Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00875-133

Healthcare Inspection

Radiology Scheduling and Other Administrative Issues Phoenix VA Health Care System Phoenix, Arizona

February 26, 2015

Washington, DC 20420

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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 made by an anonymous complainant regarding appointment scheduling, staffing, and other administrative issues in the Radiology Department of the Phoenix VA Health Care System (facility). Specifically, the complainant alleged that:

1. The use of a Microsoft Outlook software calendar for scheduling breached VA security requirements.
2. Radiology support assistants (clerks) had no access to the facility's scheduling system causing radiology appointments to not be reflected on patients' appointment lists.
3. Imaging files and records were improperly stored, and jackets (used for storing x-ray films and reports) were not easily retrievable.
4. Clerical staffing was insufficient, and some areas had no clerical coverage.

We substantiated the allegations that a Microsoft Outlook software calendar was used to supplement radiology scheduling, that radiology appointments were not reflected on patients' clinic appointment reminder lists, that radiology clerks had no access to the facility-wide scheduling system, and that some areas had no clerical coverage.

We also noted that the Radiology Department had no written scheduling guidelines and no formal training plan for radiology clerks.

We determined that the facility information security and privacy officers need to review and monitor the use of the Microsoft Outlook software calendar to ensure compliance with applicable VA requirements. We also concluded that Health Administration Service and Radiology Department managers need to consider granting radiology clerks access to the facility-wide scheduling system. We determined that the Radiology Department needed to develop and implement a scheduling policy and a structured training plan for radiology clerks to ensure consistency in scheduling practices.

We substantiated that films and files had been stored in the basement and were not easily accessible to staff. Radiology Department managers had already addressed this issue. All films and files have since been moved to the radiology file room.

We substantiated that the Radiology Department had insufficient clerical staff and that instances occurred when a check-in area had no coverage when unscheduled absences occurred. We determined that Radiology Department managers needed to assess clerical staffing needs to ensure all areas were appropriately staffed to greet patients, schedule appointments, and answer phones.

We determined that Radiology Department managers needed to take corrective actions to ensure phones were either answered within a reasonable time or phone messages

(where used) returned as soon as possible. We concluded that implementing centralized scheduling and procedures to ensure a timely response to phone calls or messages may address a majority of patient complaints.

We recommended that the Interim Facility Director ensure that the Radiology Department uses software that is consistent with VA policy to schedule appointments. We also recommended that Radiology Department managers explore the use of the scheduling system by radiology clerks, develop and implement a scheduling policy and a formal training program for clerks, monitor clerical needs to ensure all radiology areas are staffed, and implement the facility's plan for centralized radiology scheduling and procedures to ensure a timely response to phone calls or messages.

Comments

The Acting Veterans Integrated Service Network Director and Interim Facility Director concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 8–12, for the full text of the Directors' comments.) We will follow up on the planned actions 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 conducted an inspection to assess the merit of allegations concerning appointment scheduling, staffing, and other administrative issues in the Radiology Department at the Phoenix VA Health Care System (facility), Phoenix, AZ.

Background

The facility is a 280-bed tertiary care facility that provides comprehensive health care services in medicine, surgery, behavioral medicine, and long-term care. It serves veterans in central Arizona through its main medical facility, the Carl T. Hayden VA Medical Center in Phoenix, AZ, and at six community based outpatient clinics. The facility is affiliated with the University of Arizona in Tucson, AZ, and is part of Veterans Integrated Service Network 18.

The Radiology Department provides both inpatient and outpatient services, which include computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, nuclear medicine, interventional radiology, and mammography. Radiology (also known as imaging) services at the main medical facility are provided at four separate areas/locations:

- Outpatient, general radiology, MRI, and interventional: Building 1 A2200
- Inpatient, CT, ultrasound, bone density, angiography: Building 8 D210/212
- Mammography and mobile MRI: Amethyst Clinic (Building 1 Women's Health)
- Nuclear medicine and Positron Emission Tomography-CT: Building 1 A0500

Radiology services are also offered at the Northwest and Southeast community based outpatient clinics. The Radiology Department has a total of 78 full-time employees—15 staff radiologists, 51 technologists, 10 medical support staff (clerks), 1 nuclear medicine physician, and 1 picture archiving computer system administrator. Table 1 below shows the radiology workload (number of studies done) for fiscal years (FYs) 2011–2014.

