Privacy Impact Assessment
for the

Electronic Patient Care Reporting System

DHS/ALL/PIA-040

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Abstract

The Department of Homeland Security (DHS) Office of Health Affairs (OHA) is implementing a web-based Commercial off the Shelf (COTS) Internet software service called the Electronic Patient Care Reporting System (ePCR). The ePCR system will establish a standardized approach to document care rendered by DHS Emergency Medical Services (EMS) medical care providers in pre-hospital environments. The system will also enhance OHA's capability to evaluate quality of care delivery, quality assurance, performance improvement, and risk management activities. OHA conducted this privacy impact assessment because accurate documentation and quality assurance of EMS care provided necessarily includes gathering personally identifiable information (PII) from patient encounters.

Overview

The Assistant Secretary for Health Affairs and Chief Medical Officer (ASHA/CMO) exercises oversight over all medical and public health activities of DHS. Throughout its components, the DHS workforce includes approximately 3,500 EMS healthcare providers rendering care in the pre-hospital environment, primarily to DHS employees and, when necessary, to individuals encountered in the course of duty in need of emergency care. These DHS EMS healthcare providers work for Customs and Border Protection (CBP), Immigration and Customs Enforcement (ICE), United States Secret Service (USSS), Transportation Security Administration (TSA), U.S. Citizenship and Immigration Services (USCIS), Federal Law Enforcement Training Center (FLETC), Federal Emergency Management Agency (FEMA), and the Science & Technology Directorate (S&T).[1]

OHA administers oversight of DHS EMS healthcare providers through its Medical Quality Management (MQM) program to ensure DHS EMS providers deliver consistent, quality medical care. OHA operates ePCR to support MQM. After administering emergency care, DHS EMS medical care providers manually enter emergency medical care information into ePCR. ePCR captures all aspects of patient care, from the initial dispatch of a vehicle and personnel to a designated site, demographics, vital signs (initial assessment), treatment, and transfer of care and/or patient transport. ePCR improves MQM at the Department by allowing OHA to track and trend data quality, including documentation review, clinical performance, and performance improvement initiatives. This system assists OHA in assessing overall quality of care provided while ensuring that a high standard of care is continually met.

DHS EMS and ePCR Process

The majority of DHS EMS medical care providers use a paper-based standard form (SF) -558, *Emergency Care and Treatment Form* (or component equivalent form) to document care and treatment. This form is used by the provider to document care administered to a patient receiving emergency care, and assist with the transfer of patients out of DHS EMS medical care to private hospitals and other medical facilities as required. The DHS medical care provider or team responds to an emergent situation, and data

[1] USCG began piloting ePCR in Spring 2021.

is collected as to the type of event, location, persons involved. Specific medically-relevant information is collected, such as name, date of birth, age, gender, duty location, address, type of injury, current medications, allergies, past medical history, assessment of injury, chief complaint, vital signs, treatment and/or procedures provided, medication dispensed, and discharge instructions for follow-on care (if applicable).

Based on the diverse locations that DHS EMS medical care providers work, the paper-based record will continue to be used as possible to ensure that documentation can accompany the patient when transferred for continuity of care. This paper record is the official record that inform the patient's medical record, either at a private medical facility or in the employee medical file. The information electronically uploaded to ePCR is for MQM purposes, rather than medical record purposes.

After administering emergency care documented on the paper-based form, DHS EMS medical care provider manually enters information from the form into ePCR. ePCR captures all aspects of patient care, from the initial dispatch of a vehicle and personnel to a designated site, demographics, vital signs (initial assessment), treatment, and transfer of care and/or patient transport. The provider uses a variety of prompts and drop-down menus to document initial care/treatment provided, annotate care over time, and document specific injuries and types of treatment modalities provided including patient response to treatment.

