Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00661-43

Healthcare Inspection

Radiology Scheduling and Other Administrative Issues VA Loma Linda Healthcare System Loma Linda, California

November 24, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to assess the merit of allegations concerning radiology scheduling and other administrative issues at the VA Loma Linda Healthcare System (the facility). Specifically, the complainant alleged that patients were being blind scheduled (scheduling without patients' involvement) for their computed tomography (CT) exam appointments and that patients were not receiving appointment reminder letters, thus resulting in delays in treatment. The complainant also alleged that scheduling clerks were inappropriately documenting the reason for canceling CT exams. It was further alleged that:

- Staff were not uploading non-VA radiology images into the patients' electronic health records (EHRs) due to the lack of proper equipment and training.
- Early closure of the ultrasound walk-in clinic occurred due to staff mismanagement.
- Staff did not timely notify patients of Breast Imaging Reporting and Database System category zero (0) mammogram results.

We substantiated the allegations that blind scheduling occurred; however, we found no evidence of treatment delays. We determined that for 2 of the 16 patients who were blind scheduled and did not keep their appointments, facility clinicians did not document attempts to contact the patients to ascertain whether the unfulfilled CT exams should have been reordered or if other follow-up action was necessary. We determined that facility leadership and program managers needed to ensure that staff follow appropriate scheduling procedures and that patients receive ordered CT studies. We concluded that the facility needed to comply with Veterans Health Administration (VHA) recommendations for managing "no show' patients. We could not substantiate the allegation that patients did not consistently receive appointment reminder letters.

We concluded that scheduling clerks needed to consistently document patients' actions or dispositions in the Appointment Management and the Radiology Package programs. Program managers needed to monitor exam cancelations to ensure the appropriate reason is documented between these two programs. We determined that the facility needed to monitor staff compliance with the recently implemented scheduling policy.

We substantiated that non-VA imaging exams were not uploaded into the EHRs for three subject patients. However, we concluded that uploading these images would not have influenced treatment courses for the patients because clinicians were aware of the exam results. These patients received appropriate care. We determined that the facility needs to ensure that proper equipment is available for uploading images into the patient's EHR and that training is provided.

We did not substantiate the allegation of staff mismanagement in the ultrasound walk-in clinic. We concluded that the number of staff on duty as well as the volume and complexity of ultrasound orders influenced the clinic's early closure. We determined

that program managers needed to assess and track the appropriateness of early walk-in clinic closures.

We did not substantiate that staff were not timely in notifying patients with Breast Imaging Reporting and Database System category 0 results.

We recommended that the Facility Director ensure that patients are involved in the scheduling process, that program managers monitor exam cancelations, and that staff accurately document dispositions and actions taken related to patient scheduling. We recommended that clinicians review the EHRs of the two identified patients who had unfulfilled CT orders to determine whether follow-up actions are needed. We also recommended that the facility monitor compliance with the newly implemented scheduling policy.

We further recommended that the Facility Director ensure that proper equipment and software is available for uploading non-VA images and that staff are trained on the process. We also recommended that program managers periodically assess and monitor the appropriateness of early walk-in ultrasound clinic closure and take necessary steps to ensure outpatients receive timely studies.

Comments

The Acting Veterans Integrated Service Network and Facility Director concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 13–17 for the Directors' comments.) We consider recommendations 2 and 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to assess the merit of allegations concerning radiology scheduling and other administrative issues at the VA Loma Linda Healthcare System (the facility), Loma Linda, CA.

Background

The facility is a 264-bed tertiary care facility that provides comprehensive health care services in medicine, surgery, behavioral medicine, and long-term care. The Radiology Department (also known as Imaging) provides both inpatient and outpatient services, which include computed tomography (CT),[1] magnetic resonance imaging (MRI),[2] ultrasound,[3] and mammography.[4] Mammography is also provided at the VA Redlands Boulevard Clinic in Redlands, CA. The facility is affiliated with Loma Linda University in Loma Linda, CA, and is part of Veterans Integrated Service Network (VISN) 22.

