Privacy Impact Assessment for the VA IT System called:

BlueJay Mobile Health
Physical Medicine & Rehabilitation Services

Date PIA submitted for review:
7/20/20

System Contacts:

<table>
<thead>
<tr>
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<tbody>
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</tr>
</tbody>
</table>
Abstract

The abstract provides the simplest explanation for “what does the system do?” and will be published online to accompany the PIA link.

BlueJay Mobile Health offers a new, web browser-based solution to the problem of severely reduced face-to-face rehabilitation services. This includes real-time clinical video telehealth (CVT), Veteran engagement through avatar-based patient education and instruction, and formulary of several thousand therapeutic exercises that can be prescribed and remotely monitored by the Veteran’s physical therapist.

Overview

The overview is the most important section of the PIA. A thorough and clear overview gives the reader the appropriate context to understand the responses in the PIA. The overview should contain the following elements:

- The IT system name and the name of the program office that owns the IT system.
- The business purpose of the program, IT system, or technology and how it relates to the program office and agency mission.
- The expected number of individuals whose information is stored in the system and a brief description of the typical client or affected individual.
- If your system is a regional GSS, VistA, or LAN, include a list of the hospitals/medical centers, or other regional offices that fall under your system. Additionally, what region is the system under?
- A general description of the information in the IT system.
- Any information sharing conducted by the IT system. A general description of the modules and subsystems, where relevant, and their functions.
- Whether the system is operated in more than one site, and if so, a description of how use of the system and PII is maintained consistently in all sites and if the same controls are used across sites.
- A citation of the legal authority to operate the IT system.
- Whether the completion of this PIA will result in circumstances that require changes to business processes
- Whether the completion of this PIA could potentially result in technology changes
- If the system is in the process of being modified and a SORN exists, will the SORN require amendment or revision and approval?
- Does the system use cloud technology? If so, Does the system have a FedRAMP provisional or agency authorization? If the system does use cloud technology, but does not have FedRAMP authorization, explain how the Cloud Service Provider (CSP) solution was assessed and what FedRAMP documents and processes were used for the assessment in order to comply with VA Handbook 6517.
- Does a contract with Cloud Service Provider, Contractors and VA customers establish who has ownership rights over data including PII?
- NIST 800-144 states, “Organizations are ultimately accountable for the security and privacy of data held by a cloud provider on their behalf.” Is this principle described in contracts with customers? Why or why not?
- What is the magnitude of harm if privacy related data is disclosed, intentionally or unintentionally? Would the reputation of the CSP or its customers (VA) be affected?
BlueJay Mobile Health is a SaaS solution hosted in Amazon Web Services. Physical Medicine & Rehabilitation Services will utilize BlueJay Mobile Health to offer rehabilitation services to Veterans with limited or no access to face-to-face rehabilitation care. Gainseville VAMC has a signed 90-day Test Agreement in place with BlueJay to test the SaaS solution and determine future contracting from there. BlueJay will be operating at this single site. The expecting number of participants is less than 500 Veterans and Physical Therapists. The system will include Veterans’ name, email, and phone number; Providers’ name, and email; video recordings, prescribed exercises, compliance/progress data. Real-time clinical video telehealth allows clinicians and patients to video conference and allows Veterans to engage with customized instruction videos. These videos are assigned to the Veteran by the clinician. The clinician can choose from the several thousand videos in BlueJay’s library or record their own video. The system also provides a store and forward capability in which clinician is able to login and review a patient’s performance and compliance. The clinician has the ability to export these records as PDF. This system will not connect with any VA systems. The information system utilizes cloud technology and is working with Digital Transformation Center (DTC) SaaS team and Enterprise Security Architecture Cloud Security (ESA CS) team. BlueJay has begun to work on the FedRAMP documentation requirements and will pursue a full FedRAMP authorization if a formal contract is pursued after the 90-day trial agreement. Veterans Health Administration (VHA) Directive 1170.03, Physical Medicine and Rehabilitation Service. The Test Agreement does not cover data ownership, but this will be addressed if a formal contract is pursued after the Test Agreement.

**Section 1. Characterization of the Information**

The following questions are intended to define the scope of the information requested and collected as well as the reasons for its collection as part of the program, IT system, or technology being developed.