The component Medical Director and the EMS Coordinators and the ePCR Administrator have full administrative rights to view and run reports on their data in ePCR. Additionally, the Component Medical Director or his designee reviews 100% of patient records and provides feedback or requests clarification to the written/electronic patient encounter. After review, the component Medical Director validates that care rendered followed the appropriate treatment and adhered to established medical standards and protocols. Upon review and sign off by the component Medical Director and/or the component EMS Coordinator, any paper-based records are stored in a secure location and/or locked file cabinet at the component. Electronic records in ePCR are maintained by a DHS contractor on a DHS-designated server. Electronic records are protected by restricted access procedures and audit trails established by component administrator as part of the utilization of the ePCR. Users of the ePCR system have varied levels of access dependent on their role. For example, DHS medical care providers only have access to the patient encounters they have initiated and/or to those patient encounters for which they were the second responder and involved in the care rendered; component Medical Directors have full access to all patient encounters as the medical reviewer. The component Medical Director reviews the written and electronic patient records and provides feedback or requests clarification prior to signing off on the patient report. All ePCR users receive training on both use of the system and security compliance at least annually or on an as-needed basis.

DHS EMS medical care providers, OHA Medical Quality Management Branch, and OHA Medical First Responder Coordination Branch officials are given varied levels of administrative access to ePCR based on designated roles and responsibilities. Each user will a designated user identification and password and adheres to DHS CIO policy on security awareness. Designated persons (Component Medical Director, Component EMS Coordinators, and ePCR Administrator) within the components will have full administrative review access to all records for quality assurance purposes. The OHA Medical Quality Management Branch and the OHA Medical First Responder Coordination Branch will have rights to run ad hoc reports and query data as it relates to quality assurance tracking and trending indicators

(completeness of record, adherence to standards of care/protocols and training) on all component data.

Due to the sensitive and private nature of patient medical records, ePCR has been evaluated to identify risks and corresponding mitigation strategies through both the DHS Security Authorization process and through this PIA. Risks may include unauthorized disclosures, incorrect data entry, software viruses, unauthorized access to the system, sharing of data with private sector, and data security breaches. Mitigation activities involve privacy and security awareness training for all users, enforcement of access to varied aspects of ePCR (e.g., end-users only have access to their component-specific patient data and any other patient encounter reports for which they have been identified as providing care). Designated administrator access is limited to component Medical Directors and his/her backup (as required). The administrator has the capability to periodically run and maintain audit logs pertaining to access of the ePCR system patient encounters. OHA has access to all component data as it relates to quality ad hoc reporting and queries to the data based on identified data elements to be tracked for clinical and quality performance. Audit logs are periodically reviewed by OHA and the component ePCR Adminsitrator for inconsistencies. Any inconsistencies are immediately addressed through the component Medical Director, EMS coordinators, or component or Information Technology (IT) and Security Compliance Officer to correct or resolve any issues and concerns.

Section 1.0 Authorities and Other Requirements

1.1 What specific legal authorities and/or agreements permit and define the collection of information by the project in question?

The ASHA/CMO leads OHA and has primary responsibility within the Department for "ensuring internal and external coordination of all medical preparedness and response activities including training, exercises, and equipment support." See Section 516 (c) (3) of the Post Katrina Emergency Management and Reform Act, P.L. 109-295, 6 U.S.C. § 321e(c). In addition, the Secretary has delegated to the ASHA/CMO responsibility for providing oversight for all medical and health activities of the Department. See DHS Delegation to the Assistant Secretary of Health Affairs and Chief Medical Officer, No. 5001 (signed July 28, 2008).[2] As per DHS directive, the ASHA/CMO ensures the MQM program is appropriately implemented within the components providing health care services and consistently applied across the department, to include exercising oversight for development of quality assurance activities (quality improvement, risk management, documentation and medical record management) within DHS. Further, the ASHA/CMO ensures the MQM program is implemented and responsibilities are fulfilled, in part through the collection of patient care records in the ePCR. The responsibility of MQM necessitates a patient care reporting system to gather records of pre-hospital emergency medical care rendered by DHS employees, as part of their official DHS duties.

For this collection of health information, OHA is not subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulation, "Standards for Privacy of

[2] http://www.dhs.gov/xfoia/gc_1254501589035.shtm

Individually Identifiable Health Information" (Privacy Rule), 45 CFR Parts 160 and 164. OHA does not meet the statutory definition of a covered entity under HIPAA, 42 U.S.C. § 1320d-1. Because OHA is not a covered entity, the restrictions prescribed by the HIPAA Privacy Rule are not applicable.