Table 1: Radiology Workload Data

Imaging modality/section	FY 2011	FY 2012	FY 2013	FY 2014
General radiology	69,101	67,092	70,705	76,434
MRI	5,438	4,454	4,849	7,798
CT	15,100	15,127	15,280	16,852
Ultrasound	8,815	7,227	7,420	9,125
Nuclear medicine	5,710	6,602	8,266	8,558
Mammography	2,581	2,430	1,832	1,985
Interventional radiology	3,421	3,446	3,567	3,642
Total	110,166	106,378	111,919	124,394

Source: Veterans Health Administration

VHA Scheduling Policy[1]

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 date specified by the ordering clinician.

VA Information System

VA uses the Veterans Health Information Systems and Technology Architecture (VistA) for documenting clinical care and other functions. VistA is an integrated electronic health record information technology system with approximately 200 application packages that share a common data store and internal services. Two examples are the radiology/nuclear medicine (radiology) package and the scheduling system.[2]

The scheduling system automates all aspects of the outpatient appointment process, including checking-in/checking-out patients; scheduling patients for clinic appointments; and generating management reports, patient letters, and workload reports. At the facility, Health Administration Service (HAS) staff use the scheduling system to make outpatient clinic appointments; while radiology clerks use the radiology package to schedule imaging examinations or studies (exams).

The radiology package automates diagnostic functions, including order entry of requests, patient registration for exams/studies, reports/results recording, exam processing, and verification of reports online.

HAS staff have no access to the radiology package, and radiology clerks have no access to the scheduling system. Because the radiology package and the scheduling system are separate application packages, when imaging orders are scheduled through the radiology package, radiology appointments are not reflected in the computerized patient record system under clinic appointments.

Allegations

On August 4, 2014, the OIG received allegations from an anonymous complainant regarding radiology scheduling, staffing, and other administrative issues. Specifically, the complainant alleged that:

1. The use of a Microsoft Outlook (MSO) software[3] calendar for scheduling studies breached VA security requirements.
2. Radiology clerks had no access to the facility's scheduling system causing radiology appointments not to be reflected on patients' appointment lists.

[1] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[2] VistA Monograph, October 2013.
[3] Computer program that can be used with a particular computer system.

3. Imaging files and records were improperly stored, and jackets (used for storing x-ray films and reports) were not easily retrievable.
4. Clerical staffing was insufficient, and some areas had no clerical coverage.

Scope and Methodology

We conducted a site visit October 1–2, 2014. We interviewed facility leadership, the Radiology Chief, radiology supervisors and clerks, a radiologist, a privacy officer, the information security officer, and the acting lead patient advocate. We reviewed VHA policies, facility documents, staffing and workload reports, patient advocate contacts, and other relevant documents.

We toured the Radiology Department, including the four imaging areas at the main medical facility and the basement area where MRI and mammography files and films were stored temporarily.

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: Scheduling Calendar and Information Security

We substantiated the allegation that the Radiology Department breached VA security requirements by recording personally identifiable information on an MSO software calendar when scheduling patients for selected exams. The information recorded included the patient's last name, the initial of the patient's first name, the last four digits of the social security number, and the type of study and whether contrast media[4] was used. Together, this information could potentially identify the patient and was, therefore, a violation of patient privacy and information technology security. The MSO software calendar does not have the proper security controls required for VA computer systems.[5]

Clerks and supervisors told us that the MSO software calendar was a useful tool because the radiology package does not have a calendar feature, which made it difficult to determine open radiology appointment times and caused overbooking. The MSO software calendar allowed clerks to view available appointment slots in any given day, week, or month to facilitate scheduling. We confirmed that radiology continues to use the MSO software calendar in some areas such as CT and MRI; however, we were told that as of September 2014, only the patient's initials (last and first) and the type and date of the study were recorded on the calendar.

