DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

February 9, 2016

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

RE: OSC File Nos. DI-15-1267 & DI-15-2012

Dear Ms. Lerner:

I am responding to your request for supplemental information related to our August 10, 2015, report on the Phoenix Veterans Affairs Healthcare System in Phoenix, Arizona (hereafter, the Medical Center). Your request poses 20 questions covering both: 1) various aspects of the Medical Center's actions taken in response to recommendations included in the original August 2015 report; and 2) the results of the Department's additional investigation into the accessing of a whistleblower's electronic health record by certain staff of the Medical Center.

The enclosed supplemental report replies to the 20 questions and makes no additional recommendations to the Medical Center.

If you have any other questions, I would be pleased to address them. Thank you for the opportunity to respond.

Sincerely,

David J. Shulkin, M.D.

Enclosure

VA Supplemental Report
Phoenix VA Medical Center
OSC File Nos. DI-15-1267 and DI-15-2012
TRIM 2016-D-97

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Mental Health (MH) and Social Work (SW) Services of the Phoenix VA Healthcare System, (hereafter, PVAHCS) located in Phoenix, Arizona. [redacted] a rehabilitation counselor and [redacted] a substance abuse addiction counselor, both of whom consented to the release of their names, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to PVAHCS on March 16–19 and issued its report on August 10, 2015.

On November 23, 2015, OSC posed 20 follow-up questions (here in italics and listed as A through T) to VA. This supplementary report addresses those questions.

A. *Following the date of the OMI report, [redacted] learned that his electronic health records (EHR) were again improperly accessed on multiple occasions. Attached is the Sensitive Patient Access Report (SPAR) report that [redacted] requested on August 12, 2015. In the report, there are a number of individuals whose access [redacted] cannot explain. These individuals are: [redacted] and [redacted] We request that OMI investigate these potential breaches and determine whether they were authorized. If the accesses were not authorized, please explain what steps have been taken by Phoenix VA Healthcare Center (PVACHS) to address them.*

The VHA Privacy Office has investigated the accesses by the above individuals and determined them all to be authorized and permissible. Additional information related to this issue is provided below in responses to items Q, R, and S.

B. *On page iii of the OMI report, OMI recommends PVAHCS "re-evaluate the time allotted for suicide prevention training during new employee orientation to ensure the desired impact is achieved." Since transmittal of the report, have any changes been proposed or implemented regarding suicide prevention training?*

Effective August 24, 2015, PVAHCS has increased the amount of time allotted for suicide prevention training during new employee orientation from 15 minutes to 45 minutes.

C. *On page iii, OMI recommends PVACHS "assess clinician's suicide risk assessments. Since VA submitted the report to OSC, has a means for assessing a*

clinician's suicide risk assessments been developed? Has it been implemented? What have been the findings?

The PVAHCS has developed a process to assess professional competence for completing suicide risk assessments; this process is now included in the clinician's Ongoing Professional Practice Evaluation (OPPE) conducted every 6 months. Review of the documentation completed by psychiatrists from April through September 2015 was completed in December 2015, and the results are still pending. The results of the review of suicide risk assessment documentation completed by Social Workers in that same period are also pending.

D. *On page iii, OMI found that PVAHCS was previously not in compliance with the policy provisions requiring 1:1 observation of potentially suicidal patients, but noted that prior to OMI's investigation, the Medical Center had changed their practices to ensure one trained observer per patient. Is this new practice still in use?*

This practice is still in place. Staff members from the Quality Management Department conduct random observations to ensure staff compliance with this practice. Thus far, no incidents of noncompliance have been found.

E. *On page iv, OMI recommends PVACHS revise the local policy to reflect current practices. Has this revision been made?*

The policy has been revised, and staff training is in progress.

F. *On page iii, OMI found that the Medical Center did not adequately monitor ED [Emergency Department] patients with suicidal ideations, but leadership had recognized this issue prior to OMI's investigation and redesigned the physical space and their practices to reduce elopement of patients. Has the redesign (described on page 9) been implemented? Have there been any elopements since the report was submitted?*

The changes described on page 9 of the report have been completed: the observation rooms for suicidal patients are now in one area toward the rear of the ED, away from exits and the disturbances of traffic. Both patient rooms and restrooms have been modified by installing one-way door locks and removing any ligature risks and sharps containers. Patients now dress in hospital gowns or pajamas instead of their own clothing, and each suicidal patient has a 1:1 observer. The exit door has been fitted with a time-delay opening mechanism.