1.2 What Privacy Act System of Records Notice(s) (SORN(s)) apply to the information?

Three SORNs cover the information in ePCR. Members of the public who are treated by an on-duty Departmental EMS healthcare provider are covered by the DHS/ALL-034 Emergency Care Medical Records System SORN, published in the *Federal Register* concurrent with the publication of this PIA and available at www.dhs.gov/privacy. Records of patients who are DHS or other federal employees are considered part of the OPM/GOVT-10- Employee Medical File System Records, 70 F.R. 15086 (Mar. 24, 2005). Records about DHS EMS providers pertaining to care they administer while on duty at the Department are considered part of OPM/GOVT-1- General Personnel Records, 71 F.R. 35356 (Jun. 19, 2006).

1.3 Has a system security plan been completed for the information system(s) supporting the project?

Yes, the System Security Plan was completed in May 2010 and the System Test & Evaluation (ST&E) was conducted in July 2010. Certification and Accreditation with the Authority to Operate (ATO) is pending.

1.4 Does a records retention schedule approved by the National Archives and Records Administration (NARA) exist?

OHA will propose to NARA that OHA will maintain both DHS-employee ePCRs and non-DHS-employee ePCRs for 10 years to meet the requirements of MQM.

Components are responsible for retaining employee health records outside of ePCR. Components adhere to General Records Schedule (GRS) 1, Civilian Personnel Files, Section 21, Employee Medical Folder (EMF) on handling of files for temporary and short-term records and separated folders. Occupational Medical Records considered to be long-term records must be maintained for the duration of employment, plus 30 years or for as long as the Official Personnel File (OPF) is maintained, whichever is longer. Upon separation, the records must be provided to the employee's new agency, or they must be transferred to the National Personnel Records Center (NPRC), which will dispose of them in accordance with GRS 1, item 21, issued by NARA.

1.5 If the information is covered by the Paperwork Reduction Act (PRA), provide the OMB Control number and the agency number for the collection. If there are multiple forms, include a list in an appendix.

The information in ePCR is not covered under the Paperwork Reduction Act because members of the public are not submitting information via the form; rather, the form is filled out by the DHS medical

provider.

Section 2.0 Characterization of the Information

2.1 Identify the information the project collects, uses, disseminates, or maintains.

For care rendered by DHS medical care providers, ePCR contains a record of the illness or injury, treatment provided, transfer of care, transportation, and any other pertinent patient information. The types of medically-relevant PII may include: name, date of birth, age, gender, duty location, address, type of injury, current medications, allergies, assessment of injury, chief complaint, vital signs, treatment provided and/or procedures, medication administered, transfer of care, refusal of care, and/or transportation mode and destination.

The patient encounter will initially be recorded on the paper-based SF-558, *Emergency Care and Treatment Form* (or component equivalent form) and then manually entered into the web-based ePCR and saved to the DHS-designated server. The component Medical Director reviews both paper and electronic patient encounter entries for any inconsistencies before final review and close-out. Should inconsistencies be noted, the component Medical Director must resolve those with the originator of the patient encounter record and amend the record to reflect the correct changes and/or updates. The component Medical Director and the EMS Coordinators and the ePCR Administrator have full administrative rights to view and run reports on their data in ePCR. Additionally, the Component Medical Director or his designee reviews 100% of patient records and provides feedback or requests clarification to the written/electronic patient encounter. Upon completion, the component Medical Director and/or recognized and authorized component-level EMS coordinator validates that care rendered followed the appropriate treatment, and adhered to established medical standards and protocols.

Each patient encounter is a new entry that documents the episode of care and treatment; if a patient is transferred to the hospital for more definitive medical care, the report accompanies the patient to ensure continuity of care. If the same patient is treated more than once, a new patient care report is generated and is purely encounter-based. The system does not link together separate encounters with the same patient.