Issue 2: Appointments and Scheduling System

We substantiated that radiology appointments were not reflected on patients' clinic (non-radiology) appointment lists because the radiology package does not interface with the scheduling system. To aid patients in remembering clinic appointments, a printout of their future appointments is generally provided by clinic staff. Because imaging orders are scheduled through the radiology package, radiology appointments are not reflected in the computerized patient record system under clinic appointments. If non-radiology facility staff are requested to verify a radiology appointment, a staff member has to either call radiology or access the exam order to determine whether an order was already scheduled and a radiology appointment already made.

We substantiated that radiology clerks had no access to the scheduling system. Clerks told us that scheduling patients using the radiology package alone was inefficient because it does not automate important scheduling features to help patients remember their appointments. For example, automated appointment letters were not generated, and clerks had to manually create appointment reminder letters. Additionally, clerks had to call patients because the automated call reminder was not a radiology package

[4] A substance used to enhance imaging characteristics, thereby providing radiologists additional information when reading imaging studies.
[5] Talent Management System, VA Privacy and Information Security Awareness and Rules of Behavior-System 4: Conversations and Messaging.

option. Radiology Department managers told us that they have already initiated a dialogue with their HAS counterparts to discuss granting radiology clerks access to menu options for the scheduling system.

Policy and Training

We noted that the Radiology Department had no scheduling policy and no formal training program for clerks. Some clerks told us that it would be useful to have written guidelines. This is particularly important for new clerks with no prior scheduling or radiology/medical experience. Without written guidelines and a formal training plan, scheduling consistency is not assured. For example, we found that some radiology sections were using the MSO software calendar while others were not. In addition, not all radiology sections send out appointment reminder letters. We were told that each imaging section had written protocols; however, formal radiology standard operating procedures defining scheduling requirements for each modality have yet to be developed.

Issue 3: Storage of Imaging Files

We substantiated that for a short period of time, MRI and mammography files had been stored in the basement and were not easily accessible to staff. This was a known issue and was documented in the March 2014 Radiology Department staff meeting minutes:

> *Remainder of mammo films are being stored in basement but are out of order and in laundry bins making prior films extremely difficult to locate. This is impacting patient care in the Breast Imaging department because patient's prior films cannot be found for comparison.*

As of the date of our site visit, all files had been moved to the radiology file room. The facility did not report any negative patient outcomes as a consequence of the temporary storage.

Issue 4: Staffing

We substantiated the allegation that the Radiology Department had insufficient clerical staff. Managers acknowledged that prior to September 8, the Department had three vacancies, including one supervisory position. Two new clerks were hired in September, and only the clerical supervisory position remained vacant.

Clerks told us that it was not unusual to find a long line of patients waiting to be checked-in. Combined with other duties, such as answering phones and scheduling, clerks mentioned that registering patients for scheduled exams could be overwhelming. The number of check-in areas for registering imaging patients, the increase in workload in areas where exams are scheduled, and unscheduled absences influenced clerical coverage in all areas.

We also substantiated that not all radiology check-in areas were staffed during business hours. Radiology Department managers acknowledged instances when an area was

not manned because of unscheduled absences. During our site visit, the MRI section had no clerical staff, and technologists were temporarily fulfilling clerical functions. Managers told us that recently hired clerks will be trained to work in the MRI section. We also confirmed that when the clerk assigned to Women's Health was on lunch or assigned to other duties, no scheduled coverage was provided. However, the Women's Health HAS staff told us that either a mammography technologist or a radiologist was always available in the absence of the assigned radiology clerk.

Issue 5: Other Issues

Patients who have issues or comments related to their care at the facility are referred to the Patient Advocate Office (also known as Office of Patient Experience) for resolution or disposition. These patient contacts are tracked and categorized according to issues.[6] In FY 2014, the Radiology Department had 158 reported contacts, including 11 compliments. The top 3 categories of complaints were:

- Phone calls not answered/returned: 48/158 (30 percent)
- Excessive delay in scheduling or rescheduling of appointment: 38/158 (24 percent)
- Delay/postponement of test/procedure: 33/158 (21 percent)

We reviewed all complaints, and the most frequently cited area was MRI (followed by CT and then ultrasound) because of unanswered phones or scheduling issues. While onsite, we called two MRI contact numbers listed on the MRI patient notification letter, and the phone rang without being answered. We noted that CT, MRI, and ultrasound are the most commonly ordered studies, and the number of complaints may be a reflection of the exam volume. Nevertheless, managers need to take actions to address these issues, as they are important measures of the patient's care experience.

