Privacy Impact Assessment for the VA IT System called:

Oncology Application

MAVERIC

Veterans Health Administration

Date PIA submitted for review:

12/6/2021

System Contacts:

<table>
<thead>
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<th>E-mail</th>
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</tr>
</thead>
<tbody>
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<td>Privacy Officer</td>
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</tr>
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</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.

The Oncology Application (OncApps) is a data platform that aggregates patients’ longitudinal clinical history with molecular profile data and displays this information in summary table and dashboard views for providers, in order to inform clinical decisions. The database will serve as a knowledge base for providers (e.g., results of prior treatment, etc.) when encountering similar cases. A key functionality of OncApps is trial matching. Finding clinical trials for oncology patients is an important aspect of clinical care especially those with metastatic diseases. The platform will include curated data about clinical trials that the patient may be eligible for, based on information in the patient’s medical history. The system categorization is Moderate.

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.
- Indicate the ownership or control of the IT system or project.
- The expected number of individuals whose information is stored in the system and a brief description of the typical client or affected individual.
- A general description of the information in the IT system and the purpose for collecting this information.
- 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? If the system is using cloud technology, does the SORN for the system cover cloud usage or storage?

The IT system name is Oncology Application (OncApps) and the program office that owns the IT system is MAVERIC Informatics. The business purpose for OncApps is to aid clinical staff by presenting data to inform decision for their patients diagnosed with cancer. This project is supported by VA National Oncology Program Office which is built and maintained by MAVERIC Informatics. The expected number of individuals whose information is stored in the system is <100,000 and the typical affected individual are Veterans who have been diagnosed with cancer. The general description of information in IT system is the personally identifiable health information of Veterans data for the purpose of clinical trial matching. Any information sharing conducted by IT system will be as an aggregate set of information that will be shared via a web
browser to clinical staff (i.e. clinicians/nurses) and the control/access is limited by PIV enforcement. The system is operated in only one site where the database will be stored in the Martinsburg Data Center, WV. Citation of legal authority to operate IT system is that the Oncology Application (OncApps) system has been granted a short term ATO. Whether the implementation of this PIA will change business processes is not applicable because the OncApps automates a current business process. The Oncology Application (OncApps) does not modify the system and is utilizing current approved infrastructure.

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://vawww.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.

The information selected below must match the information provided in question 2.1 as well as the data elements columns in 4.1 and 5.1.

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 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
- ☐ Gender
- ☐ Integration Control Number (ICN)
- ☐ Military History/Service Connection
- ☐ Next of Kin
- ☐ Other Unique Identifying Information (list below)
No Additional Information Collected

**PII Mapping of Components**

**Oncology Application** consists of one key component (database). Each component has been analyzed to determine if any elements of that component collect PII. The type of PII collected by MAVERIC and the reasons for the collection of the PII are in the table below.

**PII Mapped to Components**

*Note:* Due to the PIA being a public facing document, please do not include the server names in the table.

### PII Mapped to Components

<table>
<thead>
<tr>
<th>Database Name of the information system 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>Oncology Application (OncApps)</td>
<td>Yes</td>
<td>Yes</td>
<td>Name, Social Security Number, Date of Birth, Personal Mailing Address, Personal Phone Number (s), Current Medications, Previous Medical Records, Race/Ethnicity, Medical Record</td>
<td>Identify patients for clinical trials enrollment</td>
<td>PIV Enforcement The VA enforces two-factor authentication by enforcing smartcard logon requirements. PIV cards are issued to employees, contractors, and partners in accordance with HSPD-12. The Personal Identity Verification (PIV) Program is an effort</td>
</tr>
</tbody>
</table>
directed and managed by the Homeland Security Presidential Directive 12 (HSPD-12) Program Management Office (PMO). IT Operations and Services (ITOPS) Solution Delivery (SD) is responsible for the technical operations support of the PIV Card Management System.

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.
Corporate Data Warehouse (CDW) & National Precision Oncology Program (NPoP) are the sources of the information in the Oncology Application (OncApps) 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.

We are using an automated SQL scripting to connect to the Corporate Data Warehouse and the National Precision Oncology Program.

1.4 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.

Validation of the data in the Oncology Application (OncApps) is checked for accuracy with the Corporate Data Warehouse along with Quality Assurance by the patient care team.