The ePCR system does not receive information from another system. Based on contract specifications, the ePCR is designed to share EMS quality data at a national level. The National EMS System encourages ePCR system users to be compliant with national standards, as such specific data elements from ePCR shared with National EMS Information System (NEMSIS), part of the National Highway Traffic Safety Administration (NHSTA). These de-identified, customized data fields and elements are automatically uploaded and transmitted to NEMSIS and are utilized for statistical purposes, informed decisions, potential best practices, and for quality assurance and performance improvement at the national level. No PII or individual cases are pulled, only aggregate data such as mechanism of injury, response times, and critical skill sets. The vendor has obtained NEMSIS Gold compliant certification.

2.2 What are the sources of the information and how is the information collected for the project?

DHS medical care providers collect medical information directly from the patient being treated. The DHS medical care provider obtains as much medically-relevant information as possible from the patient, family member, or legally designated representative, especially if there is a language barrier. In the event that the injury is incapacitating for the patient, DHS medical care providers will collect pertinent medical information from other witnesses at the scene. There is the potential for the DHS medical care provider to take a picture of the scene for investigative purposes or to photograph a picture of the wound and relay that to the component Medical Director for a more definitive diagnosis and treatment recommendation for the individual injury or medical problem. Such photographs would be stored at the component, in hard copy with the SF-558 or equivalent, and would not transfer to ePCR.

2.3 Does the project use information from commercial sources or publicly available data? If so, explain why and how this information is used.

No. Information is provided directly from the patient or his/her legally designated representative or the DHS medical care provider.

2.4 Discuss how accuracy of the data is ensured.

DHS medical care providers are trained on the use of ePCR and data entry. Each component only has access to their specific component data. Some fields will be pre-populated and specific to the component (list of personnel, type of equipment/supplies, response vehicles and receiving medical facilities).

All encounters are initially recorded on the paper-based SF-558, *Emergency Care and Treatment Form* (or component equivalent form) and then manually entered into the web-based ePCR and saved to the DHS-designated server. Based on established Standard Operating Procedures and Quality Assurance (QA) Policy for medical care reviews, the component Medical Director and/or his designee will review 100% of the paper/electronic patient encounter forms. The QA review will evaluate type of incident, and that care rendered followed the appropriate treatment and adhered to established medical standards and protocols. The component Medical Director and EMS coordinator have a mechanism to provide feedback or request clarification to both the written and electronic patient encounter entry. If a patient is transferred to a medical facility for further care and treatment, a copy of the patient encounter accompanies the patient for continuity of care. The component Medical Director and EMS coordinator will have copies of both written and electronic ePCR entries of care for quality control and medical quality management in accordance with DHS Instruction 248-01.

2.5 Privacy Impact Analysis: Related to Characterization of the Information

Privacy Risk: There is risk that more information will be collected than is necessary for the stated purpose of the ePCR.

Mitigation: The ePCR and/or standardized patient treatment forms are used to ensure that PII is accurately recorded and that information follows a logical flow and that it is current. Further, the ePCR data elements align with national standards of patient care records, namely NEMSIS patient care report elements. Alignment with NEMSIS ensures that the data elements nationally recognized as necessary for statistical purposes, informed decisions, potential best practices, and for quality assurance and performance improvement at the national level are colleted. Documentation of these nationally, standardized data elements are essential for all patient care encounters thus mitigating the potential of collecting irrelevant, inappropriate, or more information than necessary. The essential, standardized data elements collected by DHS medical care providers aid in determining the best course of treatment based on subjective and objective medical assessment and nature of injury or illness.

Privacy Risk: There is risk that the patient provides inaccurate information related to their personal medical history and/or risk that the information provided is entered into the ePCR incorrectly.

Mitigation: Medical information collected for purposes of making a medical diagnosis is based on information provided by the patient and the type of medical incident or injuries observed and assessed by the medical care provider. The medical care provider can only rely on what information the patient provided and information the provider observes first-hand. There may be instances when the patient is unable to provide a medical history and subsequently information collected is from a family member or witness. The medical care provider regardless will assess the patient and render care based on the incident and injury as presented and verify information at a later time as appropriate.

Privacy Risk: When patient encounter information is manually input from paper into ePCR, there is a risk that errors can be made in transcribing data into the appropriate fields on the ePCR.