"Blind scheduling" is the act of scheduling and notifying the patient of a scheduled appointment by letter without staff speaking with the patient regarding his or her desired appointment date. The practice of scheduling without the patient's involvement is inconsistent with Veterans Health Administration (VHA) policy and should be avoided.[5] At a recent congressional hearing, a Government Accountability Office representative testified that arbitrarily making appointments without any input from patients contributed to a 43 percent cancelation or "no show" rate.[6]

VHA Scheduling Policy[7]

VHA requires that facilities have policies regarding actions to be taken to make contact with a patient, the number of contact attempts necessary, and the documentation required when scheduling a patient for appointments. Scheduling clerks are required to offer and schedule an appointment on or as close as possible to the patient's or the requesting clinician's desired date.[8] VHA policy states that when a patient fails to

[1] CT is a noninvasive imaging procedure that uses specialized x-ray equipment to produce cross-sectional ("slices") images of the body. These sectional images are used for a variety of diagnostics and therapeutic purposes.
[2] MRI is an imaging procedure that uses strong magnetic field and radio waves. MRI can give information different from a CT scan about body structures to aid in disease detection and confirmation of diagnosis.
[3] Ultrasound is an imaging study that uses high frequency sound waves to view soft tissues such as muscles and internal organs.
[4] Mammography is an imaging procedure that uses x-rays to capture images (mammograms) of the internal structures of the breasts.
[5] Deputy Under Secretary for Health for Operations and Management (10N), *Inappropriate Scheduling Practices*, April 26, 2010.
[6] Roll Call, *Veterans Affairs Problems Run Deep, Witnesses Tell House VA Committee*, posted June 9, 2014.
[7] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[8] The date on which the patient or provider wants the patient to be seen. In Radiology, the desired date is specified by the ordering provider.

appear for a scheduled appointment (also referred to as "no show"), the electronic health record (EHR) must be reviewed to ensure that urgent medical problems are addressed timely, and the patient needs to be rescheduled as soon as possible, if clinically appropriate.

VA Information System

VA uses the Veterans Health Information Systems and Technology Architecture (VistA) for documenting clinical care and other functions. VistA consists of several integrated software applications and programs. For scheduling and canceling radiology appointments and orders, scheduling clerks use the Appointment Management (AM) (also known as scheduling package) and Radiology Package (RP) programs.

The AM program allows scheduling clerks to make and cancel appointments, discharge patients from clinics, and review clinic enrollment. Other actions that can be accomplished through the AM program are patient "check in" and "check out" or marking the patient's status as "no show." The menu options under AM are pre-determined and cannot be modified locally.

The RP software is designed to cancel radiology orders, register patients for exams, and record reports/results.[9] When canceling an order, the RP program provides the option of documenting the reason for canceling the ordered exam. Authorized facility radiology staff can modify the menu options in RP and make new cancelation reasons as necessary. The options available in the facility's RP are patient "no show," canceled by the radiologist, requesting physician canceled, canceled/rescheduled by patient, exam canceled, and re-ordered for correct desired date. "Patient refused" was at one time an option for cancelation and appeared to have been edited to patient "no-show" after June 2013.

The AM and RP programs do not interface with each other, and scheduling clerks must enter information in both programs when canceling an appointment or a radiology order.

Upload of Non-VA Exams

VHA requires that patient health information be captured and stored in the EHR for clinician access. Non-VA source documents will be maintained in a patient's EHR at the provider's written request.[10] The request must indicate the documents and images to be retained. Images must be scanned and uploaded into VistA imaging or the Radiology Picture Archiving and Communication Systems (PACS)[11] with the appropriate documentation.

[9] VistA Radiology/Nuclear Medicine User Manual Version 5.0, Department of Veterans Affairs, Health Systems Design and Development, Provider Systems, November 2013.
[10] VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.
[11] PACS is a computer-based medical system dedicated to the storage, retrieval, distribution, and presentation of images.

