THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
September 6, 2012

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File Nos. DI-12-1562, DI-12-1564, DI-12-1578, DI-12-1580

Dear Ms. Lerner:

I am responding to your letter regarding alleged violations at the Department of Veterans Affairs (VA) Western New York Healthcare System (VAWNYHCS). You asked us to determine if the alleged misconduct constituted a violation of laws, rules, or regulations.

I asked the Under Secretary for Health to review this matter and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). The investigation team consisted of personnel from the Veterans Health Administration's Privacy Compliance Assurance Office and Health Information Management Office. The investigation team reviewed the allegations and reported their findings to the Under Secretary for Health. The final report from the Under Secretary for Health is enclosed.

The investigation team substantiated most of the allegations and made seven recommendations regarding the steps needed to be taken by the VAWNYHCS and the Upstate New York Veterans Integrated Service Network (VISN) 2 Health Information Manager. The Office of General Counsel reviewed the investigation team's report and found potential violations of rules or regulations. VISN 2 and VAWNYHCS have taken immediate actions necessary to rectify the findings based on the recommendations from the investigation team. Several of those actions have been completed to date while others are ongoing. The Under Secretary for Health expects closure of all action items based on the seven recommendations to be completed by December 31, 2012. VISN 2 and VAWNYHCS' implementation of all the recommendations will be tracked by the Under Secretary for Health.

Thank you for the opportunity to respond to this issue.

Sincerely,

Eric K. Shinseki

Enclosure

PRIVACY COMPLIANCE ASSURANCE OFFICE AND HEALTH INFORMATION MANAGEMENT OFFICE

Final Report to the
Office of Special Counsel (OSC)
OSC File Numbers DI-12-1562, DI-12-1564, DI-12-1578, DI-12-1580

Records Management Practices

Department of Veterans Affairs (VA)
VA Western New York Healthcare System
Buffalo and Batavia, New York

VETERANS HEALTH ADMINISTRATION
WASHINGTON, DC

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

I. Executive Summary

The Under Secretary for Health requested that the Veterans Health Administration (VHA) Privacy Compliance Assurance (PCA) Office and the VHA Health Information Management (HIM) Office investigate complaints submitted to the Office of Special Counsel (OSC) by four whistleblowers at the Department of Veterans Affairs (VA), Western New York Healthcare System (VAWNYHCS). The complaints were submitted based on activities at the Buffalo and Batavia Health Care facility locations, both part of the VA Health Care Network Upstate New York, Veterans Integrated Service Network (VISN) 2. The whistleblowers alleged that the Health Care facilities engaged in conduct that may constitute: violations of law, rule, or regulation; gross mismanagement; and substantial and specific danger of the loss of data needed to provide Veteran services. In brief, the allegations are:

- The VAWNYHCS HIM Department failed to abide by VA regulations governing the organization and management of VA records which are stored in a Batavia, New York, warehouse; and

- The VAWNYHCS HIM Manager ordered the transfer of approximately 240 boxes containing VA medical records to the VA Records Center and Vault (RC&V) in Neosho, Missouri, despite being notified that some of the records contained in the boxes were wet and contaminated with mold.

During and prior to 2009, VISN 2 stored patient records at a VA storage facility in Canandaigua, New York, that was deemed not appropriate. After a PCA assessment, the VISN directed the facilities in VISN 2 to remove the records from the storage facility. The records were categorized into three areas by the facilities: retire directly to VA RC&V, return to the facility for review/processing, or destroy based on the Record Control Schedule. The records that were the subject of the OSC complaints were records sent back to VAWNYHCS from the Canandaigua storage location. The subsequent retirement project is the source of the allegations and includes concerns about the inventory and shipping of unfit records to VA RC&V. The Chief, HIM, and the File Room Supervisor were new to the facility from the private sector when it was determined that the records needed to be moved from the Canandaigua storage facility back to the Buffalo facility. They relied on the Records Manager at the time, who is no longer employed by the facility, the employees in the File Room, and the employees working on the retirement of these records to have the knowledge necessary to complete the retirement process.