1.5 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

SORN reference 172VA10A7 (VHA Corporate Data Warehouse-VA)
Notice of Privacy Practices, effective date 9-30-2019 (NOPP_IB163 final 7-17-19).
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8928

1.6 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 Oncology Application (OncApps) is a data platform that aggregates patients' longitudinal clinical history with molecular profile data. The database does contain PII Information; Unauthorized disclosure of this information would give visibility into an individual's Information and Health records. Additionally, it would violate the privacy act of 1974 and HIPAA. This may have a serious adverse effect on VA operations, assets, or individuals.

Mitigation:
Mitigation measures include access control, awareness and training, audit and accountability, certification, accreditation, and security assessments, configuration management, contingency planning,
identification and authentication, incident response, maintenance, media protection, physical and environmental protection, planning, personnel security, risk assessment, systems and services acquisition, system and communications protection, and system and information integrity.

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.

Oncology Application consists of nine (internal to the VA) key components consisting of

- **Name**: Used to identify the patient during appointments and in other forms of communication
- **Social Security Number**: Used as a patient identifier and as a resource for verifying income Information with the Social Security Administration
- **Date of Birth**: Used to identify age and confirm patient identity
- **Mailing Address**: Used for communication, billing purposes and calculate travel pay
- **Phone Number(s)**: Used for communication, confirmation of appointments and conduct Telehealth appointments
- **Current Medications**: Used within the medical records for health care purposes/treatment, prescribing medications and allergy interactions.
- **Previous Medical Records**: Used for continuity of health care
- **Race/Ethnicity**: Used for patient demographic information and for indicators of ethnicity-related diseases.
- **Medical Record Number**: Used to identify a patient within the medical record system without using their social security number as their identifier.

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

The Oncology Applications does not perform any analysis and no data is created.

2.3 How is the information in the system secured?
   2.3a What measures are in place to protect data in transit and at rest?

Advanced Encryption Standard (AES) 256 safeguards are in place, servers are stored in a secured environment and managed with restricted access controls

2.3b If the system is collecting, processing, or retaining Social Security Numbers, are there additional protections in place to protect SSNs?

Access and control to the Oncology Application is provided through PIV enforcement. Criteria, procedures, controls, and responsibilities regarding access is documented through PIV login.

2.3c How is PII/PHI safeguarded in accordance with OMB Memorandum M-06-15?

Controls are in place to assure that the information is handled in accordance with the uses described above to include mandatory online information security and Privacy and HIPAA training; face-to-face training for all incoming new employees conducted by the Information System Security Officer and Privacy Officer; and regular audits of individuals accessing sensitive information to ensure information is being appropriately used and controlled.

This question is related to security and privacy controls SC-9, Transmission Confidentiality, and SC-28, Protection of Information at Rest

2.4 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.

Access is requested through SharePoint and approved/declined by the program manager. Access and control to the Oncology Application is provided through PIV enforcement. Criteria, procedures, controls, and responsibilities regarding access is documented through PIV login. Approval is managed through clinical care staff of the Veterans who have been diagnosed with cancer. Access to the PII is being controlled through PIV login. The same training for clinical staff (i.e., clinicians/nurses) to access CPRS and CAPRI is applicable here.

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

The following information is retained by the system:
Social Security Number
Date of Birth
Personal Mailing Address
Personal Phone Number
Current Medications
Medical Records
Previous Medical Records
Race/Ethnicity

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. If the system is using cloud technology, will it be following the NARA approved retention length and schedule?

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 medical records are retained for a total of 75 years after the last episode of care. (Department of Veterans Affairs Record Control Schedule (RCS)10-1, Part Three, Chapter Six- Healthcare Records, Item 6000.1a. and 6000.1d.

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. (Department of Veterans Affairs Record Control Schedule (RCS)10-1, Part Three, Chapter Six- Healthcare Records, Item 6000.1a. and 6000.1d.

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

“Electronic media sanitization, when the records are authorized for destruction (or upon system decommission), will be carried out in accordance with VA Directive 6500 VA Cybersecurity Program. Paper documents are destroyed to an unreadable state in accordance with the Department of Veterans’ Affairs VA Directive 6371, (October 29, 2010),

file:///C:/Users/618707/Downloads/VA251-12-R-0228-003.PDF

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 Directive 6500, VA Cybersecurity Program (February 24, 2021), Directive_6500_24_Feb_2021.pdf (va.gov). 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 Directive 6500. Digital media is shredded or
sent out for destruction per VA Directive 6500. 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.

