



Privacy Impact Assessment for the VA IT System called:

Telecare Record Manager Plus (TRM+) Enterprise Program Management Office (EPMO)

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System Contacts:

System Contacts

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Abstract

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

TRM Plus/Triage Expert Dual Purpose (TEDP) provides clinical call agents view-only access to information in VistA and CPRS including demographics, all medications, postings, discharge summaries, consults, health summaries, radiology results, laboratory results, allergies, immunizations, and reports available in CPRS. It also provides the ability to generate TRM Plus notes and reports. The clinical call agent accesses protocols that guide assessment and documentation about the Veteran as well as previous encounters by selecting TEDP within TRM Plus. TEDP auto generates a note about the call as the clinical call agent selects patient responses to specific questions; it is used to document patient education as well as additional patient-specific documentation. TEDP Plus also selects the appropriate International Classification of Diseases Tenth Revision Clinical Modification (ICD-10 CM) and Current Procedural Terminology (CPT) codes. The output of clinical call agent’s phone interactions process are progress notes in TRM Plus and CPRS that are automatically generated when signed by the clinical call agent. TRM Plus ensures the clinical call agent workload is captured.

Some features of TRM Plus are summarized in the following:

Telehealth encounters are becoming the industry normal to handle a multitude of patient issues. The use of this product enabled the Department of Veterans Affairs Health Administration to meet this need.

TRM Plus capture numerous patient data objects during a single encounter. I.e. medications, evidence of flags in patient records, determination of which health condition to best focus on for a patient.

Call Center agents interact with a patient to get refills of medications or referrals to Pharmacists.

Triage is done of significant issues such as suicide, homicidal ideations.

Consistent flow of encounter to a referral agency or consults are completed.

Consistent patient records documentation and proof of treatment for an encounter.

Consistent documentation of any changes, modifications or accuracy of a patient records are completed.

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?*

A. TRM Plus is a system that is owned by each VISN in the VHA Domain. Example VISN 12, VISN 22 or VISN 16

B. The business process is to ensure veterans who utilize telephone access can be greeted and triaged on issues related to their health care.

C. Normal patient count can be between 250 – 400 calls per 8-hour shift. All Registered and Non-Registered Veterans.

D. Current locations include all Region 1, 2, 3 and 4.

- E. The IT system has the TRM Plus application and Call Log Reporter on a Windows application server. The primary executables are launched from this server. The local workstation does interface with VistA to ensure that authentication of the user is maintained and managed. Prior versions, technical manuals and training materials are also located here.
- F. Information sharing is not conducted on this server. This is completed by a Biometric report that is run off the SQL database.
- G. The TRM Plus server is a single server that has executables set-up to handles all sites with licensing for the VISN. There are multiple executables short-cuts for the VistA connection to be made to and from.
- H. Unknown of the citation for legal authority. Don't know what this means (KH).
- I. The completion of this PIA will not change any business processes.
- J. The completion of this PIA will not result in technology changes.
- K. This system is not being modified at this time. The current integration to the OEHRM will use the system as is.
- L. The system does not use Cloud Technology currently. A test pilot is being built to determine suitability.
- M. This is a not applicable as it is not being used in the Cloud.
- N. This will be determined once the pilot has been completed to deployed.
- O. If any information off TRM Plus is exposed it will not result in a breach of patient confidentiality or treatment. This information is stored in VistA and secured by VistA protocols.

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:

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Name | <input checked="" type="checkbox"/> Date of Birth | <input checked="" type="checkbox"/> Personal Mailing Address |
| <input checked="" type="checkbox"/> Social Security Number | <input type="checkbox"/> Mother's Maiden Name | |

- Personal Phone Number(s)
- Personal Fax Number
- Personal Email Address
- Emergency Contact Information (Name, Phone 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)

The veterans service connection is asked.

PII Mapping of Components

Telecare Records Manager Plus does not have any mapped components outside of VistA. This is not applicable. See table below.