During the interviews, it was determined that some of the personnel were not able to recall the specific timelines, events, and actions surrounding the activities and circumstances in question. This included differing accounts by some of the complainants, as well as the facility staff named in the complaint. Some of the key participants in earlier actions regarding these records are no longer in VA's employ and were potentially contributors to the state of the records as documented within this report.

II. Facility Profile

VAWNYHCS is an integrated, university-affiliated medical center providing a full continuum of medical, surgical, mental health, and long-term care services. In 1996, a full integration of the Buffalo and Batavia divisions was accomplished, establishing VAWNYHCS.

The Buffalo division is a 199-bed, general medical and surgical referral center providing comprehensive medical, surgical, mental health, and long-term care services through a full range of inpatient and outpatient programs. Opened in 1950, the Buffalo facility is the principal referral center for cardiac surgery, cardiology, and comprehensive cancer care, serving Central and Western New York and Northern Pennsylvania. In 1990, research capabilities were markedly expanded with the opening of a 38,000 square foot Research Building. The Buffalo Medical Center is academically affiliated with the State University of New York (SUNY) at Buffalo School of Medicine and Biomedical Sciences, as well as other SUNY programs in the health sciences such as: nursing, dentistry, pharmacy, physical and occupational therapy, psychology, social work, and health care administration.

The Batavia facility in Genesee County's largest city contains 112 authorized beds, providing Geriatric and Rehabilitation Medicine Services, a residential care post-traumatic stress disorder unit, and outpatient services in a renovated primary care clinic. In 1995, the New York State Veterans Home relocated to the Batavia grounds making extended care available. Outpatient services are provided in a renovated setting to include primary care, medical specialties, and a full range of mental health services.

III. Conduct of the Investigation

The Investigation Team consisted of personnel from PCA and HIM offices. The participants making up the team were the VHA Records Officer, the VHA Director of HIM, and the PCA Officer. These individuals conducted a site visit to VAWNYHCS, specifically the Buffalo and Batavia Medical Centers, from May 16-17, 2012. The team held an entrance briefing with medical center leadership, conducted a records management assessment of the health system (using the typical interview and observation methods and tools used by PCA for all VHA facilities), conducted a physical assessment of both hospitals' storage and records operations, and conducted interviews with a number of personnel pertinent to the investigation. At the conclusion of the site visit, the Investigation Team held an exit briefing with the Associate Medical Center Director.

During the site visit, the Investigation Team interviewed the following individuals to better determine the status of the health system's records management processes and practices and the circumstances surrounding the retirement of records in question:

1. The four complainants (with union representative present for two of the complainants as requested);
2. A file clerk at the Batavia VA Medical Center;
3. The VAWNYHCS Chief of HIM/Records Manager;
4. The VAWNYHCS Associate Director;
5. The My Health*e*Vet Coordinator (former VAWNYHCS File Room Supervisor);
6. The VAWNYHCS Privacy Officer;
7. Various VAWNYHCS personnel in storage and work areas during physical assessment of the facilities;
8. The VISN 2 Health Information Manager; and
9. The Supervisor Archive Specialist of VA RC&V.

In addition to the site visit to the VAWNYHCS locations, the PCA Officer and the VHA Director of HIM conducted a site visit to VA RC&V in Neosho, Missouri, May 23–24, 2012, to evaluate the records accessions in question to determine if they were properly processed for storage and whether the records were mildewed as asserted in the complaint. Joining these individuals was one of the facility employees who was also a complainant in this case. The participation in this assessment was supported by the facility in order to gain additional insight as to the status of the shipments in question.