1.1 What information is collected, used, disseminated, created, or maintained in the system?

*Identify and list all Sensitive Personal Information (SPI) that is collected and stored in the system, including Individually Identifiable Information (III), Individually Identifiable Health Information (IIHI), Protected Health Information (PHI), and Privacy-Protected Information. For additional information on these information types and definitions, please see VA Directives and Handbooks in the 6500 series (https://vaww.va.gov/vapubs/). If the system creates information (for example, a score, analysis, or report), list the information the system is responsible for creating.*

*If a requesting system receives information from another system, such as a response to a background check, describe what information is returned to the requesting system. This question is related to privacy control AP-1, Authority To Collect, and AP-2, Purpose Specification.*
Please check any information listed below that your system collects, uses, disseminates, creates, or maintains. If additional SPI is collected, used, disseminated, created, or maintained, please list those in the text box below:

- Name
- Social Security Number
- Date of Birth
- Mother’s Maiden Name
- Personal Mailing Address
- Personal Phone Number(s)
- Personal Fax Number
- Personal Email Address
- Emergency Contact Information (Name, Phone

- Name
- Social Security Number, etc. of a different individual
- Financial Account Information
- Health Insurance Beneficiary Numbers
- Account numbers
- Certificate/License numbers
- Vehicle License Plate Number
- Internet Protocol (IP) Address Numbers
- Current Medications
- Previous Medical Records
- Race/Ethnicity
- Tax Identification Number
- Medical Record Number
- Other Unique Identifying Number (list below)

### PII Mapping of Components

BlueJay Mobile Health consists of 2 key components. Each component has been analyzed to determine if any elements of that component collect PII. The type of PII collected by BlueJay and the reasons for the collection of the PII are in the table below.

#### PII Mapped to Components

<table>
<thead>
<tr>
<th>Components of the information system (servers) collecting/storing PII</th>
<th>Does this system collect PII? (Yes/No)</th>
<th>Does this system store PII? (Yes/No)</th>
<th>Type of PII (SSN, DOB, etc.)</th>
<th>Reason for Collection/ Storage of PII</th>
<th>Safeguards</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueJay TeleHealth Application Server</td>
<td>Yes</td>
<td>No</td>
<td>Patient Name, IP Address</td>
<td>Display who joins the telehealth session</td>
<td>Password to control access. PII is not stored in this component</td>
</tr>
<tr>
<td>BlueJay Engage Application Server</td>
<td>Yes</td>
<td>Yes</td>
<td>Patient name, email, phone number</td>
<td>Patient Communication</td>
<td>Password to control access, Amazon Web Service encrypted database to store PII.</td>
</tr>
</tbody>
</table>

1.2 What are the sources of the information in the system?
List the individual, entity, or entities providing the specific information identified above. For example, is the information collected directly from the individual as part of an application for a benefit, or is it collected from other sources such as commercial data aggregators?

Describe why information from sources other than the individual is required. For example, if a program’s system is using data from a commercial aggregator of information or data taken from public Web sites, state the fact that this is where the information is coming from and then in question 1.3 indicate why the system is using this source of data.

If the system creates information (for example, a score, analysis, or report), list the system as a source of information.

This question is related to privacy controls DI-1, Data Quality, and IP-1, Consent.

The Veteran or clinician will provide all the above information into the system.

1.3 How is the information collected?

This question is directed at the means of collection from the sources listed in question 1.2. Information may be collected directly from an individual, received via electronic transmission from another system, or created by the system itself. Specifically, is information collected through technologies or other technology used in the storage or transmission of information in identifiable form?

If the information is collected on a form and is subject to the Paperwork Reduction Act, give the form’s OMB control number and the agency form number.

This question is related to privacy controls DI-1, Data Quality, and IP-1, Consent.

Information will be collected directly from input made by the Veteran and Clinician.

Ahead of creating an account and collecting information, the Veteran signs a consent form to participate in Telehealth that calls out engagement with 3rd Party Vendor. Please see Appendix A for consent form.

1.4 What is the purpose of the information being collected, used, disseminated, created, or maintained?

Include a statement of why the particular SPI is collected, maintained, used, or disseminated in the system is necessary to the program’s or agency’s mission. Merely stating the general purpose of the system without explaining why this particular type of information should be collected and stored is not an adequate response to this question.
If the system collects, uses, disseminates, or maintains publicly available or commercial data, include a discussion of why commercial data is relevant and necessary to the system’s purpose. This question is related to privacy control AP-2, Purpose Specification.

Name, phone number, email—and methods to communicate regarding treatment, compliance, and test results

1.5 How will the information be checked for accuracy? How often will it be checked?

Discuss whether and how often information stored in the system is checked for accuracy. Is information in the system checked against any other source of information (within or outside your organization) before the information is used to make decisions about an individual? For example, is there a computer matching agreement in place with another government agency? For systems that receive data from internal data sources or VA IT systems, describe the system checks to ensure that data corruption has not occurred during transmission.