Mammography

VHA requires that patients be notified of mammogram results within 14 calendar days from the date the results are available.[12] Ordering providers are required to communicate results of Breast Imaging Reporting and Database System (BI-RADS)[13] categories.[14] Table 1 below provides a brief description of the BI-RADS categories 0 through 6.

Table 1: Mammogram BI-RADS Categories

0 (Additional imaging or comparison to prior mammograms is needed)
1 (Negative)
2 (Benign, non-cancerous, finding)
3 (Probably benign finding – Follow-up in a short timeframe is suggested)
4 (Suspicious abnormality – Biopsy should be considered)
5 (Highly suggestive of malignancy – at least 95 percent chance of being cancer)
6 (Known biopsy-proven malignancy)

Source: American College of Radiology

Facility Scheduling

Beginning in 2010, the facility centralized its patient scheduling for all ancillary services, including radiology. Medical support assistants (also referred to as scheduling clerks), responsible for patient appointment scheduling who were previously under radiology's supervision, were placed under Health Administration Services (HAS).

Facility's Ultrasound Walk-in Clinic

The ultrasound walk-in clinic accommodates inpatients, emergent cases, emergency department (ED) patients, and hardship cases.[15] In 2006, the facility established the walk-in clinic in response to the high number of "no shows" and patients arriving late for their scheduled appointments. Due to the facility's high volume of cases, late patients had to be rescheduled and may have had to wait another 3 months for the next appointment. The clinic's hours of operation are 7:00 a.m.–5:30 p.m., Monday through Friday.

[12] VHA Directive 2009-019: *Ordering and Reporting Test Results*, March 24, 2009.
[13] BI-RADS is a standardized system developed by the American College of Radiology to describe mammogram findings and results. Under this system, mammogram results are sorted into categories numbered 0 through 6.
[14] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010.
[15] These are patients who reside far away, have transportation issues, or are disabled.

Allegations

The complainant initially alleged that CT and MRI patients were being blind scheduled for their appointments and that patients were not receiving their appointment reminder letters, thus resulting in delays in treatment. The complainant later clarified that blind scheduling only involved CT patients. The complainant also alleged that scheduling clerks were inappropriately documenting the reason for canceling CT exams.

The complainant further alleged that:

- Staff were not uploading non-VA radiology images into the patients' EHRs due to the lack of proper equipment and training.
- Early closure of the ultrasound walk-in clinic occurred due to staff mismanagement, thus impeding patient access.
- Staff did not timely notify patients of BI-RADS category zero (0) mammogram results.
- An employee demonstrated unethical behavior.

OIG was provided with a list of 712 CT patients who were allegedly blind scheduled, the names of 3 patients who had non-VA imaging studies, and ultrasound walk-in clinic early closure data.

OHI's Initial Review

On April 5, 2013, a confidential complainant contacted the OIG Hotline Division alleging improper patient scheduling for selected radiology exams, inappropriate closure of the ultrasound clinic, and delays in patient notification of mammogram results. On April 18, OHI referred the allegations to VISN 22 for review and response. On May 30, the Facility Director responded that the allegations had already been reviewed and addressed. We reviewed the facility's response and determined that the issues were addressed, and the case was closed. From June through October 2013, the complainant made several contacts with the OIG and alleged that the facility had yet to resolve the issues and that inappropriate scheduling practices continued. In February 2014, the complainant provided additional information related to the alleged blind scheduling practices. Based on the additional information, OIG determined an independent review was warranted.

Scope and Methodology

We conducted preliminary onsite interviews with selected staff on February 7, 2014, and returned for a follow-up visit February 26–27. We interviewed facility leadership and program managers and staff from HAS, Health Information Management Service (HIMS), and Radiology (PACS, ultrasound, and mammography) Service. We also interviewed the complainant. We reviewed VHA policies, facility policies and standard

operating procedures (SOPs), workload reports, ultrasound clinic closure logs and staffing information, and other relevant documents.

We randomly sampled 40 patients from the list of 712 who were allegedly blind scheduled for CT exams. We excluded one patient who had an MRI and reviewed the EHRs of the remaining 39 patients. We also reviewed the EHRs of three patients who were transferred to the facility and had non-VA images.

