segien, Assistant Chief of Patient Services, and to Mr. Segien's supervisor, Cathleen Stephens, the Chief of the Business Office. Ms. Dunn alleged that she followed up several times to request guidance on how to proceed. However, Ms. Dunn reported that Mr. Segien told her to cease and desist all emails and communication regarding the alleged violations, and no action was taken.

III. The Agency's Report

The agency did not substantiate the whistleblowers' allegation that Ms. Cruz's patient records were improperly accessed. The report provided summaries of the testimony of Ms. Burns, Administrative Officer of the Day (AOD); Ms. Ameri, Program Assistant; and Ms. Valdez, Patient Services Assistant. Ms. Burns stated that she was assigned a project requiring her to review patient records for medical care cost recovery efforts. According to the report, the subject employees' first-line supervisor, Cathleen Stephens, confirmed that she had assigned Ms. Burns this project, and Mr. Segien, her second-line supervisor stated that he had found in a prior inquiry that her actions were a part of her assigned duties. Ms. Burns further stated that she was required to print patient appointment lists and maintain a daily patient log for her supervisor. She noted that the daily log required her to access patient diagnoses.

Ms. Ameri stated in her interview that she had accessed Ms. Cruz's records while acting as the Urgent Care clerk, in order to check Ms. Cruz in for an appointment. As a part of her check-in responsibilities, Ms. Ameri stated she had also printed a patient medication list that was requested by the nursing service, a duty that was verified by the Nurse Manager of Urgent Care and Ms. Stephens as part of the investigation.

Ms. Valdez also stated that she was required to print patient appointment lists as part of her responsibilities as Urgent Care patient flow coordinator, and to print medication lists for medication reconciliation by Urgent Care staff. Ms. Valdez further suggested that nursing staff may have used her computer to look up information in patient records. Ms. Valdez also noted that on one occasion, Ms. Cruz asked her to print a list of her upcoming appointments and, on another occasion, asked her to review Ms. Cruz's podiatry progress note. However, Ms. Valdez maintained that she did not inappropriately review Ms. Cruz's records. The agency found that Ms. Valdez did not improperly access or review Ms. Cruz's records, however, she did violate agency policies by allowing Ms. Cruz to review her podiatry progress note and nursing staff to use her computer access to review patient information.

The VA report finds the testimony of Ms. Burns, Ms. Ameri, and Ms. Valdez with regard to Ms. Cruz's patient records consistent with Mr. Parrillo's prior review in February 2011. The report also states explicitly that Mr. Parrillo did not make any conclusions based on his investigation, but simply reported the findings to Ms. Dunn.

IV. The Agency's Supplemental Report

On February 29, 2012, the agency provided this office with a supplemental report in response to additional questions regarding its initial findings. In its supplemental report, the agency clarified that administrative positions such as those held by Ms. Burns, Ms. Ameri, and Ms. Valdez require access to significant patient medical information, such as medication reconciliation, completion of a daily log, and the disposition of the patient. The supplemental report also notes that additional projects may be assigned to administrative employees, including the ongoing review of Urgent Care medical progress notes and ancillary services for billing documentation, which require access to patient records.

The supplemental report also explains that during the time period in which the alleged improper access occurred, the Brockton daily log included only the evening and overnight period from 4:00 PM to 8:00 AM. As a result, Ms. Cruz would not have been included on the daily log, because she was seen during daytime hours. The facility moved to a 24-hour daily log on October 19, 2010, after the alleged breach. The supplemental report also noted that Ms. Cruz was seen in Urgent Care on three of the dates in question.

Finally, the supplemental report stated that Ms. Valdez received an official admonishment and was required to undergo privacy retraining for violating agency policies. VABHS also reassessed its policy on access to patient records of VA employees. It directed its Privacy Officer to develop a focused training for employees who access patient records, concentrating on privacy needs of employees who are also patients. VABHS also directed its Information Security Officer to conduct regular audits of records access for patients who are VA employees, in order to validate that access is for appropriate business purposes.

V. Ms. Cruz's Comments

In her comments, Ms. Cruz stated that she is very familiar with the daily log described by Ms. Burns, Ms. Ameri, and Ms. Valdez. She explained that she worked on it herself and was trained on how to input information into the log by Ms. Burns and Ms. Valdez. She noted that at no time during her training or afterward did Ms. Burns or Ms. Valdez instruct her to retrieve information from a patient's medical records. Rather, Ms. Cruz was directed to retrieve the information from the nurse's station each morning, where a handwritten log is kept of the patient's name, last four digits of his or her Social Security Number, time of check-in and check-out, and diagnosis. She stated that this information was routinely copied by administrative staff into the daily log the next day and that there is no need to retrieve the information from the patient's medical records. Ms. Cruz provided a copy of the daily log from July 14, 2009, a date that she was seen in Urgent Care. The log shows that the clerk on duty that day copied all her necessary information without accessing her medical records, and contrary to the VA report, the log shows the clerk did not need to print a medication list. Ms. Cruz noted further that she was not on any prescribed medication at the time of her July 17, 2009, Urgent Care visit, but was on medication when she visited Urgent Care on July 29, 2010, yet no access to her medical records was found for that date.