If the system checks for accuracy by accessing a commercial aggregator of information, describe this process and the levels of accuracy required by the contract. This question is related to privacy controls DI-1, Data Quality, and DI-2, Data Integrity and Integrity Board.

The accuracy of information obtained and retained by the BlueJay system will be monitored by the attending physical therapist. There are no mechanisms for retroactive changes, however changes can be made going forward with new records created.

All details will be transferred manually by Physical Therapist to patient’s medical record in CPRS. Record Amendment requests for CPRS will follow the VHA normal record amendment request process.

1.6 What specific legal authorities, arrangements, and agreements defined the collection of information?

List the full legal authority for operating the system, specifically the authority to collect the information listed in question 1.1. Provide the authorities in a manner understandable to any potential reader, i.e., do not simply provide a legal citation; use statute names or regulations in addition to citations. Legal authorities include Federal laws, regulations, statutes, and Executive Orders. This question is related to privacy control AP-1, Authority to Collect.
Title 38, United States Code, Sections 501(b) and 304. Patient Medical Records-VA 24VA10P2 System of Records.

1.7 PRIVACY IMPACT ASSESSMENT: Characterization of the information
Consider the specific data elements collected and discuss the potential privacy risks and what steps, if any are currently being taken to mitigate those identified risks.

Consider the following Fair Information Practice Principles (FIPPs) when assessing the risk to individual privacy:

**Principle of Purpose Specification:** Explain how the collection ties with the purpose of the underlying mission of the organization and its enabling authority.

**Principle of Minimization:** Is the information directly relevant and necessary to accomplish the specific purposes of the program?

**Principle of Individual Participation:** Does the program, to the extent possible and practical, collect information directly from the individual?

**Principle of Data Quality and Integrity:** Are there policies and procedures for VA to ensure that personally identifiable information is accurate, complete, and current? This question is related to privacy control AR-1, Governance and Privacy Program, and AR-2, Privacy Impact and Risk Assessment.

Follow the format below when entering your risk assessment:

**Privacy Risk:** The information being collected (patient name, email, and IP address) poses a minimal risk if the individual’s data was accessed by an unauthorized individual or otherwise breached.

**Mitigation:** The collection of the PII is necessary for the physical therapist to be able to identify the Veteran engaging in the telerehabilitation activity. VA privacy and information security principles apply on the VA end-user side of the application.

The minimum information required to engage in the telerehabilitation application enables communication regarding the technical integrity of the app itself, monitoring of the Veteran’s compliance with the exercise regimen, and clinical video telehealth encounters between Veteran and physical therapist. These are the same identifiers used in nearly all of the telehealth platforms approved for use by VHA during the COVID-19 pandemic in addition to VA Video Connect. All further clinical data on VHA side is manually entered by the clinician into CPRS.

Information provided to the application regarding the individual is entered by the individual user and/or the attending physical therapist. Performance data are collected directly from the individual. As patients are assigned to clinicians by an administrator on the VHA side, only therapists actively involved in the Veterans care provide the information collected.
Data validation occurs by the treating physical therapist during record review and monitoring, as well as during follow-up via clinical video telehealth. The patient can also review PII during login and/or account setup.

Once data is manually transferred to CPRS, Record Amendment requests for CPRS will follow the VHA normal record amendment request process.

Section 2. Uses of the Information

The following questions are intended to clearly delineate the use of information and the accuracy of the data being used.

2.1 Describe how the information in the system will be used in support of the program’s business purpose.

Identify and list each use (both internal and external to VA) of the information collected or maintained.
This question is related to privacy control AP-2, Purpose Specification.

The information provided is to identify patient and directly help with rehabilitation.

2.2 What types of tools are used to analyze data and what type of data may be produced?

Many systems sift through large amounts of information in response to a user inquiry or programmed functions. Systems may help identify areas that were previously not obvious and need additional research by agents, analysts, or other employees. Some systems perform complex analytical tasks resulting in, among other types of data, matching, relational analysis, scoring, reporting, or pattern analysis. Describe any type of analysis the system conducts and the data that is created from the analysis.

If the system creates or makes available new or previously unutilized information about an individual, explain what will be done with the newly derived information. Will it be placed in the individual’s existing record? Will a new record be created? Will any action be taken against or for the individual identified because of the newly derived data? If a new record is created, will the newly created information be accessible to Government employees who make determinations about the individual? If so, explain fully under which circumstances and by whom that information will be used.