Further, we reviewed the EHRs of 100 randomly sampled patients from 1,758 patients who reportedly had screening mammograms at the facility in calendar year (CY) 2013.

We observed the facility's processes for uploading scanned images in the PACS program, tracking compact discs (CDs) that were uploaded in radiology back to HIMS, and scheduling and canceling CT appointments. In addition, we observed ultrasound walk-in clinic operations.

This report does not address the allegation regarding unethical conduct as this was outside the scope of our review.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Blind Scheduling, Delay in Treatment, Appointment Letters, and Cancelation Documentation

Blind Scheduling

We substantiated the allegation that CT patients were blind scheduled. Facility managers acknowledged that this practice occurred until July 3, 2013. However, we found evidence of blind scheduling occurring through at least September 2013.

In our review of the EHRs of 39 randomly selected patients, 35 (90 percent) had no documented evidence of patients' involvement with the scheduling process. For the remaining four patients, staff documented that appointment dates were discussed with the patients.

Delay in Treatment

We did not substantiate the allegation of delay in treatment in the blind scheduled patients we reviewed. Of the 39 sampled patients, we reviewed the EHRs of the 35 patients who were blind scheduled. We excluded three because the CT exams were either completed (as ordered), canceled by the requesting provider, or not done because the patient refused the procedure requiring CT guidance.

Sixteen of the remaining 32 patients (50 percent) had subsequent CT exams or alternate imaging studies completed. However, the other 16 patients did not receive the ordered CT exams (unfulfilled CT orders) and had no alternate imaging studies done. Table 2 below shows the dispositions for the 16 patients who had unfulfilled CT orders.

Table 2: CT Patients with Unfulfilled Orders

Number of Records	Reason
5	"No Show" for multiple scheduled CT appointments
4	"No Show" for initial CT appointment
1	"No Show" after one rescheduled appointment
3	CT appointments made, patients requested to be rescheduled, but no evidence patients were given or offered a new appointment
3	Refused CT appointment/exam

Source: VA OIG

For the 16 patients with unfulfilled orders, we did not find documentation that delays in treatment occurred. For 14 of these 16 patients, we found that patients' symptoms had spontaneously resolved and did not require follow-up, or facility staff made diligent attempts to schedule appointments but patients failed to show, refused the exam, or did not provide current contact information.

The remaining 2 patients did not come for their scheduled imaging studies. We did not find evidence that action was taken to complete the planned evaluation. Below are brief synopses of the cases:

- Patient 1 was a male in his 60s who presented to his VA provider with complaints of right sided neck pain that had been present for more than 1 year. The provider ordered pain medication and a CT of the neck. The patient failed to show for his CT scan appointment. Despite continued complaints of neck pain documented in subsequent notes, we did not find evidence that action was taken to follow-up on the ordered CT exam.

- Patient 2 was a male in his 30s who was seen by a non-VA provider due to intense left lumbar and lower back pain with bloody urine. A CT of the abdomen and pelvis was taken demonstrating multiple kidney stones. The day after, the patient presented at a non-VA ED and was seen 3 consecutive days due to pain. He presented to his VA provider 7 days after his last non-VA ED visit and reported that he had passed three kidney stones at the time of his 3rd non-VA ED visit. He complained of continued discomfort over the left lumbar area. The VA provider ordered pain medication and antibiotics as well as a CT of the abdomen and pelvis and an x-ray of the lumbar spine. The tests were scheduled; however, the patient failed to show for his appointments. We did not find evidence that action was taken to follow-up on the ordered exams. The provider discontinued the antibiotic when subsequent lab results showed no signs of infection.

VHA requires that when a patient is a "no show" for a scheduled appointment, the responsible provider is to review the patient's EHR and determine whether appropriate follow-up action is warranted. VHA also recommends that when patients have a pattern of multiple "no shows," the facility is to assign a case manager to oversee the care of these patients.