VA Directive 6500 mandates that Systems under development should not process “live data” or do any real processing in which true business decisions will be based. Test data used to test and develop systems, that have not yet undergone security Assessment and Authorization (A&A), must be de-identified. » Per the HIPAA Privacy laws, data that has been de-identified is no longer defined as PII. The PO can personally assure that the data has been properly de-identified or the VA form 10-250 can be used for this assurance. » Systems that are in development (pilot, proof-of-concept, or prototype) should not be attached to VA networks without first being assessed and authorized. » Healthcare Portal (i.e. MyHealthyVet, etc.) provides encryption through secure messaging for compliance with FIPS 140-2 policy. Additionally, the Healthcare Portal enrollment process supports verifying a subject’s identity before allowing access to the application for increased authentication. » Mobile media must follow the encryption standards as set forth in the ESO Data and Media Protection SOP.

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:
Due to the highly sensitive nature of this data, there is a risk that, if the data were accessed by an unauthorized individual or otherwise breached, serious harm may result for the individuals affected.

Mitigation:
OncApps employs a variety of security measures designed to ensure that the information is not inappropriately disclosed or released. These measures include access control, awareness and training, audit and accountability, certification, accreditation, and security assessments, configuration management, contingency planning, identification and authentication, incident response, maintenance, media protection, physical and environmental protection, planning, personnel security, risk assessment, systems and services acquisition, system and communications protection, and system and information integrity.

Employees complete the Privacy and HIPAA Focused training as well as the VA Privacy and Information Security Awareness & Rules of Behavior training annually. The VA enforces two-factor authentication by enforcing smartcard logon requirements. PIV cards are issued to employees, contractors, and partners in accordance with HSPD-12. The Personal Identity Verification (PIV) Program is an effort directed and managed by the Homeland Security Presidential Directive 12 (HSPD-12) Program Management Office (PMO). IT Operations and Services (ITOPS) Solution Delivery (SD) is responsible for the technical operations support of the PIV Card Management System.

Section 4. Internal Sharing/Receiving/Transmitting and Disclosure

The following questions are intended to define the scope of information sharing/receiving/transmitting within VA.

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?  
NOTE: Question 3.9 (second table) on Privacy Threshold Analysis should be used to answer this question.

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 PII/PHI data elements that are processed (shared/received/transmitted) with the Program Office or IT system</th>
<th>Describe the method of transmittal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Data Warehouse (CDW)</td>
<td>The Oncology Application (OncApps) is a data platform that aggregates patients’ longitudinal clinical history with molecular profile data, and displays this information in a summary view</td>
<td>Demographics (name, date of birth, sex, race, ethnicity), health information (diagnosis, labs, pathology reports, medications, comorbidities, procedures, oncology notes, radiology reports)</td>
<td>SQL scripting to transfer data to local instance in Martinsburg, WV</td>
</tr>
<tr>
<td>Martinsburg Data Center, WV</td>
<td>The Oncology Application (OncApps) is a data platform that aggregates patients’ longitudinal clinical history with molecular profile data, and displays this information in a summary view</td>
<td>Cancer type, staging, functional status, cancer treatment history, medications, lab results, pathology reports, radiology reports, procedures, comorbidities, oncology progress notes, biomarkers, complications from disease or treatment.</td>
<td>SQL scripting to transfer data to local instance in Martinsburg, WV</td>
</tr>
<tr>
<td>National Precision Oncology Program (NPOP) Database</td>
<td>The Oncology Application (OncApps) is a data platform that aggregates</td>
<td>cancer (type, histology) and genomic information (biomarkers, mutations)</td>
<td>SQL scripting to transfer data to local instance in Martinsburg, WV</td>
</tr>
<tr>
<td>List the Program Office or IT System information is shared/received with</td>
<td>List the purpose of the information being shared/received with the specified program office or IT system</td>
<td>List the specific PII/PHI data elements that are processed (shared/received/transmitted) with the Program Office or IT system</td>
<td>Describe the method of transmittal</td>
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<tr>
<td>patients’ longitudinal clinical history with molecular profile data, and displays this information in a summary view</td>
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### 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 application is only accessible for authorized users. Users can only see patients at their primary VA site or sites relevant for their workflow. Where possible last 4 SSN will be used instead of full SSN. The risk for unauthorized users to access PII and viewing patients not relevant to their workflow.

**Mitigation:**

Maintain PIV enforcement for control and access of PII for users to view patients at their own VA site and use last 4 SSN where possible.

### 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: Question 3.10 on Privacy Threshold Analysis should be used to answer this question.

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

<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 PII/PHI data elements that are processed (shared/received/transmitted) 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>
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No information is shared/received to outside VA.
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.

SORN reference 172VA10A7 (VHA Corporate Data Warehouse-VA).