This question is related to privacy controls DI-1, Data Quality, DI-2, Data Integrity and Integrity Board, and SE-1, Inventory of Personally Identifiable Information

Other than the clinical encounters during the episode of care and outcomes data comparing baseline performance to post-treatment levels, there are no immediate plans for further use of the
data at this time. Therapy program compliance is manually entered into CPRS by the treating physical therapist.

During the Test Agreement, there will be no data analytics from the BlueJay side. For a full contract, there is some data analytics available. That will be determined if a full contract is pursued.

2.3 PRIVACY IMPACT ASSESSMENT: Use of the information. How is access to the PII determined? Are criteria, procedures, controls, and responsibilities regarding access documented? Does access require manager approval? Is access to the PII being monitored, tracked, or recorded? Who is responsible for assuring safeguards for the PII?

Describe any types of controls that may be in place to ensure that information is handled in accordance with the uses described above. Example: Describe if training for users of the project covers how to appropriately use information. Describe the disciplinary programs or system controls (i.e. denial of access) that are in place if an individual is inappropriately using the information.

Consider the following FIPPs below to assist in providing a response:

_Principle of Transparency:_ Is the PIA and SORN, if applicable, clear about the uses of the information?

_Principle of Use Limitation:_ Is the use of information contained in the system relevant to the mission of the project? This question is related to privacy control AR-4, Privacy Monitoring and Auditing, AR-5, Privacy Awareness and Training, and SE-2, Privacy Incident response.

The information collected includes performance and compliance with prescribed therapeutic activities that would otherwise be conducted via traditional telehealth or home therapy program regimens. Significantly more information is maintained on the VHA-side electronic health record than used in the BlueJay application.

Access to BlueJay is determined by Physical Therapist recommendation and admin approval. The admin user will be identified by the Physical Therapist Section Administration. When a Physical Therapist identifies a patient as a potential candidate for the BlueJay solution, the Physical Therapist will request the admin to create accounts for the Physical Therapist and identified Veteran patient. The admin user will create both accounts. Then the Physical Therapist can search and follow patient. Once the Physical Therapist follows the patient then they can assign activities and view performance and compliance data.

Section 3. Retention of Information

The following questions are intended to outline how long information will be retained after the initial collection.

3.1 What information is retained?

Identify and list all information collected from question 1.1 that is retained by the system.
This question is related to privacy controls DM-1, Minimization of Personally Identifiable Information, and DM-2, Data Retention and Disposal

Video recordings, compliance and progress data

### 3.2 How long is information retained?

In some cases VA may choose to retain files in active status and archive them after a certain period of time. State active file retention periods, as well as archived records, in number of years, for the information and record types. For example, financial data held within your system may have a different retention period than medical records or education records held within your system, please be sure to list each of these retention periods.

The VA records officer should be consulted early in the development process to ensure that appropriate retention and destruction schedules are implemented.

This question is related to privacy control DM-2, Data Retention and Disposal.

The information is retained for 10 years on BlueJay services. There is a manual entry of notes by Physical Therapist from BlueJay to CPRS. Information is stored in CPRS within guidelines of RCS10-1 (link: [https://www.va.gov/vhapublications/RCS10/rcs10-1.pdf](https://www.va.gov/vhapublications/RCS10/rcs10-1.pdf)).

### 3.3 Has the retention schedule been approved by the VA records office and the National Archives and Records Administration (NARA)? If so please indicate the name of the records retention schedule.

An approved records schedule must be obtained for any IT system that allows the retrieval of a record via a personal identifier. The VA records officer will assist in providing a proposed schedule. The schedule must be formally offered to NARA for official approval. Once NARA approves the proposed schedule, the VA records officer will notify the system owner.

This question is related to privacy control DM-2, Data Retention and Disposal.

Yes, see 6000.2 Electronic Health Record (EHR).

### 3.4 What are the procedures for the elimination of SPI?

Explain how records are destroyed or eliminated at the end of the retention period. Please give the details of the process. For example, are paper records shredded on site, or by a shredding company and accompanied by a certificate of destruction, etc?

This question is related to privacy control DM-2, Data Retention and Disposal

BlueJay sets up a server CRON job to delete expired patient’s records. Records will be eliminated in CPRS within guidelines of RCS10-1. Paper documents are destroyed to an unreadable state in accordance with
the Department of Veterans’ Affairs VA Directive 6371, (April 8, 2014),

Electronic data and files of any type, including Protected Health Information (PHI), Sensitive Personal Information (SPI), Human Resources records, and more are destroyed in accordance with the Department of Veterans’ Affairs Handbook 6500.1, Electronic Media Sanitization (November 3, 2008), http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=416&FType=2. When required, this data is deleted from their file location and then permanently deleted from the deleted items, or Recycle bin. Magnetic media is wiped and sent out for destruction per VA Handbook 6500.1. Digital media is shredded or sent out for destruction per VA Handbook 6500.1.