The team requested the original accession lists developed by the employees in addition to the final accession lists created by the Chief of HIM. According to the facility leadership and complainants, the final accession lists were developed by merging the employee lists into the final accession list for each shipment. It was difficult to compare the employee lists to the final accession lists, as there were many lists and the box numbers on the employee lists were different numbers than the final lists. The complainants indicated during the interviews that this was an overtime project and management indicated the typing of a list with the patient names, Social Security Number (SSN), and box number should take approximately 1 hour per box. The Chief, HIM, indicated during the interview that a time study was conducted on one box to determine approximate duration for completion of one box, which was approximately 1 hour. However, the complainants indicated it took longer than 1 hour to accurately complete a box. On the August 2011 HIM Conference Call, it was relayed that the VA RC&V estimates to process an inventory for a box of perpetual record envelopes takes 1 to 2 hours.

The assessment at VA RC&V consisted of a comprehensive review of four accessions: accession #VHA-11-0287 consisting of 117 boxes, accession #VHA-11-0288 consisting of 227 boxes, accession #VHA-11-0090 consisting of 37 boxes, and accession #VHA-11-0241 consisting of 147 boxes. All 528 boxes (Appendix A) were opened and inspected for water damage and mold and mildew.

All of the boxes in accession #VHA-11-0288 were checked by pulling 2 to 3 records at random from each box to verify that the name and SSN matched the accession's inventory list for the box. An exception to this method was that of boxes 81 and 83, which were checked by reviewing every record in these boxes to verify that the name and SSN matched the accession's inventory list for the box.

For accession #VHA-11-0287 boxes 1-26, all of the records in each box were checked against the accession's inventory list. When inventory discrepancies were identified in boxes 25-26, it was determined that the entire accession would not need to be reviewed further for accuracy since sufficient inaccuracies were established. Only the records of random boxes (boxes 36, 39, 45, 47, 48, 50, 55, 58, 65, 67, 70, 75, 78, 80, 83, 85, 88, 90, 93, 95, 97, 98, 99, 105, 109, 110, 113, 114, 115, 117) were validated against the accession's inventory list.

For accession #VHA-11-0090, a sample of boxes, every fifth box (boxes 1, 10, 15, 20, 25, 30, 35) was checked by first and last record in the box and compared to the accession's inventory list. An additional smaller sample of boxes (boxes 5, 22, 37) was checked by reviewing all records within the boxes to determine the accuracy of the accession's inventory list.

For accession #VHA-11-0241, a sample of boxes (boxes 2, 6, 10, 14, 19, 20, 30, 35, 40, 44, 55, 60, 67, 72, 79, 80, 86, 89, 90, 95, 105, 107, 111, 114, 115, 120, 129, 132, 136, 139, 141, 144) was checked by first and last record in the box and compared to the accession's inventory list. An additional smaller sample of boxes (boxes 1, 25, 50, 75, 100, 125, 147) was checked by reviewing all records within the box to determine the accuracy of the accession's inventory list.

Any box discovered to have mildew or mold was separated from the rest of the shipment and held for shipment back to VAWNYHCS for preservation.

IV. Findings and Recommendations

Findings:

Failure to Abide by VA regulations governing the organization and management of VA Records at VAWNYHCS

- The Investigation Team substantiated that the Buffalo and Batavia sites have not been meeting many of the requirements for records management as defined by the National Archives and Records Administration (NARA).
  - Records are not maintained in on-site storage facilities that meet NARA requirements outlined in 36 CFR 1234.10 which states:
    - *(g) The facility must ensure that the roof membrane does not permit water to penetrate the roof.*

- *(i) The following standards apply to records storage shelving and racking systems:*
  - *(3) Compact mobile shelving systems (if used) must be designed to permit proper air circulation and fire protection*
- *(j) The area occupied by the records storage facility must be equipped with an anti-intrusion alarm system, or equivalent, meeting the requirements of UL 1076 (incorporated by reference, see § 1234.3), level AA, to protect against unlawful entry after hours and to monitor designated interior storage spaces. This intrusion alarm system must be monitored in accordance with UL 611, (incorporated by reference, see § 1234.3).*
- *(l) Records contaminated by hazardous materials, such as radioactive isotopes or toxins, infiltrated by insects, or exhibiting active mold growth must be stored in separate areas having separate air handling systems from other records.*
- *(m) To eliminate damage to records and/or loss of information due to insects, rodents, mold and other pests that are attracted to organic materials under specific environmental conditions, the facility must have an Integrated Pest Management program as defined in the Food Protection Act of 1996 (Section 303, Pub. L. 104-170, 110 Stat. 1512).*
  - *(1) Prevention. IPM is a preventive maintenance process that seeks to identify and eliminate potential pest access, shelter, and nourishment. It also continually monitors for pests themselves, so that small infestations do not become large ones.*