According to the VA National Center for Patient Safety (NCPS), elopement is defined as a patient who is aware that he/she is not permitted to leave, but does so with intent.[1] Patients are not permitted to leave if they are considered to be "at risk" for numerous reasons, including being a danger to themselves or others. Patients who are not

[1] https://psnet.ahrq.gov/webmm.

considered "at risk," have the right to accept or refuse any medical care or procedures recommended for them, and are free to leave the facility at will.[2]

[redacted] provided a list of seven police reports of alleged elopements from the PVACHS since March 2015. VA's review of this list concluded that only two of the cases were of Veterans in the ED. These two patients presented to the ED for alcohol detoxification and left after declining treatment. There have been no elopements of Veterans from the ED to date. Report number 2015-19-1900-8686 on the list did not have a corresponding report; therefore, VA was unable to evaluate the situation. The remaining four reports were not of ED patients. VA reviewed the six reports with details on the list and found:

- 2015-03-02-0892 of March 2, 2015: a Veteran in the Primary Care Clinic blood pressure check area became agitated and upset. He stated he was going to do something to himself with a gun by the end of the day and left the treatment room. Clinic staff contacted the VA Police and notified the provider, who immediately placed a medical hold on this Veteran, but the Veteran had already left the VA property. VA Police notified the local police who found the Veteran and took him to a community urgent psychiatric care center, where he was assessed and released. The following day, PVACHS contacted the Veteran, who said that he had had no intention of harming himself the previous day, but was simply expressing frustration. He was ruled out for suicidal ideation. PVACHS responded appropriately to his departure.

- 2015-05-15-1100-9709 of May 15, 2015: a CLC resident left VA property to go to his home to retrieve some music. The VA police notified the local police who found the patient at his home. Although he had previously been identified as suicidal or homicidal, at the time of the incident this Veteran was not assessed as "at risk," and this incident was not considered an elopement.

- 2015-05-31-1810-5594 of May 31, 2015: a Veteran awaiting placement in a long-term mental health facility for diminished mental capacity in a locked mental health unit left while outside on a supervised walk to smoke. VA Police were immediately called, and they notified the local police who were unable to locate the patient. The Veteran returned to PVACHS by himself and was re-admitted to the locked inpatient mental health unit.

- 2015-11-07-1715-8032 of November 7, 2015: a Veteran presented to the ED requesting alcohol detoxification. During his triage he denied suicidal and homicidal ideations. He subsequently informed the ED physician that he wanted to leave. Since he neither voiced nor displayed any indications of suicidal or homicidal ideations, he was not considered "at-risk" and was not placed on a medical hold. This Veteran did not elope, but left after declining treatment.

[2] VHA Handbook 1004.01, Transmittal Sheet August 14, 2009. *Informed Consent for Clinical Treatments and Procedures.*

- 2015-08-24-0210-8319 of August 24, 2015: an inpatient with a history of confusion and dementia left the unit without notifying the staff. He was noted as missing at 2:00 a.m.; VA Police found him 15 minutes later. He was assessed and found to have no injuries. PVACHS increased the frequency of observation of this Veteran.

- 2015-08-24-0210-8319 of September 25, 2015: family members brought a Veteran to the ED while attempting to convince him that he needed alcohol detoxification. After the family members left the ED, the Veteran went outside to the facility's parking lot, where VA police persuaded him to return to the ED. An ED provider and a social worker assessed the Veteran and found him to be stable and a low suicide risk. The Veteran refused detoxification and was discharged later the same evening. This Veteran did not elope and was discharged after declining treatment,

G. *On page iv, OMI found that, "the lack of routine communication between the Medical center and the community based detoxification center results in a gap in continuity of Veteran care." What has been completed since the investigation to eliminate this gap? Is there VHA policy that outlines how VA facilities are to hand off patients to community health centers?*

Non-VA providers under contract with VA to provide care to Veterans are required to provide VA a handoff about that VA-funded care. However, the detoxification center noted in the report is funded by the State of Arizona, not by VA; and therefore, is under no contractual obligation to provide a handoff to VA about Veteran patients. In an effort to maintain continuity of care for the Veterans who go to such centers, PVACHS created a Community Liaison Social Worker position. This Social Worker communicates weekly with the community behavior health treatment centers to follow Veterans' care and improve the coordination of health services Veterans receive; this communication proactively resolves potential problems or barriers to care.