Additionally, this system follows Field Security Service (FSS) Bulletin #176 dated April 9, 2014 for Media Sanitization Program, SOPs - FSS - All Documents as well as FSS Standard Operating Procedures (SOP) MP-6 Electronic Media Sanitization

3.5 Does the system, where feasible, use techniques to minimize the risk to privacy by using PII for research, testing, or training?

Organizations often use PII for testing new applications or information systems prior to deployment. Organizations also use PII for research purposes and for training. These uses of PII increase the risks associated with the unauthorized disclosure or misuse of the information. Please explain what controls have been implemented to protect PII used for testing, training and research. Have policies and procedures been developed to minimize the use of PII for testing, training, and research? This question is related to privacy control DM-3, Minimization of PII Used in Testing, Training and Research

Other than the clinical case level and comparison to traditional outcomes for the purposes of the pilot, there are no immediate plans to conduct research or testing using the PII. There are no plans to use the PII for training at this time.

3.6 PRIVACY IMPACT ASSESSMENT: Retention of information

Discuss the risks associated with the length of time data is retained and what steps, if any, are currently being taken to mitigate those identified risks.

While we understand that establishing retention periods for records is a formal process, there are policy considerations behind how long a project keeps information. The longer a project retains information, the longer it needs to secure the information and assure its accuracy and integrity. The proposed schedule should match the requirements of the Privacy Act to keep the minimum amount of PII for the minimum amount of time, while meeting the Federal Records Act. The schedule should align with the stated purpose and mission of the system.
Consider the following FIPPs below to assist in providing a response:

**Principle of Minimization:** Does the project retain only the information necessary for its purpose? Is the PII retained only for as long as necessary and relevant to fulfill the specified purposes?

**Principle of Data Quality and Integrity:** Has the PIA described policies and procedures for how PII that is no longer relevant and necessary is purged?

*This question is related to privacy controls DM-1, Minimization of Personally Identifiable Information, and DM-2, Data Retention and Disposal.*

Follow the format below:

**Privacy Risk:** There is a risk that the information maintained by BlueJay could be retained for longer than is necessary to fulfill the VA mission. Records held longer than required are at greater risk of being unintentionally released or breached.

**Mitigation:** The data shared with the BlueJay system is the minimum amount of PII in order for successful use. CPRS is the official System of Record. All applicable VHA privacy and information security regulations are adhered to.

### Section 4. Internal Sharing/Receiving/Transmitting and Disclosure

The following questions are intended to define the scope of information sharing/receiving/transmitting within VA. NOTE: Question 5 on Privacy Threshold Analysis should be used to answer this question.

**4.1 With which internal organizations is information shared/received/transmitted? What information is shared/received/transmitted, and for what purpose? How is the information transmitted?**

*Identify and list the names of any program offices, contractor-supported IT systems, and any other organization or IT system within VA with which information is shared.*

*State the purpose for the internal sharing. If you have specific authority to share the information, provide a citation to the authority.*

*For each interface with a system outside your program office, state what specific data elements (PII/PHI) are shared with the specific program office, contractor-supported IT system, and any other organization or IT system within VA.*

*Describe how the information is transmitted. For example, is the information transmitted electronically, by paper, or by some other means? Is the information shared in bulk, on a case-by-case basis, or does the sharing partner have direct access to the information?*

*This question is related to privacy controls AP-2, Purpose Specification, AR-3, Privacy Requirements for Contractors and Service Providers, AR-8, Accounting of Disclosures, TR-1, Privacy Notice, and UL-1, Internal Use.*
Data Shared with Internal Organizations

<table>
<thead>
<tr>
<th>List the Program Office or IT System information is shared/received with</th>
<th>List the purpose of the information being shared/received with the specified program office or IT system</th>
<th>List the specific data element types such as PII/PHI that are shared/received with the Program Office or IT system</th>
<th>Describe the method of transmittal</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

4.2 PRIVACY IMPACT ASSESSMENT: Internal sharing and disclosure

Discuss the privacy risks associated with the sharing of information within the Department and what steps, if any, are currently being taken to mitigate those identified risks.
This question is related to privacy control UL-1, Internal Use.