Ms. Cruz further noted that when Mr. Parrillo questioned Ms. Burns about the daily log, she provided him with a printout showing that Ms. Cruz checked into Urgent Care on December 15, 2009. Ms. Cruz explained that the printout was not, in fact, the log mentioned in the report. Moreover, the date of the log does not explain the access to Ms. Cruz's records that occurred on December 11, 2009. On that date, Ms. Cruz's records were accessed by Ms. Valdez, not Ms. Burns. Ms. Burns had accessed Ms. Cruz's records September 22, 2009, two months prior to the date of the printout provided to Mr. Parrillo. Similarly, Ms. Cruz noted that the agency's explanation that the special projects assigned to Ms. Burns were completed for the month prior does not explain the September 2009 access, as Ms. Cruz's last visit prior to that date had been in July. Further, Ms. Cruz stated that the agency's explanation for the possible discrepancies in the

dates refers to needs that never applied to her, such as ordering an ambulance or arranging a wheelchair.

Ms. Cruz described several other instances in which the dates of access to her records do not coincide with the explanations the agency provided. For example, she noted that on four dates when she did check into Urgent Care, neither Ms. Burns nor Ms. Valdez was recorded as accessing her medical records. She also pointed out that the report does not state that any of the mentioned logs were produced for review by investigators, or that individuals holding Ms. Burns' position accessed Ms. Cruz's records at any time. Ms. Cruz also stated that she had never asked Ms. Valdez to print a list of her upcoming appointments or allow Ms. Cruz to view her podiatry progress note. Ms. Cruz further asserted that she was never interviewed by the VA investigator on this matter.

VI. Ms. Dunn's Comments

In her comments, Ms. Dunn clarified that at no point was it the responsibility of Patient Services Assistants like Ms. Ameri and Ms. Valdez to print medication reconciliation lists, and that this is solely a nursing staff responsibility. She noted that if, in fact, Ms. Ameri printed medication reconciliation lists, as Ms. Ameri testified, she had done so in violation of a direct order from Ms. Dunn. Patient Services staff are not under the supervision of the Nursing staff, but rather are supervised by Ms. Dunn and the Business Office.

VII. The Special Counsel's Findings

I find the agency's conclusions in OSC File Nos. DI-11-2679 and DI-11-2798 unreasonable. The VA did not provide satisfactory explanations for the access to Ms. Cruz's records.

With regard to the incidents on September 22 and December 11, 2009, Ms. Cruz explicitly stated that she did not visit Urgent Care on those dates. In his initial investigation, Mr. Parillo stated that he was unable to find a copy of the daily log from those dates, and the agency did not contend that it had viewed the log for those days. Further, when we requested a supplemental report clarifying the access on these dates, the agency stated that on September 22, 2009, Ms. Burns accessed the records as part of the special project she was working on. In its initial report, however, the agency explained that Ms. Burns indicated that she "may" have accessed the records as part of her assignment. While Mr. Segien verified that Ms. Burns was assigned to the project, the report offers no support, other than Ms. Burns' testimony, for its finding. The agency also states that Ms. Burns may have accessed Ms. Cruz's records as part of the daily log, but provides no explanation for the fact that Ms. Cruz did not visit Urgent Care that day. At no point does the agency indicate that it obtained or reviewed the daily logs for this date or any other date of access.

With regard to the December 11, 2009, incident, the supplemental report states that Ms. Valdez accessed Ms. Cruz's records at Ms. Cruz's request, and this was supported by the testimony of management. However, in her comments Ms. Cruz asserts that she never asked

Ms. Valdez to access her records, she was never questioned about the request in the course of the agency's investigation, and she never discussed any such request with Mr. Segien because it never occurred. The supplemental report also states that on July 17, 2009, Ms. Cruz's records were accessed during Urgent Care check-in. In the initial report, the agency stated that Ms. Ameri entered the records to print a medication list as required the nursing service. However, Ms. Cruz explained that she was not on medication prior to arriving at Urgent Care, and that the access was recorded in the morning prior to her appointment. Further, Ms. Cruz noted that at a later appointment on July 29, 2010, when she was taking a prescription medication, no access was recorded for any purpose, even though according to the report it was the clerks' duty to do so. Indeed, Ms. Cruz notes that there are many occasions when she checked into Urgent Care and no access to her medical records was recorded, which contradicts the agency's assertion that such access was required for the check-in process.

Based upon the foregoing, it does not appear that the agency conducted a thorough and unbiased investigation. I believe that the findings in the agency's reports do not adequately address the factual inconsistencies recorded by Ms. Cruz and Ms. Dunn. Indeed, the reports provide shifting explanations that strain credibility. Thus the reports' conclusions are unreasonable.

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

Respectfully,

Carolyn N. Lerner

Enclosure

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[1]The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA cited Exemptions 6 and 7(C) of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) and various case law as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version as an accommodation.