ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Medical Center in San Antonio, Texas
March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation began after the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received information from the South Texas VA Healthcare System (STVHCS), San Antonio, TX, that a member of the support staff (SS1) at the Frank Tejeda VA Outpatient Clinic in San Antonio provided a list of 161 patient names, the last four digits of each patient's Social Security number, and telephone numbers to ABC affiliate, News 4 WOAI (News 4), in San Antonio. A second employee (SS2) at the same clinic was later identified as an individual suspected of releasing patient information to the media.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed five VA employees during the course of this investigation.

- **Records Reviewed:** VA OIG reviewed training records, VA emails of SS1 and SS2, and data relating to access to the protected information.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The subjects' supervisor denied releasing any patient information in a manner that was unauthorized; he indicated that all clerks have the capability of accessing a recall reminder list.

- The privacy officer learned about the release of patient information after the News 4 story ran. She contacted the reporter to identify the VA patients whose identities had been compromised. The reporter was reluctant to release the documentation that the "confidential informants" had provided him. The reporter agreed to release a typed list of the patients' names he had received. The privacy officer subsequently received a fax from the reporter with 161 VA patients' names. VA notified all the veterans found on the list of the disclosure.

- An employee in Medical Administration Service (MAS) stated that any clerk with access to scheduling could pull any clinic's recall delinquency lists. She heard about the story on News 4, but the information was incorrect. The news story alleged that new patients were being placed on a recall reminder list instead of an electronic waiting list (EWL), which was incorrect because the two systems are completely different. She explained that recall reminders are for people who are existing/established patients with scheduling appointments more than 90 days out. EWLs are for new patients to the clinic, which had

no openings. Since recall reminder patients are specific to a particular doctor and clinic, the delinquencies are typically worked by that particular clinic's clerk assigned to the Patient-Aligned Care Team (PACT). She was able to link the patients' names forwarded to the privacy officer on June 9, 2014, to patients listed on recall delinquency lists at the end of April and the beginning of May 2014 for SS1 and SS2. She did state that some clerks were assisting other clerks with "working" recall delinquency lists. She admitted that it would not be odd to see one clerk with another clerk's recall delinquency list.

- SS1 denied releasing any VA patient information to the media. SS1 stated that, about 4 or 5 months ago, support personnel from all over STVHCS were working delinquent recall reminder lists. It was also noted that any scheduler with VistA access can retrieve the delinquent recall reminder list for a specific clinic.

- When interviewed, SS2 denied releasing any VA patient information to the media.

Records Reviewed

- A review of the subjects' VA training records for compliance training associated with HIPAA [Health Insurance Portability and Accountability Act], Ethics, and the Privacy Act verified that SS1 completed VA Talent Management System training in all three areas in September 2013. It was also determined that SS2 completed five courses within these three areas between August 2012 and July 2014.

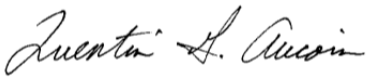
- A review of VA emails for both SS1 and SS2 did not identify any related to the disclosure of patient information to the media. There were no emails from SS1 or SS2 that suggest that either communicated with News 4 or any individual regarding VA-protected information.

- A review of access data showed that while SS1 and SS2 had access to the patient information that was released, the information also was accessible by numerous VA employees, not just SS1 and SS2.

4. Conclusion

The allegations were not substantiated. The investigation did not reveal direct or circumstantial evidence indicating that either SS1 or SS2 was involved in the release of patient information to the media.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015.



QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.