Mitigation: OHA has mitigated this risk by requiring that the component Medical Director to review both paper and electronic patient encounter entries for any inconsistencies before final review and close-out. Should inconsistencies be noted, the component Medical Director must resolve those with the originator of the patient encounter record and amend the record to reflect the correct changes and/or updates. The system is designed to accurately reflect date, time and person(s) should amending of a patient record be required. Additionally, the paper record will be maintained on file with the component should questions regarding the provision of care arise.

Section 3.0 Uses of the Information

3.1 Describe how and why the project uses the information.

DHS Directive 248-01, Medical Quality Management (MQM), as well as the DHS Instruction, 248-01-001 requires that components have an active and effective MQM Program that includes a quality assurance and improvement program addressing oversight, peer review, risk management, patient safety, training, documentation of organizational structures, standard of care, health care policies, and protocols.

As part of the MQM Program implementation, offering a standardized documentation tool for DHS medical care providers is beneficial in capturing care rendered in diverse environments. OHA chose ePCR because it is a standard patient care platform used by many other non-DHS Emergency Medical Services (EMS) providers to capture pertinent patient demographics, care and treatment rendered, and patient

disposition (treat, release, and/or transfer to medical facility for more definitive care), in accordance with national standards.

Additionally, the ePCR system provides a quality assurance module that affords OHA, the component Medical Directors, and the component EMS Coordinators to evaluate overall standard of care and adherence to established DHS SOPs and protocols; and based on findings, to identify areas to improve upon as they relate to skills competency, training improvement opportunities, and quality of care delivered.

3.2 Does the project use technology to conduct electronic searches, queries, or analyses in an electronic database to discover or locate a predictive pattern or an anomaly? If so, state how DHS plans to use such results.

Yes. A feature of the ePCR system is the quality assurance/risk management module to track and trend quality assurance data. Each component Medical Director is granted administrative rights to run ad hoc reports regarding component-specific data (e.g., completeness of record, adherence to standards of care/protocols and training). OHA designated staff will have the capability to query all quality data across components for utilization in the MQM Program and to identify trends and areas for improvement. Component quality data will be collected and reported to the ASHA/CMO as it relates to performance and performance improvement initiatives related to the overall provision of care practices. All quality data collection is used solely for internal DHS purposes and the MQM Program.

3.3 Are there other components with assigned roles and responsibilities within the system?

Yes. Each component using the ePCR system only has access to their component-specific data and designate specific administrative rights to those component employees that have access (username, password and agency) to the system. The majority of DHS medical care providers only have access in creating, writing and closing patient encounter entries. Designated persons (component Medical Director, component EMS Coordinators, and ePCR Administrator) within the components will have full administrative review access to all records for quality assurance purposes. The OHA Medical Quality Management Branch and the OHA Medical First Responder Coordination Branch will have rights to run ad hoc reports and query data as it relates to quality assurance tracking and trending indicators (completeness of record, adherence to standards of care/protocols and training) on all component data.

3.4 Privacy Impact Analysis: Related to the Uses of Information

Privacy Risk: There is risk that information is shared or leaked to sources who are not entitled to that information.

Mitigation: DHS medical care providers are trained and practice under the guidance of ensuring patient privacy and confidentiality. ePCR contains a standardized template to document patient encounters to ensure PII is accurately recorded, and that pertinent medical information is collected by DHS medical care providers in order to make a diagnosis and provide appropriate treatment in a timely manner without injury to the patient.

Should an incident occur where information is shared or leaked to media or other sources, appropriate actions by the component Medical Director and/or the component's EMS coordinator would be taken with the DHS medical care provider or other individuals as appropriate. Medical providers are trained to report certain medical information; however, should there be a breach of information that compromised or affected the patient and overall standard of care, steps would be taken to notify appropriate medical and legal authorities regarding questionable practices.

Privacy Risk: There is risk that ePCR patient encounters could be accessed by other than the medical care providers identified on the patient encounter.