Radiology Department managers told us that they plan to initiate centralized scheduling and showed us the office designated for this activity. A centralized scheduling section would enable clerks to be more efficient, as there would be less disruption from other duties such as checking-in patients and answering phones. However, managers need to implement procedures to address problems with unanswered phones and unreturned calls that may not be resolved with centralized scheduling.

Conclusions

We substantiated the allegations that the MSO software calendar was used to supplement radiology scheduling, that radiology appointments were not reflected on patients' clinic appointment reminder lists, and that radiology clerks had no access to the scheduling system. We also noted that the Radiology Department had no written scheduling guidelines and no formal training plan for clerks.

[6] Contacts include patients' complaints or compliments.

We determined that the facility information security and privacy officers needed to review and monitor the use of the MSO software calendar to ensure compliance with applicable VA requirements. We also concluded that Radiology Department and HAS managers should consider granting radiology clerks access to the scheduling system. We determined that the Radiology Department needed to develop and implement a scheduling policy and a structured training plan for clerks to ensure consistency in scheduling practices.

We substantiated that films and files had been stored in the basement and were not easily accessible to staff. Radiology Department had already addressed this issue. All films and files have since been moved to the radiology file room.

We substantiated that the Radiology Department had insufficient clerical staff and that instances occurred when a check-in area had no coverage when unscheduled absences occurred. We determined that program managers needed to assess clerical staffing needs to ensure all areas were appropriately staffed to greet and register patients, schedule appointments, and answer phones.

Based on patient complaints, we determined that managers needed to take corrective actions to ensure phones were either answered within a reasonable time or phone messages (where used) returned as soon as possible. We concluded that centralized scheduling may resolve a majority of patient complaints related to timely scheduling of radiology appointments and postponed procedures. However, concerns regarding unanswered or unreturned phone calls needed to be addressed.

Recommendations

1. We recommended that the Interim Facility Director ensure that the Radiology Department uses software that is consistent with VA policy to schedule appointments.

2. We recommended that the Interim Facility Director ensure that Radiology Department managers explore the use of the scheduling system by radiology clerks to ensure that appointments are reflected on patients' appointment lists and that automated reminder letters and phone calls are generated or initiated.

3. We recommended that the Interim Facility Director ensure that Radiology Department managers develop and implement a scheduling policy and a formal training program for clerical staff to ensure consistency in scheduling practices.

4. We recommended that the Interim Facility Director ensure that Radiology Department managers assess and monitor clerical needs to ensure all check-in areas are staffed, appointments are scheduled/rescheduled, and phones are answered or calls are returned timely.

5. We recommended that the Interim Facility Director ensure that Radiology Department managers implement the facility's plan for centralized radiology scheduling and procedures to ensure a timely response to phone calls or messages.

Appendix A

Acting VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 7, 2015

From: Acting Network Director, VISN 18 (10N18)

Subj: Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, AZ

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

Director, Management Review Service (VHA 10AR MRS)

1. I have reviewed and concur with the findings and recommendations of the Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, AZ report.

2. If you have any questions or concerns, please contact Jennifer Kubiak, Quality Management Officer, VISN 18, at 480-397-2781.

Jennifer Kubiak for
Kathleen R. Fogarty
Acting Network Director

Appendix B

Interim Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: December 22, 2014

From: Interim Facility Director, Phoenix VA Health Care System (644/00)

Subj: Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, AZ

To: Acting VISN Director, VA Southwest Health Care Network (10N18)

1. Please find the proposed comments regarding the Office of Inspector General Healthcare Inspection – Radiology Scheduling and Other Administrative Issues Review conducted the week of October 1, 2014.

2. If you have any questions, please contact Michelle Bagford, Chief, Quality, Safety and Improvement, at (602) 277-5551 extension 6092.

GLEN W. GRIPPEN
Interim Medical Center Director

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 Interim Facility Director ensure that the Radiology Department uses software that is consistent with VA policy to schedule appointments.