We determined that facility clinicians did not document compliance with VHA requirements related to management of "no show" patients to ascertain whether changes in care plans were indicated based on the patients' clinical needs and whether the unfulfilled CT exams should have been reordered. We noted that the facility reported no patient complaints or tort claims related to timeliness of CT exams for CY 2013.

CT Appointment Reminder Letters

We could not substantiate the allegation that patients did not consistently receive appointment reminder letters because the facility had no requirement for tracking and documenting when appointment letters were sent out or when undelivered letters were returned. VHA policy does not address appointment letter notifications.[16] Of the

[16] VHA Directive 2010-027.

39 EHRs reviewed, only 4 contained documented evidence that patients were informed of their appointment dates.

Documentation in the AM and RP Programs

We substantiated the allegation that scheduling clerks were incorrectly documenting patient actions or dispositions in the AM and the RP programs. Of the 39 randomly selected patient EHRs that we reviewed, 38 patients had at least one canceled CT appointment.[17] In all 38 cases, scheduling clerks consistently documented "no show" in the AM program but used several different options in the RP program. "No show" did not appear to be an option in the RP until June 2013. Prior to this date, "patient refused" was one of the options for canceling a CT order. Table 3 below shows the inconsistency between the two programs.

Table 3: Cancelation Documentation

Number of Records 38	Cancelation Reason	
	AM	RP
16	No Show	Patient Refused[18]
17	No Show	No Show[19]
4	No Show	Patient Rescheduled
1	No Show	Provider Canceled

Source: VA OIG

Program managers informed us that the incompatibility between the AM and the RP programs and the duplicate process for annotating the reason for canceling an exam presented challenges. The scheduling clerks cancel the appointment in the AM program but must access the RP program to cancel the order.

Scheduling Policy

We noted that the facility had no formal policy addressing patient scheduling for outpatient examinations. As a result, scheduling clerks had developed their own "informal" scheduling procedure for CT exams. We received a copy of a draft SOP on *Outpatient Scheduling Processes, Procedures, and Practices* after our site visits, and on May 8, 2014, the facility issued a formal scheduling policy.

Issue 2: Problems with Facility Services—Uploading of Non-VA Images, Lack of Equipment, and Staff Training

We substantiated that for the three patients whose names were provided to OIG, non-VA imaging exams (actual images) were not uploaded into the EHRs. However, the reports or results of the exams were available to providers. We substantiated that HIMS

[17] Of the 39 originally sampled patients, 1 patient's CT exam was completed.
[18] This option appeared to have been edited to "No Show" in the RP after June 2013.
[19] This option was not available in the RP prior to June 2013.

did not have the proper equipment and software application to upload images from non-VA facilities that were stored on a CD. We did not substantiate the allegation of untrained staff.

For the three patients, it was not possible to determine whether the CDs containing the images were sent to radiology for uploading. We reviewed the patients' EHRs and concluded that although images were not available, responsible providers were aware of the imaging exam results. Therefore, uploading the non-VA images would probably not have impacted clinical care or treatments. However, we determined that the facility needed to ensure that proper equipment is available to scan and upload images to make sure clinicians have all available clinical data at their disposal when developing care plans and to make certain current images are available to radiologists during their interpretation of imaging studies.

HIMS staff have been trained to scan and upload non-VA documents. However, training for uploading non-VA imaging studies is pending until the appropriate equipment with the necessary software is purchased and activated.

Issue 3: Mismanagement of Ultrasound Staff Resulting in Early Clinic Closure

We did not substantiate the allegation that staffing mismanagement resulted in early closure of the ultrasound walk-in clinic. The number of staff on duty as well as the volume and complexity of ultrasound orders may have altered the number of exams that staff could perform in a given day. However, ultrasound services remained accessible to inpatients, emergent outpatient cases, and ED patients.