PII Mapped to Components

PII Mapped to Components

Components of the information system (servers) collecting/storing PII	Does this system collect PII? (Yes/No)	Does this system store PII? (Yes/No)	Type of PII (SSN, DOB, etc.)	Reason for Collection/ Storage of PII	Safeguards
Telecare Records Manager Plus Biometric Service	Yes	Yes	Person full name (first, middle, and last), Social Security Number, Date and place of birth, address, telephone number, etc.	Ensure the right person is on the call, and the correct records is retrieved from VistA	Data is encrypted

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.

TRM+ sources of information are reported via telephone interview. Other sources of data come from VistA Electronic Health Record, VistA Capri and VBA documented information in Electronic Health Record. A normal medical review is not conducted such as vitals, Global Assessment Functioning (GAF) or Minnesota Multiphasic Personality Inventory (MMPI). Therefore, this type of patient cannot be physical reviewed. However, use of a mini mental exam, and certain question scripts have been done to asses these areas.

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.

The Patient/Veteran is asked questions over the phone during a patient telephone interview. No information is kept, but the information is gathered from this telephone interview from the questions are: Person full name (first, middle, and last), Social Security Number, Date and place of birth, address, telephone number, etc. Then from the information given during the interview the review of data is then extracted from VistA Electronic Health Record, VistA Capri and VBA documents in the Electronic Health Record.

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 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.

Purpose to ensure a continuum of care is maintained after a telephone triage session. This include determining if the patient has symptoms of know medical issues. Then provide continuance of services at approved medical facilities in case of emergent symptoms. Lastly, to improve veterans experience with the Department of Veterans Affair Healthcare system.

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.

Hourly data checks are completed via VistA mirroring. The TRM Plus Server has a persistent report that monitors pre-determined threshold of services ran and completed.

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

The SSN serves as a unique patient identifier that is used primarily for treatment, billing purposes and health care services. Title 38, U.S.C. Chapter 3, Section 210 (c) (1), Title 38 U.S.C. 7301, 5 U.S.C. 552a. and Executive order 9397. System of Record Notice (SORN) 24VA10P2; 79VA10.” Another applicable System of Records Notices (SORN) are 24VA10A7, Patient Medical Record-VA, and 121VA10A7, National Patient Databases-VA, and would likely not require amendment. <https://www.va.gov/vhapublications/rcs10/rcs10-1.pdf>. Official record held in the office of record. Temporary; destroy 6 years after final payment or cancellation, but longer retention is authorized if required for business use. (GRS 1.1, Item 010 <https://www.archives.gov/>) (DAA-GRS-2013-0003-0001) <https://www.archives.gov/files/records-mgmt/grs/grs01-1.pdf>

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 TRM Plus application retrieves and reviews Personally Identifiable Information (PII), Protected Health Information (PHI), and other highly delicate Sensitive Personal Information (SPI). If this information were to be breached or accidentally released to inappropriate parties or the public, it could result in financial, personal, and/or emotional harm to the individuals whose information is contained in the system. All strategies to ensure secure telephone transmissions are taken by each TRM Plus end user. This is done via the physical phone lines they use at a medical facility. Each record is reviewed by the Call Center Manager daily and weekly. Discrepancies are reported and corrected with the type of correction and strategies to counter them.

Mitigation: The Department of Veterans Affairs is careful to only collect the information necessary to identify the Veteran in crisis, identify the potential issues and concerns, and offer assistance to the Veteran so that they may find the help they need to get through their crisis. By only reviewing the minimum necessary information, the VA is able to better protect the Veterans' information. Users are trained on how to handle sensitive information by taking VA Privacy and security awareness training and reading and attesting they understand the VA Rules of Behavior on an annual basis.

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.

All data collected or documented is placed into the patient Electronic Health Record. It is maintained for the life of the health record in VistA. In supporting proper medical triage at a telephone interactive point. Each triage encounter is screened during medical records committee reviews.