- Records are not maintained in on-site storage facilities that meet NARA requirements outlined in 36 CFR 1234.14 which states:
  - *(a) Paper-based temporary records. Paper-based temporary records must be stored under environmental conditions that prevent the active growth of mold. Exposure to moisture through leaks or condensation, relative humidities in excess of 70%, extremes of heat combined with relative humidity in excess of 55%, and poor air circulation during periods of elevated heat and relative humidity are all factors that contribute to mold growth.*
  - *(c) Paper-based permanent, unscheduled, and sample/select records must be stored in records storage space that provides 24 hour/365 days per year air conditioning (temperature, humidity, and air exchange) equivalent to that required for office space. See ANSI/ASHRAE Standard 55 (incorporated by reference, see § 1234.3), and ASHRAE Standard 62 (incorporated by reference, see § 1234.3), for specific requirements.*
- Although the facility was not aware of how or when the records were damaged, when it was determined that damaged records existed, the facility did not report the records to the VHA Records Officer or to NARA in accordance with 36 CFR 1230.14 which states:
  - *The agency must report promptly any unlawful or accidental removal, defacing, alteration, or destruction of records in the custody of that*

agency to the National Archives and Records Administration, Modern Records Programs (NWM), 8601 Adelphi Road, College Park, MD 20740-6001, phone number 301-837-1738.

- Records Manager was not aware of large numbers of records that were housed in the Medical Records File Room.
- Personnel were not aware of their records management responsibilities in accordance with 36 CFR 1222.24 which states:
  - *(b) Agencies must provide the training described in § 1220.34(f) of this subchapter and inform all employees that they are responsible and accountable for keeping accurate and complete records of their activities.*
- Although the facilities' Records Management policy was compliant, the workforce was not consistently following the policy as required in 36 CFR 1222.22 which states:
  - *(e) Document the formulation and execution of basic policies and decisions and the taking of necessary actions, including all substantive decisions and commitments reached orally (person-to-person, by telecommunications, or in conference) or electronically.*
- There was no accurate overarching records inventory for the facilities or the health system that ensures retrieve-ability of all records in accordance with 36 CFR 1222.34 which states:
  - *Agencies must implement a records maintenance program so that complete records are filed or otherwise identified and preserved, records can be readily found when needed, and permanent and temporary records are physically segregated from each other or, for electronic records, segregable.*
    - *Agency records maintenance programs must:*
      (a) Institute procedures for organizing and storing records;
      (b) Maintain electronic, audiovisual and cartographic, and microform records in accordance with 36 CFR parts 1236, 1237, and 1238 of this subchapter, respectively;
      (c) Assign responsibilities for maintenance of records in all formats within each agency component, including designation of the officials that are responsible for maintenance and disposition of electronic records and management of automated systems used for recordkeeping;
      (d) Institute reference and retrieval procedures and controls that:
      (1) Facilitate the finding, charging out, and refiling of records, including safeguards against loss during transit; and
      (2) Ensure that access to electronic records minimizes the risk of unauthorized additions, deletions, or alterations;

(e) Issue appropriate instructions to all agency employees on handling and protecting records;
(f) Maintain records and nonrecord materials separately, in accordance with § 1222.16;
(g) Maintain personal files separately from records in accordance with § 1222.20; and
(h) Comply with 36 CFR parts 1232 and 1234 of this subchapter when storing records in a records facility.