H. *On page vi, OMI noted that "the VA did not substantiate that Veteran 4 had presented to the Medical Center's ED for care related either to suicidal ideation or pain management." However, in a suicide note left by the veteran (attached), he indicates that he presented to the VA in January 2015 and received what he believed to be grossly inadequate care for pain management. Was OMI aware of the suicide note written by veteran 4 in making the above determination?*

VA was aware of the suicide note. The Veteran was seen in January 2015 for complaints of shoulder pain. His radiologic studies indicated no apparent abnormalities in that shoulder. The Veteran had not been prescribed pain medications by VA since 2013, despite the indication in his suicide note that VA was attempting to take away his pain medications. There is no documentation that the Veteran was dissatisfied with care received during the January 2015 visit, and the care provided to address his complaints was appropriate.

I. *On page 4, OMI reported that, with regard to suicide awareness training, the standardized presentation is part of all VA new employee orientation programs and is usually allotted 30 to 60 minutes, however on page 5, OMI notes that the mandated suicide training at new employee orientation takes place every two weeks, but that the program is allotted only 15 minutes on the orientation schedule. Please explain this discrepancy. How much time does suicide awareness training actually take in practice?*

In the past, the mandated suicide training was allotted only 15 minutes during new employee orientation. Currently, this training is allotted 45 minutes.

J. *On page 5, OMI reported that, "On February 20, 2015, the ED Nurse Manager notified nursing staff in that department that additional training will be provided on the management of patients with suicidal ideation. The additional training will be mandatory and include suicide risk prevention and evaluation." Was the additional training given? How regularly is the training given?*

The Medical Center provided additional training to the ED registered nurses, as of this report, 41 of the 44 ED registered nurses have completed the training. Additional training will be provided on an annual basis.

K. *On page 6, OMI noted that a social worker (SW) had been incorrectly instructed by a supervisor to rate intoxicated patients as low risk for suicide until they were sober and could be reassessed. OMI also noted that the SW was appropriately reeducated. Was the SW's previous supervisor reeducated as well?*

Yes, he was re-educated.

L. *On page 11, OMI describes an incident in which* [redacted] *escorted an intoxicated patient who had twice expressed suicidal ideation to the ED and then left after handing the patient off to a nurse. Based on the patient's electronic health records (EHR), during the triage process, the patient expressed that he was in fact not suicidal. This eventually led to the patient not being monitored as a suicide risk. What is PVAHCS' policy regarding patients that express a suicidal ideation and then retract that sentiment? Is the prior statement of suicidal ideation ignored?*

A patient who has not been deemed incompetent must be taken at his/her word, unless he/she exhibits signs or symptoms that would indicate otherwise. The Veteran in question did not display any symptoms that would contradict his claim that he was not suicidal. Preventing a patient who has not been deemed a danger to himself or others from leaving would, at the least, be considered patient abuse and a direct violation of the patient's right to refuse care and could be considered false imprisonment or kidnapping.

M. *On page 12 of their report, OMI reported that they were unable to find any record of the five patient elopements supposedly to have taken place during the week of*

January 23, 2015. [redacted] in his comments on the report, noted that generally a suicidal veteran is taken to a triage waiting room without completing the enrollment process. Therefore, if the patient leaves the triage waiting room before the process is complete, there would be no record generated that the veteran came to the ED. Did OMI base their finding that they did not substantiate that five patients had eloped solely on enrollment records? If not, what means were used to make this finding?

VA based its conclusion on the documentation available, which included all elopement reports and reports of patients who left the ED prior to receiving treatment, as well as staff interviews. VA did not find any record of five patient elopements during the week of January 23, 2015.