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

For all records that are developed concerning a patient they are reviewed by the local Medical Facility - Medical Records Committee. The Telehealth record is reviewed and audited using this same process and procedure. These records are reviewed weekly to monthly as prescribed in the Joint Commission Accreditation standards. For IT systems, the VistA system undergoes a consistent, constant and predefined data review each day. Mirroring and authenticated storage are completed by the VA OI&T Office of Information Security.

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.

PII access is followed by a Service Administrative Officer/Supervisor/designee(s) submit an ePAS request for new user's Veterans Health Information Systems and Technology Architecture (VistA) ePAS request can include VistA menu options/security keys, Clinical Patient Record System (CPRS) access, etc. The local VHA site OI&T is responsible to complete the ePAS request. The monitoring is based on audits provided by Privacy Office for the facility or whoever is responsible. There is no use outside of medical records documentation. If there is a reason to assess a medical records data collection than that would need to be addressed by that agency. TRM Plus is not assessed for PII or PHI since it is solely documented in the medical records.

Privacy Risk:

PII/PHI may be put at risk in a case where a hacker might attempt to break in to a patient, customer service agent interview call to steal a patients identification.

Mitigation:

All VHA staff is responsible for assuring safeguards for the PII. Organizational and Non-Organizational users are required to take the Talent Management System (TMS) VA Privacy and Information Security Awareness and Rules of Behavior Training yearly. VHA facilities ISSO is responsibility to monitor VistA access and verify the TMS training has been completed and current. Careful attention to the Electronic Medical Record document process is followed and utilized by the recorder. Unauthorized person(s) are not allowed into this system. Agent and the caller must assume responsibility to not discuss what is outside of the needed items for proper documentation. So, the same definition of how a medical provider handles sensitive information is the same an agent will adhere to.

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

Records related to treatment, diagnosis and disposition are maintained in Accordance With current Records Control Schedule 10-1 and disposal procedures are set forth in 44 U.S.C. Chapter 33. protocols.

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.

Patient care (PHI and PII are maintained by the VistA system until archived or patient expiration. These are normally backed up and saved into an archival database according to Records Control Schedule 10-1 and VHA HANDBOOK 1907.01 for a period of 75 years.

<https://www.va.gov/vhapublications/rcs10/rcs10-1.pdf>

The TRM Plus records are to be maintained indefinitely as long as necessary in the Veterans Health Information Systems and Technology Architecture (VistA) System. Whenever technically feasible, all records are retained indefinitely in the event of additional follow-up actions on behalf of the individual. VA Electronic Health Records (EHR) system permanently retains data as part of ongoing healthcare.

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.

Official record held in the office of record. Temporary; destroy 6 years after final payment or cancellation, but longer retention is authorized if required for business use. (GRS 1.1, Item 010 <https://www.archives.gov/>) (DAA-GRS-2013-0003-0001) <https://www.archives.gov/files/records-mgmt/grs/grs01-1.pdf>

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

For TRM Plus, there is no paper record documented for a veteran. The Electronic health Record follows prescribed criteria after a patient is no longer active. The TRM Plus records are to be maintained indefinitely as long as necessary; the records are all electronic (no paper). No records have ever needed to be destroyed, whenever technically feasible, all records are retained indefinitely in the event of additional follow-up actions on behalf of the individual. VA Electronic Health Records (EHR) system permanently retains data as part of ongoing healthcare.

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

No use of “Live” patient data is provided for training purposes. There is a specific “Test VistA” that will be used for training and research of product purposes. In cases of research for Telehealth a direct review of the Telehealth process and procedures would need to be accomplished.

TRM Plus Patches (VistA KIDS build and GUI executable) are released Nationally for installation prior to testing. With an approved MOU (Memorandum of Understanding) from the IOC (Interoperability Operational Coordination) site(s), the vendor, Document Storage System (DSS Inc.), Test Patches are installed and tested in the VistA and TRM Plus Pre-Production Test System. IOC site(s) tester(s) complete the Test Site(s) User’s Acceptance VistA Pre-Production System document prior to VistA and TRM Plus Production System installation.