The ultrasound department has six technicians to accommodate 50–65 procedures per day. Program managers acknowledged instances when the clinic had to close early to walk-in outpatients because of a high volume of requests from clinics, inpatient units, and the ED. In addition, staff reported that more complex[20] procedures require additional staff time and that this could limit the number of patients that could be seen. When this occurred, program managers reported that outpatients who presented to the clinic were either scheduled to be seen the next day or given a future appointment. Further, staff informed us that once demand subsided, the lead technician could reopen the clinic to walk-in patients as soon as it was feasible. However, the facility was not able to provide information as to whether the clinic was reopened during early closure days.

The complainant provided information related to clinic closure for January through March 2013, and the facility furnished data for April through December 2013. Based on the data provided, we determined that the clinic was closed early on approximately 61 days (24 percent)[21] in CY 2013. We did not identify a pattern suggesting that the

[20] In most cases, an ultrasound exam takes 20–60 minutes to complete. However, more complex studies could take up to 120 minutes.
[21] This was calculated using 251 operating (business) days in CY 2013 (Monday through Friday excluding holidays).

primary reason for the clinic closure was due to insufficient staff or inappropriate staff deployment. However, we determined that program managers need to periodically assess the appropriateness of the clinic's early closure to ensure walk-in patients receive timely ultrasound studies.

Table 4 shows the number of early closure days for the walk-in clinic, the number of staff on duty, and the number of exams for each day the clinic was closed early in CY 2013. For example, in January, the clinic was reportedly closed early 9 days. For 1 day, there were 5 staff on duty; for 3 days, there were 4 staff on duty; and for 5 days, there were 3 staff on duty.

Table 4: Ultrasound Walk-In Clinic Early Closure Data

2013 Month	Number of Early Closure Days	Staffing		Workload	
		Number of Days	Staff on Duty	Dates	Number of Exams Completed
January	9	1	5	1/8	59
		3	4	1/4; 1/7; 1/11	No data; 53; 51
		5	3	1/2; 1/3; 1/22; 1/23; 1/29	No data; No data; 43; 45; No data
February	11	2	5	2/19; 2/28	No data available
		6	4	2/4; 2/7; 2/12; 2/15; 2/21; 2/25	No data; No data; No data; 41; No data; No data
		3	3	2/5; 2/6; 2/8	No data available
March	8	1	5	3/1	No data available
		6	4	3/4; 3/5; 3/6; 3/7; 3/12; 3/21	
		1	3	3/20	
April	1	1	5	4/23	59
May	2	2	5	5/14; 5/29	69; 57
June	5	1	6	6/5	72
		4	5	6/6; 6/10; 6/12; 6/13	60; 64; 61; 56
July	4	2	6	7/9; 7/18	65; 66
		2	5	7/2; 7/16	61; 60
August	8	1	5.7	8/23	57
		2	5.5	8/26; 8/27	57; 61
		3	5	8/8; 8/15; 8/19	60; 58; 56
		2	4.5	8/20; 8/22	50; 59
September	3	2	6	9/16; 9/30	58; 57
		1	5	9/3	61
October	2	1	6	10/15	65
		1	5	10/22	60
November	4	3	6	11/8; 11/15; 11/18	61; 63; 65
		1	5	11/12	59
December	4	1	6	12/2	60
		3	5	12/9; 12/11; 12/12	59; 62; 56
Total	**61 out of 251 (24 percent) early closure business days in CY 2013**				

Source: VA OIG

Issue 4: Notification of Mammography Patients with BI-RADS Zero Results

We did not substantiate the allegation that mammography patients with BI-RADS category 0 were not notified within 14 days from the date the results were available.

We reviewed the EHRs of 100 randomly sampled patients who reportedly had screening mammograms at the facility in CY 2013. We excluded two records from our review—one with a non-VA mammogram and one with a non-screening mammogram. For the 98 patients reviewed, we found documented evidence of patient notification for all but 1 patient who had a negative BI-RADS 1 mammogram result. For the remaining 97 patients, we measured the elapsed days from the date the results were available and patient notification. For all BI-RADS categories, patients were notified within a mean of 6 days. For the 19 patients with BI-RADS category 0 results, patients were notified within a mean of 7 days. Table 5 below shows the mean elapsed days for each category.