- Records are not dispositioned in accordance with VHA Record Control Schedule 10-1.
- Vital records were not maintained in accordance with VA and VHA policy addressed in VA Handbook 6300.2, VA Handbook 6300.2/1, VHA Directive 6300, and NARA requirements outlined in 36 CFR 1223.14. Title 36 CFR 1223.14 states:
  - *To achieve compliance with this section, an agency's vital records program must contain all elements listed in FCD 1, Annex I (incorporated by reference, see § 1223.4). In carrying out a vital records program, agencies must:*
    (a) Specify agency staff responsibilities;
    (b) Appropriately inform all staff about vital records;
    (c) Ensure that the designation of vital records is current and complete; and
    (d) Ensure that vital records are adequately protected, accessible, and immediately usable.
- PCA records management assessment conducted during the interview showed an overall records management score of 2.6 for VAWNYHCS. Detailed component scores are demonstrated in Appendix B.

- The Investigation Team substantiated that various records are stored in a sub-standard storage warehouse in the Batavia location with no inventories of the records and with some of these records showing evidence of water damage to the boxes.
- The Investigation Team substantiated that Veteran records found in some boxes were not documented on the accession inventory. This was found to be the case for accessions #VHA-11-0288, #VHA-11-0241, #VHA-11-0090 and #VHA-11-0287. A random review of the employee inventory lists against the final accession inventory lists also reflected that the Veteran records found in some boxes were missing from the employee inventory lists.
- The Investigation Team substantiated that Veteran records contained on the accession inventory lists were missing from the box. This was found to be the case for accessions #VHA-11-0241 and #VHA-11-0287. A random review of the employee inventory lists also reflected that the Veteran names were missing from the boxes.
- The Investigation Team substantiated that large numbers of SSNs were not properly attributed to the correct Veteran name on the accession inventories. This was found to be the case for accession #VHA-11-0288 (boxes 74, 180, 181, 187, and 188). A random review of the employee inventory lists for boxes 74, 181, and 187 matched

the final accession inventory lists.

- The Investigation Team substantiated that there were a number of typographical errors in the inventory lists where the Veteran name or SSN was not correct compared to the data within the file. This was found to be the case for all four accessions evaluated in this investigation. This was also found to be the case with both the individual inventories developed by the employees working on the retirement project as well as in the final inventory lists.
- The Investigation Team substantiated that in one accession (#VHA-11-0287) the names on the inventory lists did not correspond to the records in the boxes (boxes 25 and 26). A review of the employee inventory lists matched the final accession inventory lists.

Transfer of approximately 240 boxes containing VA medical records to VA RC&V in Neosho, Missouri, despite being notified that some of the records contained in the boxes were wet and contaminated with mold

- The Investigation Team substantiated that the VAWNYHCS HIM Manager authorized the transfer of 227 boxes of records to VA RC&V, of which five boxes were discovered to be damaged by water and mildew.
    - Two (boxes 76 and 78) of the five boxes from accession #VHA-11-0288 were discovered by VA RC&V staff when processing a recall for the Buffalo facility that was submitted on October 4, 2011. VA RC&V returned the two boxes to the Buffalo facility on October 6, 2011.
    - Three additional boxes (boxes 74, 81, 83) from accession #VHA-11-0288 were found to contain mildew discovered by PCA and VHA HIM when conducting a review of accessions #VHA-11-0287, #VHA-11-0288, #VHA-11-0090, and #VHA-11-0241 at VA RC&V on May 23-24, 2012.
- The Investigation Team substantiated that the facility Records Manager did not inform the VHA Records Officer of the five damaged boxes which resulted in NARA not being properly notified in accordance with 36 CFR 1230.14 and VA Handbook 6300.1 "Records Management Procedures." VA Handbook 6300.1 directs any unlawful or accidental destruction, defacing, alteration, or removal of VA records must be reported to the Director, Enterprise Records Service (Records Management Service as indicated on the Records Management Frequently Asked Questions document), who must notify NARA.