Follow the format below:

**Privacy Risk:** N/A

**Mitigation:** N/A

Section 5. External Sharing/Receiving and Disclosure

The following questions are intended to define the content, scope, and authority for information sharing external to VA, which includes Federal, State, and local governments, and the private sector.

5.1 With which external organizations (outside VA) is information shared/received? What information is shared/received, and for what purpose? How is the information transmitted and what measures are taken to ensure it is secure?

Is the sharing of information outside the agency compatible with the original collection? If so, is it covered by an appropriate routine use in a SORN? If not, please describe under what legal mechanism the IT system is allowed to share the information in identifiable form or personally identifiable information outside of VA.

**Note:** This question is #7 in the Privacy Threshold Analysis.
Identify and list the names of any Federal, State, or local government agency or private sector organization with which information is shared.

For each interface with a system outside VA, state what specific data elements (PII/PHI) are shared with each specific partner.

What legal mechanisms, authoritative agreements, documentation, or policies are in place detailing the extent of the sharing and the duties of each party? For example, is the sharing of data compatible with your SORN? Then list the SORN and the applicable routine use from the SORN. Is there a Memorandum of Understanding (MOU), Computer Matching Agreement (CMA), or law that mandates the sharing of this information?

Describe how the information is transmitted to entities external to VA and what security measures have been taken to protect it during transmission.

This question is related to privacy control UL-2, Information Sharing with Third Parties.
### Data Shared with External Organizations

<table>
<thead>
<tr>
<th>List External Program Office or IT System information is shared/received with</th>
<th>List the purpose of information being shared / received / transmitted with the specified program office or IT system</th>
<th>List the specific data element types such as PII/PHI that are shared/received with the Program or IT system</th>
<th>List the legal authority, binding agreement, SORN routine use, etc. that permit external sharing (can be more than one)</th>
<th>List the method of transmission and the measures in place to secure data</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If specific measures have been taken to meet the requirements of OMB Memoranda M-06-15 and M-06-16, note them here.

N/A

### 5.2 PRIVACY IMPACT ASSESSMENT: External sharing and disclosure

Discuss the privacy risks associated with the sharing of information outside the Department and what steps, if any, are currently being taken to mitigate those identified risks.

Discuss whether access controls have been implemented and whether audit logs are regularly reviewed to ensure appropriate sharing outside of the Department. For example, is there a Memorandum Of Understanding (MOU), contract, or agreement in place with outside agencies or foreign governments.

Discuss how the sharing of information outside of the Department is compatible with the stated purpose and use of the original collection.

This question is related to privacy control AR-2, Privacy Impact and Risk Assessment, AR-3, Privacy Requirements for Contractors and Service Providers, and AR-4, Privacy Monitoring and Auditing.

Follow the format below:

**Privacy Risk:** N/A

**Mitigation:** N/A
Section 6. Notice

The following questions are directed at providing notice to the individual of the scope of information collected, the right to consent to uses of the information, and the right to decline to provide information.

6.1 Was notice provided to the individual before collection of the information? If yes, please provide a copy of the notice as an appendix. (A notice may include a posted privacy policy, a Privacy Act notice on forms, or a system of records notice published in the Federal Register.) If notice was not provided, why not?

This question is directed at the notice provided before collection of the information. This refers to whether the person is aware that his or her information is going to be collected. A notice may include a posted privacy policy, a Privacy Act statement on forms, or a SORN published in the Federal Register. If notice was provided in the Federal Register, provide the citation.

If notice was not provided, explain why. If it was provided, attach a copy of the current notice.

Describe how the notice provided for the collection of information is adequate to inform those affected by the system that their information has been collected and is being used appropriately. Provide information on any notice provided on forms or on Web sites associated with the collection. This question is related to privacy control TR-1, Privacy Notice, and TR-2, System of Records Notices and Privacy Act Statements, and TR-3, Dissemination of Privacy Program Information.

Consent Form, please see Appendix A. The Notice of Privacy Practices can be found at: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3048

6.2 Do individuals have the opportunity and right to decline to provide information? If so, is a penalty or denial of service attached?

This question is directed at whether the person from or about whom information is collected can decline to provide the information and if so, whether a penalty or denial of service is attached. This question is related to privacy control IP-1, Consent, IP-2, Individual Access, and IP-3, Redress

Veterans have the absolute right to decline to participate and/or to provide PII. They will be offered the opportunity to engage in traditional telerehabilitation and/or face-to-face visits when COVID-19 restrictions are relaxed.

6.3 Do individuals have the right to consent to particular uses of the information? If so, how does the individual exercise the right?