Notice of Privacy Practices, effective date 9-30-2019 (NOPP_IB163 final 7-17-19).
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 SORN reference 172VA10A7. Notice of Privacy Practices, effective date 9-30-2019 (NOPP_IB163 final 7-17-19).

Information is needed to administer benefits to veterans and other potential beneficiaries. While an individual may choose not to provide information, this may prevent them from obtaining services and benefits.

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


Individuals must submit a request in writing to their facility Privacy Officer. The request must state what information and/or to whom the information is restricted and must include their signature and date of the request. Individuals may also request to Opt-Out of the facility directory during an inpatient admission. If the individual chooses to opt-out, no information on the individual is given out.

Individuals can request further limitations on other disclosures. A veteran, legal guardian or court appointed Power of Attorney can submit a request to the facility Privacy Officer to obtain information.

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:**
Indi[403x67]viduals are unaware of the process to amend health records.

**Mitigation:**
Notice is provided through the Notice of Privacy Practices which is provided to patients upon enrollment and upon revision.

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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 have a right of access under the Privacy Act of 1974. Individuals may request a copy of their records and receive an Accounting of Disclosures thru Health Information Management Service.

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.

Individuals may contact facility Privacy Officer for Amendment Request.

Individuals are required to provide a written request to amend or correct their records to the appropriate Privacy Officer or System Manager as outlined in the Privacy Act SOR. Every Privacy Act SOR contains information on Contesting Record Procedure which informs the individual who to contact for redress.

Veterans are informed of the amendment process by many resources to include the VHA Notice of Privacy Practice (NOPP) which states: Right to Request Amendment of Health Information. You have the right to request an amendment (correction) to your health information in our records if you believe it is incomplete, inaccurate, untimely, or unrelated to your care. You must submit your request in writing, specify the information that you want corrected, and provide a reason to support your request for amendment. All amendment requests should be submitted to the facility Privacy Officer at the VHA health care facility that maintains your information. If your request for amendment is denied, you will be notified of this decision in writing and provided appeal rights. In response, you may do any of the following:

File an appeal
File a “Statement of Disagreement”
Ask that your initial request for amendment accompany all future disclosures of the disputed health information.

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.
Thru the Notice of Privacy Practices, individuals are notified of process to amend health information and request restriction.

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 ensures data accuracy.

Redress is provided thru Amendment and Restriction processes. Individuals are required to provide a written request to amend or correct their records to the appropriate Privacy Officer or System Manager as outlined in the Privacy Act SOR. Every Privacy Act SOR contains information on Contesting Record Procedure which informs the individual who to contact for redress.

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:
Includes inaccurate health information such as demographics, medical information, sex, age, medications, etc.
There is a risk that members of the public will not know the relevant procedures for gaining access to, correcting, or contesting their information.

**Mitigation:**
Individuals have a right to request amendment and restriction of use of information contain within the Oncology Application system.

VA Boston mitigates the risk of incorrect information in an individual’s records by authenticating information when possible using the resources discussed in question 1.5. Additionally, staff verifies information in medical records and corrects information identified as incorrect during each patient’s medical appointments.

As discussed in question 7.3, the NOPP, which every enrolled Veteran receives every three years or when there is a major change. The NOPP discusses the process for requesting an amendment to one’s records.

VA Boston’s Release of Information (ROI) office is available to assist Veterans with obtaining access to their health records and other records containing personal information.

The Veterans’ Health Administration (VHA) established MyHealtheVet program to provide Veterans remote access to their medical records. The Veteran must enroll and have access to the premium account to obtain access to all the available features. In addition, VHA Directive 1605.01 Privacy and Release of Information establishes procedures for Veterans to have their records amended where appropriate.

**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.

The control and access to the OncApps is controlled and maintained by PIV enforcement.
Individuals receive access to the Area Boston by gainful employment in the VA or upon being awarded a contract that requires access to the Area systems. Upon employment, the Office of Information & Technology (OI&T) creates computer and network access accounts as determined by employment positions assigned. Users are not assigned to software packages or network connections that are not part of their assigned duties or within their assigned work area. VA Area Boston requires access to the GSS be requested using the local access request system. VA staff must request access for anyone requiring new or modified access to the GSS. Staff are not allowed to request additional or new access for themselves.

Access is requested utilizing Electronic Permission Access Area Boundary (ePAS). Users submit access requests based on need to know and job duties. Supervisor, ISSO and OI&T approval must be obtained prior to access granted. These requests are submitted for VA employees, contractors and all outside agency requests and are processed through the appropriate approval processes. Once access is granted, individuals can log into the system(s) through dual authentication, i.e., a PIV card with a complex password combination. Once inside the system, individuals are authorized to access information on a need-to-know basis.