Recommendations:

The Healthcare System should:

1. Develop a strategic plan for the creation of an effective records management program that allows the facility to properly create, maintain, and dispose of records in accordance with VHA Directive 6300, VA Directive 6300, and 36 CFR 1222.3.
2. Complete and enforce its policies and procedures for records management functions in accordance with VHA Directive 6300, VA Directive 6300, and 36 CFR 1222.22.
3. Process the boxes of health record documents in the Buffalo File Room and the

Batavia storage warehouse to determine if they need filed/scanned into Veteran health records or disposition in accordance with the Record Control Schedule.

4. Evaluate and modify all on-site storage locations to ensure that all applicable NARA requirements outlined in 36 CFR 1234 are met for on-site storage facilities, including but not limited to, the Buffalo File Room and the Batavia on-site storage location.
5. Recall and validate the accession lists against the records in the boxes for all VAWNYHCS accessions from VA RC&V that have the potential to be inventoried incorrectly including the following accessions at a minimum: #VHA-11-0287, #VHA-11-0288, #VHA-11-0090, #VHA-11-0241, and any other records that were originally housed in the Canandaigua storage facility. Any accession inventory lists found to be inaccurate should be updated.

The VISN 2 Health Information Manager should:

1. Monitor the progress of VAWNYHCS's implementation of the strategic plan to ensure its completion in a timely manner.
2. Evaluate other facilities in the Network who had stored records in the Canandaigua location to ensure that their records management actions are consistent with VHA Directive 6300, VA Directive 6300, and 36 CFR 1234.