Mitigation: DHS medical care providers are trained on the use of the ePCR System and data entry. Each component will have access to their specific component data only. Some fields will be pre-populated and specific to the component (e.g.,list of personnel, type of equipment/supplies, response vehicles and receiving medical facilities). The component ePCR administrator designates levels of access within ePCR for the medical care providers. Medical care providers only have access to their specific patient encounter information, unless they were included as response personnel on another provider's encounter form.

Section 4.0 Notice

4.1 How does the project provide individuals notice prior to the collection of information? If notice is not provided, explain why not.

Individuals receive notice at the time of collection from the DHS medical providers, who collect information directly from the individual. Additionally, notice is provided via this PIA, the OPM/GOVT-10 Employee Medical Files SORN, and the DHS/OHA-002 Emergency Care Medical Records SORN.

4.2 What opportunities are available for individuals to consent to uses, decline to provide information, or opt out of the project?

All patients can decline to provide medical information and decline evaluation and treatment. It is the responsibility of the DHS medical care provider to inform the patient regarding proposed treatment and medical interventions/procedures so as to better assist the patient in making an informed decision about medical care they would be receiving. The DHS medical care provider will also annotate in the note that patient declined or refused to receive care during this encounter. In addition, if possible, the patient will sign that he or she refused or declined care. Those documents will be included with the EMF. In the event that the individual requires further medical intervention (such as for a life/limb saving-treatment) and the patient is unable to make decisions, the DHS medical care providers must render care based on sound medical judgment and make critical decisions to medically evacuate a patient based on current location, environment, and availability of medical resources.

4.3 Privacy Impact Analysis: Related to Notice

Privacy Risk: There is a risk that patients may not know that DHS is using information collected

from their encounter with DHS EMS providers for quality management purposes in ePCR.

Mitigation: Patients are present and given the right to refuse treatment and/or be transported to a medical facility for further care at the time DHS collects their information. A medical care provider has the professional duty and responsibility to gather pertinent medical history and information related to injury or illness to make a sound medical decision about appropriate treatment modalities, and OHA has the authority and responsibility to ensure a high standard of care is administered by DHS EMS providers. The information in ePCR will not be used for other purposes within DHS. The importance of ensuring quality medical care justifies the risks presented by centralizing data in this manner.

Section 5.0 Data Retention by the project

5.1 Explain how long and for what reason the information is retained.

OHA will propose to NARA that OHA will maintain both DHS-employee ePCRs and non-DHS-employee ePCRs for 10 years to meet the requirements of MQM.

Components are responsible for retaining employee health records outside ePCR. Components adhere to GRS 1, Civilian Personnel Files, Section 21, EMF on handling of files for temporary and short-term records and separated folders. Occupational Medical Records considered to be long-term records must be maintained for the duration of employment, plus 30 years or for as long as the OPF is maintained, whichever is longer, in which complies with the OPM/GOVT-10 SORN for Employee Medical Files and Part 293, Subpart E of Title 5 of the Code of Federal Regulations, Employee Medical File System Records (2009) (b). Upon separation, the records must be provided to the employee's new agency, or they must be transferred to the NPRC, which will dispose of them in accordance with GRS 1, item 21, issued by NARA.

5.2 Privacy Impact Analysis: Related to Retention

Privacy Risk: There is risk that patient medical information is held longer than is necessary, putting the information at risk for unauthorized disclosure.

Mitigation: DHS has identified based on contract-specific tasks that there will be ready access to all archived data from the DHS-designated server for a period of no less that 7 years. In accordance with NARA, General Records Schedule 1, Civilian Personnel Records, Section 21 Employee Medical Folder (EMF), a. Long-term medical records as defined in 5 CFR Part 293, Subpart E., § 293.510 (1) Transferred employees: See 5 CFR Part 293, Subpart E, (2) Separated employees. Transfer to NPRC, St. Louis, MO, 30 days after separation. NPRC will destroy 75 years after birth of employee; 60 years after date of the earliest document in the folder, if the date of birth cannot be ascertained; or 30 years after latest separation, whichever is later. b. Temporary or short-term records as defined in the Federal Personnel Manual (FPM) destroyed 1 year after separation or transfer of employee. Additionally, §293.511, Retention Schedule, (a) & (b) addresses temporary EMF Records and Occupational Medical Records.

