U.S. OFFICE OF SPECIAL COUNSEL
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June 15, 2017

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

Re: OSC File No. DI-14-0062

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding the Department of Veterans Affairs (VA) reports based on disclosures of wrongdoing at the Northport VA Medical Center (Northport VAMC), Northport, New York. I reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the investigation, whistleblower comments, and my findings.[1]

The whistleblower, Dr. Linda Honkanen, a VA physician, disclosed that agency employees improperly and repeatedly accessed her medical records. Dr. Honkanen consented to the release of her name. OSC referred her allegations to former Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). On March 28, 2014, former VA Chief of Staff Jose D. Riojas submitted the VA report to OSC based on an investigation conducted by the VA's Office of the Medical Inspector (OMI). OSC requested additional information from the VA, and on September 30, 2014, the VA submitted a supplemental report to OSC. On February 6, 2015, Dr. Honkanen provided comments to the reports pursuant to 5 U.S.C. § 1213(e)(l). OSC requested additional information, and on August 6 and 26, 2015, the VA submitted a second and a third supplemental report. On December 2, 2015, Dr. Honkanen provided comments to the supplemental reports.

The following is a summary of the underlying matter. In January 2012, Dr. Honkanen reported to VA officials sexual harassment by a patient at the Northport VAMC. She also

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[1] 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) and (g). 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)(l).

filed an Equal Employment Opportunity Commission (EEOC) complaint regarding the matter. She subsequently received her Sensitive Patient Access Report and found that a number of Northport VAMC employees accessed her electronic health record (EHR) shortly after she filed the sexual harassment incident reports. She identified 28 instances of improper access of her EHR, including twice by her supervisor, the associate chief of staff for Primary Care (ASOCPC), and six times by the Occupational Health Clinic (OHC) director. Many of the other employees accessing her EHR were administrative personnel who appeared to have no reason for accessing the records.

The VA substantiated Dr. Honkanen's allegation and found that her medical records were wrongfully accessed in six of the 28 alleged breaches, including one by the ACOSPC and two by the OHC director. The VA determined that these breaches violated the Privacy Act of 1974, 5 U.S.C. § 552a, and the HIPAA Privacy Rule, 45 CFR §§ 164.400-164.414. OMI found the remaining accesses proper, because they were in relation to Dr. Honkanen's January 30, 2012 appointment with the OHC director, who recommended a consultation with outpatient psychiatry. Although the consultation request was ultimately discontinued because Dr. Honkanen is not a veteran, it still resulted in numerous view alerts, which account for many of the accesses OMI deemed proper. In addition, although OMI found the ACOSPC's access to co-sign the OHC director's note from January 30, 2012 to be proper, OMI questioned the advisability of the ACOSPC serving as the collaborating physician because of his supervisory relationship with Dr. Honkanen.

As a result of the investigation, the VA took disciplinary action against those employees who had inappropriately accessed the whistleblower's medical records and were still employed at the facility. The ACOSPC received a letter of reprimand and the OHC director, a radiology medical support assistant, a dental program assistant, and an ambulatory care medical support assistant received written counseling. The VA reported the substantiated violations to the agency's Privacy and Security Events Tracking System (PSETS) pursuant to VA Breach Policy, VA Handbook 6500.2, Management of Security and Privacy Incidents. The VA's Incident Resolution Team (IRT) reviewed the PSETS report and the medical center director sent a letter to Dr. Honkanen informing her of the results of the investigation.

The VA retrained OHC employees on the scope of their responsibilities and limited authority to access an employee's EHR and conducted several training sessions with all Northport VAMC employees to reinforce privacy requirements for accessing medical records. In addition, the VA implemented new and revised policies to provide additional guidance on employee medical record documentation and disclosures in relation to employees seeking occupational health services.

The agency reviewed its process for granting and terminating access to Northport VAMC electronic health records, updated the process in September 2014, and made modifications to its standard operating procedures (SOP). Northport VAMC leaders have implemented a process for deactivating computer access for staff whose training has expired. The VA also instituted a SOP identifying an alternate physician to serve as the collaborating

physician for OHC appointments in the event that one of the ACOSPC's employees seeks service.

In her comments, Dr. Honkanen disagreed with the VA's finding that certain instances of access to her medical records were permissible. In particular, she maintained that OMI's justification in this regard was flawed and questioned the view alert notification system. Dr. Honkanen also expressed concern that her medical records have been accessed an additional 14 times by nine employees since OSC referred the allegation for investigation.

As a result, OSC requested further information from the VA addressing these concerns. In its supplemental report, the VA confirmed that 11 out of the 14 accesses into her records occurred as a result of and during OMI's investigation. The remaining three were impermissible, but appeared to be inadvertent on the part of the employees. The VA took disciplinary action against the medical support assistant and utilization review nurse who improperly accessed Dr. Honkanen's EHR.

I have reviewed the original disclosures, the agency reports and the whistleblower comments. Based on that review, I have determined that the reports meet all statutory requirements and the findings of the agency appear reasonable. As a result of Dr. Honkanen's disclosures, the VA has taken a number of actions to ensure that its employees do not violate other employees' privacy rights. I am satisfied with the OMI investigation, the resulting changes implemented by the agency, and the disciplinary action taken by the VA against the employees who engaged in misconduct. However, I note that I have received similar allegations from other Northport VAMC employees. I still await reports from the Secretary of the VA for those four additional disclosures regarding improper accessing of employee health records at the Northport VAMC.[2]

As required by 5 U.S.C. §1213(e)(3), I have sent unredacted copies of the agency reports and the whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of the reports in our public file, which is available online. OSC has now closed this file.

Respectfully,

Adam Miles
Acting Special Counsel

Enclosures

[2] *See* OSC File Nos. DI-17-1124, DI-17-0483, DI-16-5652, and DI-16-4805.