N. *Did OMI listen to the audio recording of the January 23, 2015 social work department meeting? If so, how do they square their conclusions with the comments by a social worker in the recording that five suicidal patients had eloped? Was OMI able to identify who made these statements and interview that person?*

We were not able to access or listen to the audio recording provided, because of compatibility issues between the audio file sent by the whistleblower and our VA devices. The VA team reviewed the transcript of the meeting and was not able to identify the individual making the transcribed statements. The team later interviewed a social worker who said she was the person speaking on the audio recording and also stated that she believed suicidal Veterans were eloping from the ED. She did not; however, recall five patients eloping during the week of January 23, 2015.

O. *The OMI report did not mention the training given (or lack thereof) regarding how to properly complete the mandatory Suicide Risk Assessments (SRAs). What training is given to employees on how to complete SRAs? Is any training required by regulation? Part of mental health training, part of departmental orientation for example [redacted] as referenced previously in the report.*

All degree programs for social workers include training to assess suicidal ideations. In addition, PVACHS requires Suicide Risk Assessment training through the Talent Management System (TMS) for all clinicians, including social workers. TMS is an online educational platform utilized by VA to provide and document training events. The VA reviewed PVACHS's documentation for TMS Course VA6201, Suicide Risk Assessment Training for Clinicians and found that 94 percent of its social workers had completed this training in the last 12 months. PVACHS also evaluates competency of social workers annually, and both mental health and ED social workers' competencies include evaluating the ability to assess suicidal and homicidal risk. There is no regulation that requires specific training on the completion of the form.

P. *Regarding the access of [redacted] EHR by SW [redacted] (described in the OMI report on page 14-15), the OMI report noted that the Phoenix Network and Security Operations Center deemed the access, "a low risk for breach of information." Did NSOC make a finding as to whether the breach was inadvertent? The facility made the determination that although in advertent, it was a violation.*

For clarification, the incident was reported to the Privacy and Security Events Tracking System (PSETS) for review by the VA Data Breach Resolution Service (DBRS) (formerly VA Incident Resolution Team). While the NSOC often enters PSETS tickets for the facility, the NSOC does not make any determinations regarding whether an incident is a data breach: that is the responsibility of the DBRS and Data Breach Core Team (DBCT). The DBRS reviewed the incident and determined it to be no more than a low risk of compromise based on the risk assessment criteria. Therefore, it was not a data breach as outlined in the HIPAA Breach Notification Rule, even though it was a privacy violation.

Q. *Please explain the repeated accesses of* [redacted] *EHR as four accesses (possibly five) in the span of 12 months appears to be more than a coincidence or mistake?*

This question appears to be related to the above request for investigation of additional accesses. The VHA Privacy Office investigated the additional accesses provided and determined that the reasons for all of the accesses were for an appeal follow-up from VBA Veterans Service Representatives and a privacy complaint investigation by the facility. [redacted] filed a privacy complaint regarding unauthorized access, and the facility Privacy Office requested the Supervisors of the offending employees to review the accesses for appropriateness. As a result, the Supervisors now show up on the SPAR for [redacted] All employees had documentation to support their accesses. See Attachment A for more detail.

R. *Consider that* [redacted] *has not received Medical Care at PVAHCS since January 2, 2015, has personal relationships with many of the staff members responsible for these accesses, and does not share a name (or one that is close) with any veterans receiving care at PVAHCS.*

There is another Veteran with a similar name in the Medical Center's computer system. He has the same last name and five letters in common with [redacted] first name, including the first and the last letters, only two vowels were different. To maintain this other Veteran's privacy, we are not listing his name in this response.

S. *On page 15, the Phoenix VA determined that 10 out of 12 people that accessed* [redacted] *EHR "were conducting official duties related to treatment, payment, or health care operations." How was this determination made? What documents formed the basis of that determination? Which individuals were responsible for which duties?*