OHA has established a process to review the DHS-designated server for archived data annually. OHA, along with DHS Chief Human Capital Office (CHCO), will validate whether a DHS employee is active or retired from the system. OHA will prepare records for archival purposes per NARA guidance.

OHA maintains a tracking log of all DHS employee EMFs that are reviewed and archived to include dates, times and names of those individuals coordinating files.

Section 6.0 Information Sharing

6.1 Is information shared outside of DHS as part of the normal agency operations? If so, identify the organization(s) and how the information is accessed and how it is to be used.

Yes. In the event that a patient requires transfer to a medical facility and non-DHS medical care provider for further care, a copy of the SF-558, *Emergency Care and Treatment Form* (or component equivalent patient encounter form) may accompany the patient as part of the record of care. At minimum, for continuity of care purposes, a verbal report of treatment rendered and assessment findings are conveyed to the receiving medical facility or transport unit. Subsequently, an entry of the patient encounter will be stored in ePCR for continuity and quality assurance. Any paperwork that is created at the receiving medical facility may be included in the employee's EMF if requested by the DHS Employee. DHS does not have access to the medical facility records unless provided by the patient for inclusion in a worker's compensation claim or through formal legal channels. DHS may also disclose to a requesting agency, organization, or individual the home address and other relevant information on those individuals who it reasonably believed might have contracted illness or might have been exposed to or suffered from a health hazard while employed in the federal workforce.

Additional data sharing occurs within OHA in conducting quality assurance reviews, to include tracking and trending data related to clinical performance and standard of care practices. Reports are also sent to NEMSIS for compliance with national standards of care. No PII is queried or included in reports. Reports provide a snapshot of quality assurance-related activities and identify areas for improvement.

6.2 Describe how the external sharing noted in 6.1 is compatible with the SORN noted in 1.2.

The purpose of ePCR is to support OHA's MQM program, which is why sharing from ePCR is limited to notification of medical hazard, worker's compensation claims, or through formal legal channels, and not otherwise shared.

6.3 Does the project place limitations on re-dissemination?

DHS does not place limitations on re-dissemination because sharing would be limited to other medical professionals, who already operate under external re-dissemination controls, and formal legal channels, which also have external controls.

6.4 Describe how the project maintains a record of any disclosures outside of the Department.

For routine uses of sharing patient information, the individual component and/or OHA creates a

log of the request for information. The log will contain requestor, date/time, purpose of the request and OHA or component contact working the request for information. Only copies of the record will be released. All originals will be retrieved and secured in a locked cabinet or locked room.

6.5 Privacy Impact Analysis: Related to Information Sharing

Privacy Risk: There is risk associated with sharing of PII.

Mitigation: To mitigate this risk, OHA has established a limited number of roles with administrative rights. The component Medical Director and the EMS Coordinators and the ePCR Administrator have full administrative rights to view and run reports on their data in ePCR. Additionally, the Component Medical Director or his designee reviews 100% of patient records and provides feedback or requests clarification to the written/electronic patient encounter. The agency that operates and maintains the DHS-designated server runs audit reports and checks for any compromise to the system. In addition, the DHS Information System Security Officer (ISSO) will review access controls, check system patch activity and audit logs routinely for any malicious activities and/or compromise. OHA receives archived data as specified in the contractual agreement.

Section 7.0 Redress

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

DHS employees, having received care from DHS medical care providers, have access to their EMFs through their respective personnel departments and/or occupational health units. Individuals who are not DHS employees who receive care will be transferred to outside medical facilities with their paper medical file and are able to obtain it at that time or from the facility at any time afterward.

In addition, the Freedom of Information Act (FOIA) and the Privacy Act allow individuals to gain access to their own information. Specific information on how to do so is posted on the DHS public-facing website at www.dhs.gov/foia under "How to Submit a FOIA or Privacy Act Request."