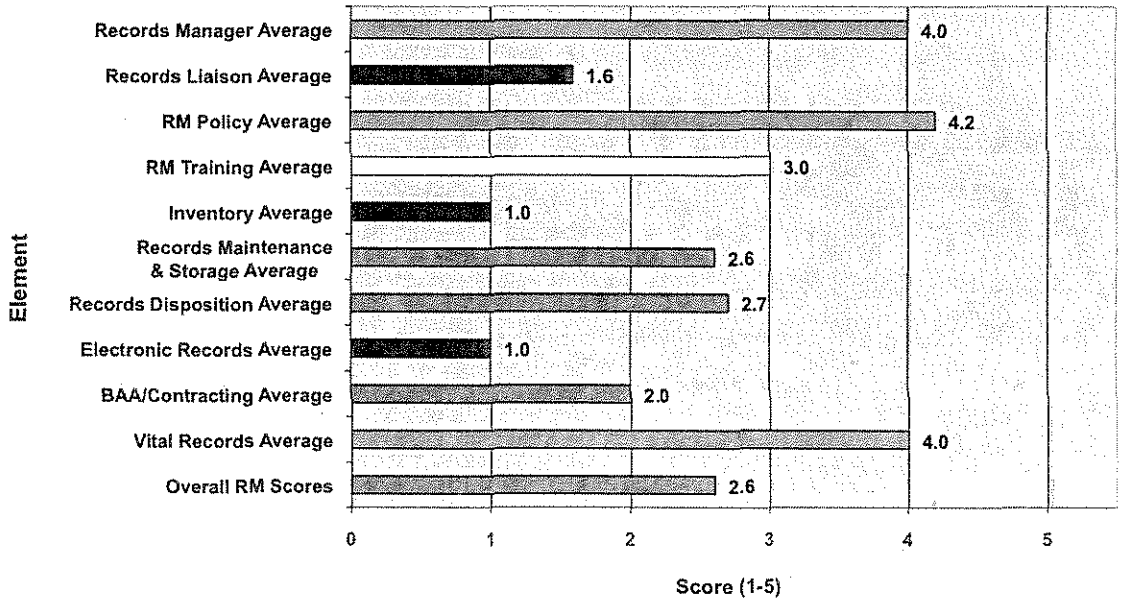
V. Summary Statement

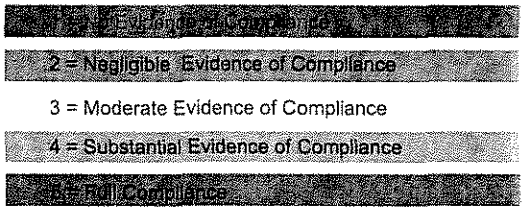
The Investigation Team substantiated the majority of the whistleblower's allegations and agrees that these are significant issues that must be corrected. The investigation shows that there is some existence of a records management program, and VAWNYHCS has begun to implement a number of practices that will strengthen the management of Federal Records in this health care system. However, to date, these efforts fall short of ensuring that Veterans' records can be consistently found and that the records are maintained in good condition. The Investigation Team was not able to substantiate allegations that gross mismanagement of the Records Management Program at VAWNYHCS was intentional. There was a lack of proper attention to the Records Management Program based on the number of issues identified, such as the storage of records at the Canandaigua facility, the lack of training of staff that were new to the facility and the project, and the failure to follow policies contained in VHA Directive 6300, VA Directive 6300, and 36 CFR concerning the Records Management Program at VAWNYHCS.

Appendix A

Accession Number	Total # of Boxes	# of Boxes Randomly Checked	# of Boxes Randomly Checked with Issues Identified
VHA-11-0090	37	10	3
VHA-11-0241	147	37	7
VHA-11-0287	117	56	6
VHA-11-0288	227	227	34

PCA Records Management Assessment:
VAWNYHCS Records Management Scores by Program Component





Score Category Descriptions

Records Manager Average: This category measures how well the facility has defined and developed the role of the Records Manager. The primary factors affecting the score include: (1) the level of experience of the Records Manager, (2) whether staff know who the Records Manager is and what he or she does, and (3) whether the Records Manager has a significant role in the facility's operations.

Records Liaison Average: A Records Liaison is the Records Management expert within a specific service or department. This category measures whether the facility has named enough Records Liaisons to support its records management needs. The primary factors affecting the score are: (1) the percentage of services with a designated Records Liaison, (2) how visible Records Liaisons are to service/department staff, (3) whether Records Liaisons provide effective assistance to service/department staff, and (4) whether Records Liaisons have done a full inventory of the records within each service or department.

RM Policy Average: This category shows how much Records Management guidance the facility provides its workforce. The main factors affecting the score are: (1) whether the facility has written records management policies and procedures, (2) whether the policies cover all Federal requirements, and (3) whether facility employees are aware of their records management responsibilities.

RM Training Average: This category measures how well the facility has trained its workforce on Federal Records Management requirements. The score emphasizes whether the Records Manager and Records Liaisons are prepared to act as subject matter experts for records management.

Inventory Average: A complete, current records inventory may be the most important aspect of an effective records management program. This category measures the quality of the facility's records inventory process. The main factors are: (1) whether the facility has created a complete records inventory and (2) whether there is a process for updating the records inventory.

Records Maintenance & Storage Average: This category measures the quality of the facility's record storage locations and practices. The score shows whether the storage locations meet the requirements for Federal records. These standards address structural, environmental, property, and life-safety considerations. On-site, off-site, and commercial storage locations are all included in this score.

Records Disposition Average: The score for this category shows whether the facility retains and disposes of records as required by Federal regulations. The regulations that apply to most VHA facilities are VHA Records Control Schedule 10-1 and the General Records Schedule.

Electronic Records Average: This category measures how well the facility has included electronic records into its overall records management program. The score includes: (1) whether the facility has completed an electronic records inventory, (2) whether the facility is storing them appropriately, and (3) how the facility preserves the electronic records of departing employees.

BAA/Contracting Average: This score measures how well the facility protects Federal records when a contract for services requires that the contractor has some level of

physical control over them. In order to earn a high score, the facility must: (1) include records management language in contractual documents and Business Associate Agreements, (2) educate members of the staff on records management requirements that apply to purchased services, and (3) monitor contractors/vendors to ensure they are complying with Federal records management requirements.

Vital Records Average: This category reflects what the facility has done to ensure it will have access to mission-critical information in the event of a disaster (i.e., Has the facility identified its vital records, and has it taken adequate steps to protect them from catastrophic loss?).

Overall RM Scores: This is a weighted average of all the scores for the categories described above. It reflects the overall quality of the facility's records management program.