The VHA Privacy Office followed the standard procedures for conducting a privacy violation investigation. They requested that the PVAHCS's Privacy Officer interview the 12 employees who allegedly accessed [redacted] health record without authority. The Privacy Officer asked each employee's supervisor to inquire into the accesses by their respective employees. The information used to determine whether the access was

authorized or unauthorized consisted of: 1) information from Supervisors' interviews of their employees; as the supervisors know their employees' job responsibilities, and therefore, can verify whether the access was authorized, 2) review of documents, e.g., emails, supporting the access, and 3) Review the Computerized Patient Record System (CPRS) to determine whether a progress note or other document had been written there in regard to the access. Upon completion of their interviews and documentation reviews, the supervisors provided the results to the PVAHCS's Privacy Officer for review and determination based on whether the access was for treatment, payment, or health care operations. The definitions of what constitute treatment, payment, and health care operations are in VHA Handbook 1605.1 and the HIPAA Privacy Rule. Based on this review, the Privacy Officer determined that two people accessed the complainant's health record accidently, instead of that of the similarly named Veteran. These two accesses were treated as unauthorized, and appropriate action was taken. The VHA Privacy Office reviewed the documentation and provided the determination VA used in the report. See attachment A.

T. *On pages 15-16, OMI describes two incidents in which two PVACHS employees accessed* [redacted] *EHR without authorization. OMI sated that VHACO Privacy Office treated both incidents as unauthorized accesses and took appropriate administrative action. What action was taken? Were any steps taken to ensure future unauthorized accesses?*

While mistakes or errors in patient selection happen, VHA still considers these accesses unauthorized. When these unauthorized accesses were brought to the attention of the supervisors of the offending employees, the supervisors made sure that the employee's privacy training was up-to-date. In addition to the annual privacy training requirement, steps have been taken in an attempt to ensure that future unauthorized accesses do not occur. In the fall of 2014, the Interim Medical Center Director (MCD) sent an all-user email regarding sensitive chart access per VHACO Action Item. On April 27, 2015, the Interim MCD sent another all-user email regarding appropriate access to personally identifiable information or protected health information. The VHA Office of Informatics and Analytics has submitted a new service request for modifying the sensitive patient record warning methodology in order to decrease the number of mistakes or errors in patient selection to prevent these unauthorized accesses.

Attachment A

SPAR Review February 12, 2012 – November 25, 2014

USER	DATE	OPTION or PROTOCOL	INPT?	SERVICE	REASON FOR ACCESS	AUTHOR-IZED?
[redacted]	APR 24, 2015 @10:11	CPRS Chart version 1.	No	Ratings Veteran Service Repre-sentative (RVSR) with VBA Albuquer-que Regional Office (RO)	All of [redacted] accesses are related to an appeal, namely the Board of Veterans' Appeals (BVA) remand dated March 9, 2015. On April 24th [redacted] entered a Phoenix VAMC examination request into CAPRI. He is identified as the Requestor on the VA Examination Request Form 2507. [redacted] also uploaded Phoenix VAMC progress notes dated 11/26/2001-6/30/2014 and Phoenix VAMC clinical documents dated 6/24/1997-6/30/2014 into VBMS in support of the claim review. Due to volume is may take several different accesses to capture all of the documents and upload them into VBMS. You will note that all of the accesses are within a span of just over an hour. Also while the access may show "CPRS Chart version1", all of accesses were through CAPRI. VHA has been informed that when a user accesses the VistaWeb Tab in CAPRI the SPAR logs this as "CPRS Chart version1". It is [redacted] custom to upload all available CAPRI records, especially while adjudicating an appeal	Yes

Employee 2	APR 24, 2015 @10:14	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	APR 24, 2015 @10:39	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	APR 24, 2015 @10:44	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	APR 24, 2015 @10:45	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	APR 24, 2015 @10:58	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	APR 24, 2015 @11:14	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 4/24/2015	Yes
Employee 2	MAY 04, 2015 @06:31	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Employee 2 authorized and was working a rating decision for the Whistleblower. It is his custom and standard practice to review a Veteran's records in CAPRI before finalizing a rating decision, just to be sure no new records have been created that might require a change in decision.	Yes
Employee 2	MAY 04, 2015 @06:50	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Same as above for 5/04/2015	Yes
Employee 2	MAY 04, 2015 @06:56	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Same as above for 5/04/2015	Yes
Employee 2	MAY 04, 2015 @07:08	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 5/04/2015	Yes
Employee 2	JUN 05, 2015 @13:32	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Employee 2 accessed VistAWeb through CAPRI in order for scanned document to be pulled and uploaded into Veterans Benefits	Yes