7.2 What procedures are in place to allow the subject individual to correct inaccurate or erroneous information?

Employees may periodically review their EMFs and work with their respective personnel departments and/or occupational health units to resolve any perceived inaccuracies in their file. As noted above, individuals can also file requests under the FOIA/Privacy Act to gain access to their own information. Any perceived inaccuracies may be addressed through the component and, if warranted, the inaccuracy will be rectified.

7.3 How does the project notify individuals about the procedures for correcting their information?

Individuals receive notice at the time of collection from the DHS medical providers, who collect

information directly from the individual. Additionally, notice is provided via this PIA, the OPM/GOVT-10 Employee Medical Files SORN, and the DHS/OHA-002 Emergency Care Medical Records System SORN.

7.4 Privacy Impact Analysis: Related to Redress

Privacy Risk: There is risk that individuals may not be able to correct their medical records on file with DHS.

Mitigation: Because medical records tend to be an account of what occurred at a point in time, the records are mostly for historical purposes and are generally not required to be corrected. In the event that a correction does need to be made, individuals have multiple channels through which to correct data, including directly with the provider and via formal Privacy Act amendment requests, as outlined above. Additionally, component Occupational Health Clinics (FOH, CMS) have in place directions on how to request and/or amend medical information contained in Employee Medical File. Inquires can also be made through the OHA Medical Quality mailbox at OHAMedicalQualityManagement@dhs.gov.

Section 8.0 Auditing and Accountability

8.1 How does the project ensure that the information is used in accordance with stated practices in this PIA?

Each component using the ePCR system only has access to their component-specific data and will designate specific administrative rights to those employees that will have access to the system. The majority of DHS medical care providers will only be able to create, write and close patient encounters. Designated persons (component Medical Director, ePCR Administrator, component EMS Coordinator) within the component will have full administrative review access to all records for quality assurance purposes. OHA Medical Quality Management Branch and the Medical First Responder Coordination Branch will have full administrative rights to run ad hoc reports and query data as it relates to quality assurance tracking and trending indicators (e.g., completeness of record, adherence to standards of care/protocols, and training) on all component ePCR data.

It will be the responsibility of the individual component and OHA staff to review audit logs of those persons requesting or gaining access to the ePCR system. In the event of a potential breach or questionable entry, actions would be taken to investigate with the person(s), component Medical Director, component EMS Coordinator, and designated IT representative, as appropriate.

As part of contract specifications, the designated ISSO will review audit records weekly to ensure that no compromise has occurred related to DHS files either remotely or at the host DHS-designated server site.

8.2 Describe what privacy training is provided to users either generally or specifically relevant to the project.

All DHS personnel are required to participate in annual privacy training. Security awareness training for authorized end-users of ePCR is performed, recorded and maintained by global DHS training and awareness policies. Privacy and Security awareness training is conducted by personnel managing the

DHS-designated server

8.3 What procedures are in place to determine which users may access the information and how does the project determine who has access?

Each DHS medical care provider using ePCR will be provided the minimum necessary access based on his or her designated role and use of the system. The majority of ePCR end users have access to initiate a patient encounter, document care and treatment rendered, and return to complete the record; however, once signed and locked, the creator of the record cannot go back. Training managers and designated Medical Directors have access to review and sign off the record and provide feedback to the employee if further clarification of the encounter is required. OHA Medical Quality Management Branch and the Medical First Responder Coordination Branch have specific administrative rights to review all component documents, which includes the ability to run de-identified ad hoc reports and query de-identified data in regards to quality assurance reports for tracking and trending patient care indicators.

8.4 How does the project review and approve information sharing agreements, MOUs, new uses of the information, new access to the system by organizations within DHS and outside?

There is no requirement for MOUs or sharing agreements for this project. Other than in the limited context of patient transfers, any information sharing with an external medical organization it is at the request of the patient.

All patient encounters will be stored to the DHS-designated server at the host location. The only mechanism to pull information will be at the request of DHS for internal purposes as per the contractual agreement for archiving and requesting data.

Responsible Officials

Kathryn Brinsfield
Director, Workforce Health and Medical Support Division
Office of Health Affairs

Approval Signature

Original signed and on file with the DHS Privacy Office.

Mary Ellen Callahan
Chief Privacy Officer
Department of Homeland Security