New TRM Plus Patches are released for National installation after the IOC Test Site(s) User’s Acceptance VistA Production System document(s) are received.

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: No data to store within the TRM Plus System. The normal risk is associated with the information could be compromised or breached in the Veterans Health Information Systems and Technology Architecture (VistA) System. The only risk identified with storage, maintenance and disposition would be catastrophe failure. In the event of total continental geographic disaster. All storage electronic VistA systems have at least four storage redundancy locations. These cover Pacific time zone, Mountain time zone, Central Time zone and East time zones. So, in the event one area/time zone went down the others would pick-up the storage or retention.

Mitigation:

All Veterans Health Information Systems and Technology Architecture (VistA) Systems are stored on an milli-second basis to a shadow system. This shadow is then saved to a set of off-site systems. These systems are in the various time zone of the continental United States. Each is interconnected as to have a up to the minute retrieval or re-recreation and setback to the original state of functioning.

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.

<i>List the Program Office or IT System information is shared/received with</i>	<i>List the purpose of the information being shared /received with the specified program office or IT system</i>	<i>List the specific data element types such as PII/PHI that are shared/received with the Program Office or IT system</i>	<i>Describe the method of transmittal</i>
Veterans Health Administration	Triage symptoms as reported by patient. Patient information is documents only in VistA Progress Note.	System Log files, sample clinical data that may contain Protected Health Information (PHI)	Electronically pulled from VistA thru Computerized Patient Record System (CPRS)

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: The privacy risk associated with maintaining PII/PHI is that sharing data within the Department of Veteran’s Affairs could happen, and that data may be disclosed to individuals who do not require access and heightens the threat of the information being misused.

Mitigation: The principle of need-to-know is strictly adhered to by the population Healthcare and non-Healthcare providers. Only personnel with a clear business purpose are allowed access to the system and the information contained within the system. Users are trained how to handle sensitive information by taking VA Privacy and security awareness training and reading and attesting they understand the VA Rules of Behavior on an annual basis.

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

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

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: The privacy risk associated with maintaining PII/PHI is that sharing data outside of the Department of Veteran’s Affairs could happen and that data may be disclosed to individuals who do not require access and heightens the threat of the information being misused.

Mitigation:

Only personnel with a clear business purpose are allowed access to the system and the information contained within the system. All personnel accessing veteran information must have a successfully adjudicated.

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.

Each triage call begins with the notification that will be encountering a live medical person. This process begins with them verifying their authenticated items. Then a discussion of the privacy policy is instituted at first contact. All data in TRM Plus is secondary data, displayed from the VistA data contained in the Electronic Health Record. The VistA data is generated as part of routine medical care. Veterans are provided with Privacy Act statements as part of routine medical care. Additional notice is provided by the system's System of Record Notice (SORN), Veterans health information systems and technology architecture (VistA) Records VA SORN 79VA10. A third form of notice is provided by this Privacy Impact Assessment, which is available online as required by the eGovernment Act of 2002, Pub.L. 107-347 §208(b)(1)(B)(iii). https://www.oprm.va.gov/docs/Current_SORN_List_12_23_2020.pdf

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

Yes. A veteran is not denied service but rather is asked to comply as to provide the best service that can be given. If they do not comply treatment of presented issues will not be fully provided. Rather, the veteran will be informed they cannot be treated for any symptoms or issues which a provider is not aware of. In addition, treatment for a problem or verifying an issue cannot be accomplished.

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

Yes. The veteran is advised of the purpose of collection information is for proper disposition. Any disclosure of this information is documented in the Electronic Health record and will not be disclosed otherwise. The Privacy Act and VA policy require that personally identifiable information only be used for the purpose(s) for which it was collected, unless consent (opt-in) is granted. Individuals must be provided an opportunity to provide consent for any secondary use of information, such as use of collected information for marketing.