					Management System (VBMS)	
[redacted]	JUN 05, 2015 @13:32:10	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	[redacted] accessed VistAWeb through CAPRI in order for scanned document to be pulled and uploaded into Veterans Benefits Management System (VBMS)	Yes
[redacted]	JUL 29, 2015 @08:15	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	[redacted] authored a rating decision for the Whistleblower. It is standard practices to review Veterans records before finalizing a rating decision to ensure new records were not added that may or may not affect a rating decision. All accesses occurred within 4 minutes.	Yes
[redacted]	JUL 29, 2015 @08:17	Capri GUI (Broker)	No	RVSR with VBA Albuquerque RO	Same as above for 7/29/2015	Yes
[redacted]	JUL 29, 2015 @08:19	CPRS Chart version 1.	No	RVSR with VBA Albuquerque RO	Same as above for 7/29/2015	Yes
[redacted]	JUL 22, 2015 @12:42	CAPRI GUI (Broker)	No	Veteran Service Representative (VSR) with VBA Albuquerque RO	As a VSR, [redacted] uses CAPRI to see if examinations are uploaded and completed in the system. VSR are at a lower level than RVRS and usually assist in getting information and correspondence for their assigned RVSR. [redacted] is [redacted] RVSR for her assigned primary digits 00-23, which the Whistleblower falls within. The Whistleblower had an appeal which [redacted] was working. [redacted] accessed the record to obtain information for the appeal, likely at the request of [redacted]	Yes

Employee 4	APR 20, 2015 @15:19	PCMM GUI Workstation	No	Administrative Assistant Mental Health	The Whistleblower filed a privacy complaint regarding unauthorized access in April 2015. Employee was asked by the facility Privacy Officer to investigate why one of his employees accessed the complainant's health record. The Privacy Officer and Employee have emails supporting his access for this purpose, which is part of health care operations.	Yes
Employee 5	APR 22, 2015 @11:35	CPRS Chart version 1.	No	Administrative Assistant Mental Health with Phoenix VAMC	The Whistleblower filed a privacy complaint regarding unauthorized access in April 2015. Employee was asked by the facility Privacy Officer to investigate why one of his employees accessed the complainant's health record. The Privacy Officer and Employee have emails supporting his access for this purpose, which is part of health care operations.	Yes
Employee 6	APR 22, 2015 @08:10	CPRS Chart version 1.	No	Occupational Health (OH) Physician with Phoenix VAMC	The Whistleblower filed a privacy complaint in April 2015. The facility Privacy Officer requested Employee 6 investigate possible reasons why an OH employee accessed the complainant's CPRS record. She has the email from the Privacy Office that requested her to access the Whistleblower's record and the email that showed her findings of her investigation.	Yes
Employee 6	APR 22, 2015 @08:11	PCE Encounter Data Entry	No	Occupational Health (OH) Physician with Phoenix VAMC	The Whistleblower filed a privacy complaint in April 2015. The facility Privacy Officer requested Employee 6 investigate possible reasons why an OH employee accessed the complainant's CPRS record. She has the email from the Privacy Office that requested her to access the Whistleblower's record and the	Yes

					email that showed her findings of her investigation.	
[redacted]	APR 22, 2015 @08:12	Appointment Management	No	Occupational Health (OH) Physician with Phoenix VAMC	The Whistleblower filled a privacy complaint in April 2015. The facility Privacy Officer requested [redacted] investigate possible reasons why an OH employee accessed the complainant's CPRS record. She has the email from the Privacy Office that requested her to access the Whistleblower's record and the email that showed her findings of her investigation.	Yes
[redacted]	JUN 10, 2015 @10:37	Capri GUI (Broker)	No	VSR with VBA Albuquerque RO	[redacted] is a VSR at the Albuquerque RO reviews VBA claims . In June 2015 he was working on a claim made by the Whistleblower. [redacted] loaded a End Product (EP) 930 claim into the Veterans Benefit Management System (VBMS) from CAPRI.	Yes
[redacted]	JUL 21, 2015 @12:56	Capri GUI (Broker)	No	VSR with VBA Albuquerque RO	[redacted] reviewed his productivity log and it showed that he was following up on a claim for [redacted] RVSR. [redacted] also processed an award on July 30, 2015 but did not go into CAPRI at that time. As a VSR, part of [redacted] job is to gather documents, including from CAPRI, for the Raters.	Yes