Table 5: Patient Notification Timeliness

BI-RADS Category	Number of Records 97	Elapsed Days of Patient Notification (Mean)
0	19	6.89
1	31	5.1
2	41	6.22
3	4	8.75
4	1	0
5	NA	NA
6	1	0
All BI-RADS 0–6	97	5.97

Source: VA OIG

Conclusions

We substantiated the allegations that blind scheduling occurred. We did not substantiate the allegation of treatment delays for 16 patients who had unfulfilled CT orders. However, for 2 of the 16 patients who were blind scheduled and did not keep their appointments, facility clinicians did not document attempts to contact the patients to ascertain whether the unfulfilled CT exams should have been reordered or if other follow-up action was necessary. We determined that facility leadership and program managers needed to ensure that staff follow appropriate scheduling procedures and that patients receive ordered CT studies. We concluded that the facility needed to comply with VHA requirements for managing “no show’ patients.

We could not substantiate the allegation that patients did not consistently receive appointment reminder letters because the facility had no requirement for tracking and documenting when appointment letters were sent out or when undelivered letters were returned.

We concluded that scheduling clerks did not consistently document patients' actions or dispositions in the AM and the RP programs. Program managers needed to periodically monitor exam cancelations to ensure the appropriate reason is accurately and consistently documented between these two programs.

On May 8, 2014, the facility implemented a scheduling policy for outpatient examinations to ensure consistency in documentation and scheduling practices. We determined that the facility needed to monitor the newly implemented policy for compliance.

We substantiated that non-VA imaging exams were not uploaded into the EHRs for the three subject patients. However, we concluded that uploading these images would not have influenced treatment courses for the patients. We determined that the facility needed to ensure that proper equipment is available for uploading images into the patient's EHR and that training on the process for designated staff is provided.

We did not substantiate the allegation of staff mismanagement of the ultrasound walk-in clinic. We concluded that the number of staff on duty as well as the volume and complexity of ultrasound orders influenced the clinic's early closure. We determined that program managers needed to assess and track the appropriateness of early walk-in clinic closures to ensure outpatients receive timely studies.

We did not substantiate that staff were not timely in notifying patients with BI-RADS category 0 results.

Recommendations

1. We recommended that the Facility Director strengthen processes to ensure that patients are involved in the scheduling process, that program managers periodically monitor exam cancelations, and that staff accurately document patient dispositions and actions taken related to patient scheduling.

2. We recommended that the Facility Director ensure that clinicians review the electronic health records of the two patients who had unfulfilled computed tomography orders to determine whether follow-up actions are needed.

3. We recommended that the Facility Director monitor compliance with the facility's newly implemented scheduling policy.

4. We recommended that the Facility Director ensure that proper equipment and software is available for uploading non-VA images and that staff are trained.

5. We recommended that the Facility Director ensure that program managers periodically assess and monitor the appropriateness of early walk-in ultrasound clinic closure and take necessary steps to ensure outpatients receive timely studies.

Appendix A

Acting VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: October 1, 2014

From: Acting Network Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, CA (Draft Report)

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10AR MRS)

1. I concur with the findings and recommendations in the Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California, recommendations 1–5.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Jimmie Bates, VISN 22 QMO

for Barbara Fallen, FACHE

Attachment

Appendix B

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: September 30, 2014

From: Director, VA Loma Linda Healthcare System (605/00)

Subj: Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, CA

To: Director, Desert Pacific Healthcare Network (10N22)

1. I concur with the VA Loma Linda Healthcare System's response and action plans as detailed within this report.

Barbara Fallen, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director strengthen processes to ensure that patients are involved in the scheduling process, that program managers periodically monitor exam cancelations, and that staff accurately document patient dispositions and actions taken related to patient scheduling.

Concur

Target date for completion: January 15, 2015

Facility response: Several actions have been put into place since February 2014, to strengthen the scheduling process in Imaging Service.