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: If notice isn't provided then individuals will unknowingly be giving up their information that will be used for other purposes.

Mitigation: To prevent any inaccurate data, only authorized VA clinical personnel have access to the information. Notice is provided by SORN 79VA10 and all individuals should check their local VA facilities VistA PIA for more information regarding notice and consent (if applicable).

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.

VHA Directive 1605.01 Privacy and Release Information', section 7(b) states the rights of the Veterans to request access to review their records. VA Form 10-5345a, Individual's Request for a Copy of Their Own Health Information, may be used as the written request requirement. All requests to review must be received by direct mail, fax, in person, or by mail referral from another agency or VA office. All requests for access must be delivered to and reviewed by the System Manager for the concerned VHA system of records, the facility Privacy Officer, or their designee. Each request must be date stamped and reviewed to determine whether the request for access should be granted.

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.

Under the jurisdiction of VHA, VHA Directive 1605.01 Privacy and Release Information', section 8 states the rights of the Veterans to amend their records. The request must be in writing and adequately describe the specific information the individual believes to be inaccurate, incomplete, irrelevant, or untimely and the reason for this belief. A request for amendment of information contained in a system of records must be delivered to the System Manager, or designee, for the concerned VHA system of records, and the facility Privacy Officer, or designee Privacy Office/FOIA 1-877-750-3642 /1-877-750-3642, email: privacyservice@va.gov.

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.

Notification for correcting the information must be accomplished by informing the individual to whom the record pertains. The individual making the amendment must be advised in writing that the record has been amended and provided with a copy of the amended record. The System Manager for the concerned VHA system of records, the facility Privacy Officer, or their designee, must notify the relevant persons or organizations who had previously received the record about the amendment. If 38 U.S.C. 7332- protected information was amended, the individual must provide written authorization to allow the sharing of the amendment with relevant persons or organizations request to amend a record must be acknowledged in writing within 10 workdays of receipt. If a determination has not been made within this time period, the System Manager for the concerned VHA system of records or designee, and/or the facility Privacy Officer, or designee, must advise the individual when the facility expects to notify the individual of the action taken on the request. The review must be completed as soon as possible, in most cases within 30 workdays from receipt of the request. If the anticipated completion date indicated in the acknowledgment cannot be met, the individual must be advised, in writing, of the reasons for the delay and the date action is expected to be completed. The delay may not exceed 90 calendar days from receipt of the request.

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.

Notification for correcting the information must be accomplished by informing the individual to whom the record pertains. The individual making the amendment must be advised in writing that the record has been amended and provided with a copy of the amended record. The System Manager for the concerned VHA system of records, the facility Privacy Officer, or their designee, must notify the relevant persons or organizations who had previously received the record about the amendment. If 38 U.S.C. 7332- protected information was amended, the individual must provide written authorization to allow the sharing of the amendment with relevant persons or organizations request to amend a record must be acknowledged in writing within 10 workdays of receipt. If a determination has not been made within this time period, the System Manager for the concerned VHA system of records or designee, and/or the facility Privacy Officer, or designee, must advise the individual when the facility expects to notify the individual of the action taken on the request. The review must be completed as soon as possible, in most cases within 30 workdays from receipt of the request. If the anticipated completion date indicated in the acknowledgment cannot be met, the individual must be advised, in writing, of the reasons for the delay and the date action is expected to be completed. The delay may not exceed 90 calendar days from receipt of the request.

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 the individual accidentally provides incorrect information in their correspondence.

Mitigation: Veterans provide information at the local VAMC. Any validation performed would merely be the Veteran personally reviewing the information before they provide it. Individuals are allowed to provide updated information for their records by submitting new forms or correspondence and indicating to the VA that the new information supersedes the previous data.

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.