Concur

Target date for completion: April 30, 2015

Facility response: Radiology scheduling staff will fully utilize Appointment Manager software in conjunction with the Radiology Scheduling package consistent with VA policy by April 30, 2015. To date, both mammography and Nuclear Medicine sections are compliant with using this software. All remaining Radiology modality clinics will be built and Appointment Management software will be fully implemented by April 30, 2015. Effective August 20, 2014, the Microsoft Office Calendar system was scrubbed of all personally identifiable information.

Recommendation 2. We recommended that the Interim Facility Director ensure that Radiology Department managers explore the use of the scheduling system by radiology clerks to ensure that appointments are reflected on patients' appointment lists and that automated reminder letters and phone calls are generated or initiated.

Concur

Target date for completion: March 1, 2015

Facility response: The PVAHCS Radiology Department will develop Standard Operating Procedures (SOP) for using the Appointment Management software package with the Radiology software package. The SOP will be completed by PVAHCS Radiology Department by March 1, 2015.

The VistA Appointment Management package will allow for appointments to be viewed on the patient's appointment list and will automatically generate reminder letters for patients with appointments greater than ten days from the date the appointment is created.

Recommendation 3. We recommended that the Interim Facility Director ensure that Radiology Department managers develop and implement a scheduling policy and a formal training program for clerical staff to ensure consistency in scheduling practices.

Concur

Target date for completion: April 30, 2015

Facility response: A scheduling policy that incorporates standardized scheduling requirements and SOPs for each imaging modality will be in place by April 30, 2015. Formal training that includes Appointment Manager software training and softskills will be completed by all schedulers by April 30, 2015. As a component of New Employee Orientation, new Radiology Scheduling staff will receive training within 30 days of onboarding and the training will be renewed annually in accordance with the current VHA Directive (Scheduling and Radiology Scheduling). Continuing compliance will be audited through TMS to ensure all staff receive and maintain current training. Results of the audits will be reported in the Radiology Staff Meeting minutes and forwarded to the Clinical Executive Board.

Recommendation 4. We recommended that the Interim Facility Director ensure that Radiology Department managers assess and monitor clerical needs to ensure all check-in areas are staffed, appointments are scheduled/rescheduled, and phones are answered or calls are returned timely.

Concur

Target date for completion: March 31, 2015

Facility response: Radiology Management routinely reviews staffing levels to ensure that scheduling and check-in areas are fully staffed. On December 15, 2014, the most recent staffing assessment was completed and seven new MSA positions were approved by the facility Position Management Committee.

	Authorized FTEE 4/1/14	On Board FTEE 4/1/14	New FTEE Added after 4/1/14	New Authorized FTEE Ceiling	Current On Board FTEE	Current Vacancies	Selections Made (FTEE in On Boarding Process)	FTEE Currently being Recruited
Supervisor/MSA's	11	9	7	18	10	8	0	8

Effective March 31, 2015, a continuing audit will be conducted to ensure that quality practices for scheduling and rescheduling are maintained in compliance with the Scheduling Directive Outlined in VHA Directive 2010-027. The target rate of compliance for each audit will be at or above 90% staffing for MSA's.

Until additional scheduling staff are onboard, current staff are working overtime to address incoming calls and retrieve messages and return calls on a daily basis.

Recommendation 5. We recommended that the Interim Facility Director ensure that Radiology Department managers implement the facility's plan for centralized radiology scheduling and procedures to ensure a timely response to phone calls or messages.

Concur

Target date for completion: March 31, 2015

Facility response: By March 31, 2015, all Radiology scheduling MSA's will be relocated to a central suite (D242) in Inpatient Radiology. Radiology Managers will continue to

monitor the number of complaints about scheduling and phone calls through the Patient Advocate Tracking System (PATS) on a monthly basis to ensure the facility's centralized scheduling plan routes calls appropriately and timely and evaluate the effectiveness of actions taken.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Daisy Arugay-Rittenberg, MT, Team Leader Julie Kroviak, MD Kathleen Shimoda, RN Jackelinne Melendez, MPA, Program Support Assistant

Appendix D

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