This question is directed at whether an individual may provide consent for specific uses or the consent is given to cover all uses (current or potential) of his or her information. If specific consent is required, how would the individual consent to each use?
This question is related to privacy control IP-1, Consent

The individual has the right to consent and that would be part of the terms of service/end-user agreement when creating a user account in the BlueJay application itself.

6.4 PRIVACY IMPACT ASSESSMENT: Notice
Describe the potential risks associated with potentially insufficient notice and what steps, if any, are currently being taken to mitigate those identified risks.

Consider the following FIPPs below to assist in providing a response:

**Principle of Transparency:** Has sufficient notice been provided to the individual?

**Principle of Use Limitation:** Is the information used only for the purpose for which notice was provided either directly to the individual or through a public notice? What procedures are in place to ensure that information is used only for the purpose articulated in the notice?

*This question is related to privacy control TR-1, Privacy Notice, AR-2, Privacy Impact and Risk Assessment, and UL-1, Internal Use*

Follow the format below:

**Privacy Risk:** The Veteran may overlook or not read the consent form

**Mitigation:** If the user does not agree, the account will not be created. If the user changes their mind later, BlueJay requires approval from VA management for an account to be deleted. An individual Veteran can request deletion of their account through their Physical Therapist. The Physical Therapist can escalate this request through the admin user and their management to coordinate this request between VA management and BlueJay.

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**Section 7. Access, Redress, and Correction**

The following questions are directed at an individual’s ability to ensure the accuracy of the information collected about him or her.

7.1 What are the procedures that allow individuals to gain access to their information?

Cite any procedures or regulations your program has in place that allow access to information. These procedures, at a minimum, should include the agency’s FOIA/Privacy Act practices, but may also include additional access provisions. For example, if your program has a customer satisfaction unit, that information, along with phone and email contact information, should be listed in this section in addition to the agency’s procedures. See 5 CFR 294 and the VA FOIA Web page at http://www.foia.va.gov/ to obtain information about FOIA points of contact and information about agency FOIA processes.
If the system is exempt from the access provisions of the Privacy Act, please explain the basis for the exemption or cite the source where this explanation may be found, for example, a Final Rule published in the Code of Federal Regulations (CFR).

If the system is not a Privacy Act system, please explain what procedures and regulations are in place that covers an individual gaining access to his or her information. This question is related to privacy control IP-2, Individual Access, and AR-8, Accounting of Disclosures.

Individuals are able to sign onto their BlueJay account to see updated information. Any information in CPRS the patient will follow all applicable VHA release of information regulations regarding data obtained during the therapeutic encounter, whether via telehealth or face-to-face sessions.

7.2 What are the procedures for correcting inaccurate or erroneous information?

Describe the procedures and provide contact information for the appropriate person to whom such issues should be addressed. If the correction procedures are the same as those given in question 7.1, state as much.
This question is related to privacy control IP-3, Redress, and IP-4, Complaint Management.

On the VHA side of the encounter, all applicable VHA regulations regarding the Veteran’s right to request correction of erroneous information remain in force as the data are entered into CPRS. On the BlueJay side, new records can be created should an error be identified.

7.3 How are individuals notified of the procedures for correcting their information?

How are individuals made aware of the procedures for correcting his or her information? This may be through notice at collection or other similar means. This question is meant to address the risk that even if procedures exist to correct information, if an individual is not made fully aware of the existence of those procedures, then the benefits of the procedures are significantly weakened.
This question is related to privacy control IP-3, Redress, and IP-4, Complaint Management.

Correcting information will be handled through CPRS. The Notice of Privacy practices provides information on how patients may request an amendment to their records. Additionally, patients may consult with their facility privacy officer for more information.

7.4 If no formal redress is provided, what alternatives are available to the individual?
Redress is the process by which an individual gains access to his or her records and seeks corrections or amendments to those records. Redress may be provided through the Privacy Act and Freedom of Information Act (FOIA), and also by other processes specific to a program, system, or group of systems.

This question is related to privacy control IP-3, Redress, and IP-4, Complaint Management.

Example: Some projects allow users to directly access and correct/update their information online. This helps ensure data accuracy.

Patients who have been denied formal redress may appeal that decision to the office of general counsel. Directions are provided patients in the correspondence sent to them by the facility Privacy Officer.

7.5 PRIVACY IMPACT ASSESSMENT: Access, redress, and correction

Discuss what risks there currently are related to the Department’s access, redress, and correction policies and procedures for this system and what, if any, steps have been taken to mitigate those risks. For example, if a project does not allow individual access, the risk of inaccurate data needs to be discussed in light of the purpose of the project. For example, providing access to ongoing law enforcement activities could negatively impact the program’s effectiveness because the individuals involved might change their behavior.