Users are granted access to TRM Plus via two methods. First, they must be added via VistA Secondary and Primary Menu's. These are given after proper request is submitted via VistA access methods. I.e. ePAS, ECAR or local access requests. The second area is via Windows Active Directory security groups. This group is only given by OI&T after a proper submission is made by the supervisory TRM Plus Manager using: I.e. ePAS, ECAR or local access requests. For new application user's Veterans Health Information Systems and Technology Architecture (VistA) System account and the new application user have completed the Talent Management System (TMS) VA Privacy and Information Security Awareness and Rules of Behavior Training.

OI& Technical staff:

ePAS approval for System Administrator, Application Administrator, VistA Management permission.

Talent Management System (TMS) Inform Security for IT Specialist, Information Security for System Admin, Elevated Privileges for System Access, and VA Privacy and Information Security Awareness and Rules of Behavior Training.

Non-Mail enabled account (NMEA) and associated token (USB/OTP) to access the servers

Note: Organizational and Non-Organizational users are required to take the Talent Management System (TMS) VA Privacy and Information Security Awareness and Rules of Behavior Training yearly.

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. Contractors and vendors does not have access to COTS Interface Division servers/applications.

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.

Personnel that will be accessing information systems must read and acknowledge their receipt and acceptance of the VA National Rules of Behavior (ROB) or VA Contractor's ROB (for AITC technicians) prior to gaining access to any VA information system or sensitive information. The rules are included as part of the security awareness training which all personnel must complete via the VA's TMS. After the user's initial acceptance of the Rules, the user must re-affirm their acceptance annually as part of the security awareness training. Acceptance is obtained via electronic acknowledgment and is tracked through the TMS system. All VA employees must complete annual HIPAA, Privacy and Security training. Users agree to comply with all terms and conditions of the National Rules of Behavior, by signing a certificate of training at the end of the training session.

8.4 Has Authorization and Accreditation (A&A) been completed for the system? No

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**.

No. TRM+ is in the process of submitting for an ATO in eMASS once all artifacts are uploaded. TRM+ is currently a minor under Clinical Case Registries (CCR) the ATO expires 12 June 2021.

Section 9. References

Summary of Privacy Controls by Family

Summary of Privacy Controls by Family

ID	Privacy Controls
AP	Authority and Purpose
AP-1	Authority to Collect
AP-2	Purpose Specification
AR	Accountability, Audit, and Risk Management
AR-1	Governance and Privacy Program
AR-2	Privacy Impact and Risk Assessment
AR-3	Privacy Requirements for Contractors and Service Providers
AR-4	Privacy Monitoring and Auditing
AR-5	Privacy Awareness and Training
AR-7	Privacy-Enhanced System Design and Development
AR-8	Accounting of Disclosures
DI	Data Quality and Integrity
DI-1	Data Quality
DI-2	Data Integrity and Data Integrity Board
DM	Data Minimization and Retention
DM-1	Minimization of Personally Identifiable Information
DM-2	Data Retention and Disposal

ID	Privacy Controls
DM-3	Minimization of PII Used in Testing, Training, and Research
IP	Individual Participation and Redress
IP-1	Consent
IP-2	Individual Access
IP-3	Redress
IP-4	Complaint Management
SE	Security
SE-1	Inventory of Personally Identifiable Information
SE-2	Privacy Incident Response
TR	Transparency
TR-1	Privacy Notice
TR-2	System of Records Notices and Privacy Act Statements
TR-3	Dissemination of Privacy Program Information
UL	Use Limitation
UL-1	Internal Use
UL-2	Information Sharing with Third Parties

Signature of Responsible Officials

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

Privacy Officer, Andrea Wilson

Information Systems Security Officer, Roland Parten

System Owner, Christopher Brown

APPENDIX A-6.1

Please provide a link to the notice or verbiage referred to in Section 6 (a notice may include a posted privacy policy; a Privacy Act notice on forms).

https://www.oprm.va.gov/docs/Current_SORN_List_12_23_2020.pdf