All scheduling clerks received TMS and face-to-face training regarding scheduling procedures. **Completed**

A lead clerk has been added to Imaging to improve training, supervision and auditing of scheduling practices. The scheduling duties have been segregated and assigned to a clerk in a back office to minimize distractions. **Completed**

Weekly scheduling audits have been in effect since May 2014, which require supervisors to review five scheduled appointments per week of each scheduler for review of appropriate scheduling practices. **Ongoing**

Action Plan:
A Standard Operating Procedure (SOP) has been developed which clearly defines the number and type of contact attempts, proper documentation of contact attempts and reconciling appointment cancelations in VistA Appointment Manager (AM) and the Radiology Package (RP). Staff will be trained on the SOP.
Target date for completion: October 15, 2014

Hire an additional supervisor to cover Imaging, Audiology and Compensation and Pension staff lowering the staff/supervisor ration to 19:1.
Target date for completion: November 30, 2014

Weekly scheduling audits in Imaging will include the supervisor contacting Veterans weekly to validate that the SOP is being followed and no blind scheduling is occurring. This added verification will be ongoing for a 90-day cycle.
Target date for completion: January 15, 2015

Recommendation 2. We recommended that the Facility Director ensure that clinicians review the electronic health records of the patients who had unfulfilled computed tomography orders to determine whether follow-up actions are needed.

Concur

Target date for completion: Completed

Facility response: Clinical chart reviews were performed on both patients. No findings were apparent on review and both patients were called and asked if they wanted to schedule a follow up CT Scan appointment.

Recommendation 3. We recommended that the Facility Director monitor compliance with the facility's newly implemented scheduling policy.

Concur

Target date for completion: Completed

Facility response: Several actions have been put into place since May 2014, to monitor compliance on the facility's new scheduling policy.

Weekly scheduling audits have been in effect since May 2014, across all services and staff who schedule appointments. The tool utilized was developed by VISN 22 staff and will be rolled out nationally in the near future. The tool provides a random sampling to each supervisor of patients that each of their staff have scheduled during that week. Corrective action is immediately taken when staff is non-compliant with the VHA national directive as well as the facility's scheduling policy. Health Administration Service (HAS) leadership and the Chief of Staff's Office monitor completion of the audits.

Executive Leadership performs monthly rounds in all clinics and CBOCs to talk with front-line staff about scheduling practices in their clinics. Appropriate scheduling practices are validated during rounds. Staff who schedule appointments are also invited to attend monthly listening sessions with leadership to discuss scheduling compliance and access to care.

Recommendation 4. We recommended that the Facility Director ensure that proper equipment and software is available for uploading non-VA images and that staff are trained.

Concur

Target date for completion: November 30, 2014

Facility response: Estimated completion date is based on resolving Patch 118 VistA Imaging routing problems. Patch 118 is installed but not fully functional. Imaging

Service and Information Technology Service are working to resolve the VistA Imaging routing problems.

As an interim measure, Imaging Service, HAS and the Clinical Application Coordinator's (CACs) have developed a contingency plan that tracks the disk of non-VA images and ensures that the requested imaging studies are available to the clinicians through PACS and VistA Imaging/CPRS. Staff has been trained on the process and on the Patch 118 upgrade.

Recommendation 5. We recommended that the Facility Director ensure that program managers periodically assess and monitor the appropriateness of early walk-in ultrasound clinic closure and take necessary steps to ensure outpatients receive timely studies.

Concur

Target date for completion: December 31, 2014

Facility response: Imaging Service monitors the Ultrasound Clinic saturation rate daily. Once saturation levels are obtained and walk-ins are no longer accepted, the clinic is required to continue performing ultrasound scans for STAT, ED and inpatients. During saturation periods, ultrasound requests for walk-ins are triaged and completed on a case-by-case basis. The patients that cannot be seen during the walk-in clinic saturation period are offered a scheduled appointment during the next few days, so they can be seen in a timely fashion.

A vacant Ultrasound Technologist and a term-appointment Ultrasound Technologist are currently under recruitment. The additional technologists will decrease future saturation and early walk-in clinic closure.

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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