Consider the following FIPPs below to assist in providing a response:

Principle of Individual Participation: Is the individual provided with the ability to find out whether a project maintains a record relating to him?

Principle of Individual Participation: If access and/or correction is denied, then is the individual provided notice as to why the denial was made and how to challenge such a denial?

Principle of Individual Participation: Is there a mechanism by which an individual is able to prevent information about him obtained for one purpose from being used for other purposes without his knowledge?

This question is related to privacy control IP-3, Redress.

Follow the format below:

Privacy Risk: There is a risk that erroneous information is placed into BlueJay system.

Mitigation: This information is directly incorporated into CPRS and will be made part of the patient electronic health record. Any erroneous entry within CPRS is subject to formal record amendment procedures that the patient can initiate.

Section 8. Technical Access and Security

The following questions are intended to describe technical safeguards and security measures.
8.1 What procedures are in place to determine which users may access the system, and are they documented?

Describe the process by which an individual receives access to the system.

Identify users from other agencies who may have access to the system and under what roles these individuals have access to the system. Who establishes the criteria for what PII can be shared?

Describe the different roles in general terms that have been created to provide access to the system. For example, certain users may have "read-only" access while others may be permitted to make certain amendments or changes to the information.

This question is related to privacy control AR-7, Privacy-Enhanced System Design and Development.

Admin user adds patient and clinician to the BlueJay Solution by site. Once both clinician and patient are in the same site then the clinician has the ability to search for a patient within the same site and add them as a patient. At this time clinician can see patient compliance details and assign patient rehabilitation work. Clinician is unable to view patients from other sites. Clinician is unable to see patient data until clinician and patient are linked.

Each clinician is able to unfollow a patient. When a clinician unfollows a patient, the patient will no longer show up in the clinician’s patient list.

8.2 Will VA contractors have access to the system and the PII? If yes, what involvement will contractors have with the design and maintenance of the system? Has a contractor confidentiality agreement or a Non-Disclosure Agreement (NDA) been developed for contractors who work on the system?

If so, how frequently are contracts reviewed and by whom? Describe the necessity of the access provided to contractors to the system and whether clearance is required. If Privacy Roles and Responsibilities have been established to restrict certain users to different access levels, please describe the roles and associated access levels. Explain the need for VA contractors to have access to the PII.

This question is related to privacy control AR-3, Privacy Requirements for Contractors and Service Providers.

No, VA contractors will not have access to system.

8.3 Describe what privacy training is provided to users either generally or specifically relevant to the program or system?
VA offers privacy and security training. Each program or system may offer training specific to the program or system that touches on information handling procedures and sensitivity of information. Please describe how individuals who have access to PII are trained to handle it appropriately. This question is related to privacy control AR-5, Privacy Awareness and Training.

VA clinicians go through HIPAA and Privacy, Security Awareness, and Rule of Behavior (RoB) training via VA Talent Management System (TMS).

8.4 Has Authorization and Accreditation (A&A) been completed for the system?

If Yes, provide:

1. The date the Authority to Operate (ATO) was granted,
2. Whether it was a full ATO or ATO with Conditions,
3. The amount of time the ATO was granted for, and
4. The FIPS 199 classification of the system (LOW/MODERATE/HIGH).

Please note that all systems containing SPI are categorized at a minimum level of “moderate” under Federal Information Processing Standards Publication 199.

If No or In Process, provide your Initial Operating Capability (IOC) date.

In process, target date is July 31, 2020. Moderate categorization.
## Section 9. References

### Summary of Privacy Controls by Family

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APPENDIX A – VA Consent to Participate Form

Consent to Participate

I am aware that this system involves telecommunication and video teleconferencing and I agree to participate in rehabilitation services through this technology. I am aware that I do not have to participate and do not have to enroll and can cancel or stop participating at any time.

I also agree to use of my video image by VA third party partners as part of this program. I understand that the therapy program is monitored and appropriately advanced by telehealth and/or occasional face-to-face visits as needed and will be conducted as indicated in my plan of care. I am aware that I can stop care at any time.

The Notice of Privacy Practices can be found at: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3048
Signature of Responsible Officials

The individuals below attest that the information provided in this Privacy Impact Assessment is true and accurate.

CHRISTIAN D LOFTUS 222466

PO, Christian Loftus

Karen A. McQuaid 321576

Information Security Systems Officer, Karen A. McQuaid

Steven P Kostas 187775

System Owner, Steven P Kostas