Strict physical security control measures are enforced to ensure that disclosure to these individuals is also based on this same principle. Generally, VA file areas are locked after normal duty hours and the facilities are protected from outside access by the Federal Protective Service or other security personnel. Access to computer rooms at VA Area Boston is generally limited by appropriate locking devices and restricted to authorized VA IT employees. Access to information stored on automated storage media at other VA locations is controlled by individually unique passwords/codes. Access by Office of Inspector General (OIG) staff conducting an audit, investigation, or inspection at the health care area, or an OIG office location remote from the health care area, is controlled in the same manner.

Access to the Area Boston working and storage areas is restricted to VA employees who must complete both the HIPAA and Information Security training. Specified access is granted based on the employee’s functional category. Role based training is required for individuals with significant information security responsibilities to include but not limited to Information System Security (ISSO), local Area Manager, System Administrators, Network Administrators, Database Managers, Users of VA Information Systems or VA Sensitive Information.

Human Resources notify Divisions, IT of new hires and their start date(s), through email. The Division that the person is going into fills out the local access form, Automated Systems Access Request form, with name, SSN and/or claim number, job title, division, and telephone number, along with marking the boxes on the form for application access the user will need on the computer system. This form starts at the Division level, is signed by the Division Chief, and Director, for signatures and then to IT for implementation.

• Individuals are subject to a background investigation before given access to Veterans’ information.
• All personnel with access to Veterans’ information are required to complete the VA Privacy and Information Security Awareness training and Rules of Behavior annually AND Privacy and HIPAA Focused Training.

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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, Business Associate Agreement (BAA), 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 have access to the OncApps.

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.

10176 VA Privacy and Security Information Training – TMS, renewed annually. 10203 Privacy and Security Awareness, ROB, renewed annually.

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

If Yes, provide:

1. The Security Plan Status,
2. The Security Plan Status Date,
3. The Authorization Status,
4. The Authorization Date,
5. The Authorization Termination Date,
6. The Risk Review Completion Date,
7. 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.
A temporary ATO has been granted that expires on Jan 28, 2022. System Categorization dated 09/28/2021 as Moderate Impact

**Section 9 – Technology Usage**

The following questions are used to identify the technologies being used by the IT system or project.

9.1 **Does the system use cloud technology? If so, what cloud model is being utilized?**

*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. Types of cloud models include: Software as a Service (SaaS), Infrastructure as a Service (IaaS), Platform as a Service (PaaS), Commercial off the Shelf (COTS).*

*This question is related to privacy control UL-1, Information Sharing with Third Parties.*

*Note: For systems utilizing the VA Enterprise Cloud (VAEC), no further responses are required after 9.1.*

No.

9.2 **Does the contract with the Cloud Service Provider, Contractors and VA customers establish who has ownership rights over data including PII? (Provide contract number and supporting information about PII/PHI from the contract)**

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

N/A

9.3 **Will the CSP collect any ancillary data and if so, who has ownership over the ancillary data?**

*Per NIST 800-144, cloud providers hold significant details about the accounts of cloud consumers that could be compromised and used in subsequent attacks. Ancillary data also involves information the cloud provider collects or produces about customer-related activity in the cloud. It includes data collected to meter and charge for consumption of resources, logs and audit trails, and other such metadata that is generated and accumulated within the cloud environment.*
This question is related to privacy control DI-1, Data Quality.

N/A

9.4 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 are the roles and responsibilities involved between the organization and cloud provider, particularly with respect to managing risks and ensuring organizational requirements are met?

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

N/A

9.5 If the system is utilizing Robotics Process Automation (RPA), please describe the role of the bots.

Robotic Process Automation is the use of software scripts to perform tasks as an automated process that executes in parallel with or in place of human input. For example, will the automation move or touch PII/PHI information. RPA may also be referred to as “Bots” or Artificial Intelligence (AI).

N/A
### Section 10. References

Summary of Privacy Controls by Family

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Signature of Responsible Officials

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

Nora B. Begley
179351

Digitally signed by Nora B. Begley
Date: 2022.01.06 09:37:48 -05'00'

Privacy Officer, Nora Begley

Digitally signed by ANDREW VILAILACK 1811006
Date: 2022.01.03 11:54:57 -05'00'

Information Systems Security Officer, Andrew Vilailack

Digitally signed by NICHOLAS C. BEST 309835
Date: 2022.01.06 09:26:18 -05'00'

Information Systems Owner, Nicholas Best
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.va.gov/vhapublications/ViewPublication.asp?pub_ID=8928