VA Office of Inspector General

Veterans Health Administration

Review of an Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

October 4, 2016
14-02890-425

ACRONYMS

CID	Clinically Indicated Date
CY	Calendar Year
FY	Fiscal Year
HCC	Health Care Center
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OSC	Office of Special Counsel
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

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Highlights: Review of an Alleged Radiology Exam Backlog at VHA's W.G. (Bill) Hefner VAMC in Salisbury, NC

Why We Did This Review

The VA Secretary forwarded to the Office of Inspector General (OIG) allegations received from the Office of Special Counsel (OSC) regarding access to radiological care at the W.G. (Bill) Hefner VA Medical Center, Salisbury, NC (VAMC Salisbury). The complainant made six allegations related to the existence of a large backlog of radiology exams at VAMC Salisbury. These allegations are in addition to the allegations investigated and published on October 4, 2016 in the *Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times–VA Medical Center in Salisbury, North Carolina* by the OIG's Office of Investigations.

What We Found

We substantiated the allegation that VAMC Salisbury had a backlog of about 3,300 pending orders for radiology exams but did not substantiate the other five allegations. We confirmed the existence of a backlog of more than 3,000 pending orders for radiology exams at a specific point in time in 2014 near the date identified by the complainant. However, VAMC Salisbury Imaging Service decreased the more than 3,000 pending exams and the number of pending orders. The facility averaged 1,358 pending orders from January 1, 2014 through March 31, 2016, but was unable to eliminate the backlog.

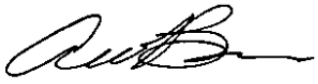
Furthermore, our review found the Imaging Service was not effectively managing its pending radiology exam workload to ensure patients received timely exams. Some patients experienced significant delays in the completion of ordered exams. We reviewed the records of 15 patients who died before the completion of a total of 16 ordered exams but did not determine that any of the deaths or adverse clinical outcomes resulted from the delays.

What We Recommended

We recommended the Salisbury Imaging Service Director require staff review all unscheduled radiology exam orders that are 30 days past the clinically indicated date and either cancel the orders if the exams are not needed or ensure the exams are scheduled. We also recommended the Director make unscheduled urgent and STAT orders a priority in the staff's review of unscheduled radiology orders and identify whether potential harm has occurred to patients due to delays in care. Finally, we recommended the VA Mid-Atlantic Health Care Network Director ensure VAMC Salisbury develops a plan to address existing demand for radiology exams and ensure future patients receive access to exams in accordance with Veterans Health Administration policy.

Agency Comments

The VA Mid-Atlantic Health Care Network Director and the VAMC Salisbury Director concurred with our findings and recommendations and provided an appropriate corrective action plan.



ANDREA C. BUCK
Chief of Staff for
Healthcare Oversight Integration

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INTRODUCTION

Allegation

In May 2014, the VA Office of Inspector General (OIG) received two complaints regarding scheduling irregularities and potential manipulation of wait times at the W.G. (Bill) Hefner VA Medical Center (VAMC), located in Salisbury, NC (VAMC Salisbury). The OIG began a criminal investigation to review these issues. In June 2014, the Secretary of the Department of Veterans Affairs received a complaint from the Office of Special Counsel (OSC) alleging six different, but related, conditions regarding delays in obtaining radiology exams at the same facility. Specifically, the OSC complainant alleged that:

- VAMC Salisbury had about 3,300 patients waiting for radiology exams, with some patients waiting since 2007.
- The backlog resulted from employing Nuclear Medicine technicians for one 8-hour shift per day, rather than multiple shifts or longer shifts.
- Nuclear Medicine patients were scheduled and scanned during a 4-hour window.
- The Nuclear Medicine department performed fewer than 10 scans per day, which was insufficient to reduce the size of the patient pending list.
- The Radiological Administrative Officer told the supervisor of the Nuclear Medicine technicians not to make any overtime requests.
- Nuclear Medicine department administrators refused to refer patients to outside facilities because of cost concerns.

These allegations are in addition to those investigated and published by the OIG's Office of Investigations.[1] Accordingly, the OIG deployed a multidisciplinary team composed of auditors and health care inspectors to review these additional allegations.

Radiology Scheduling Procedures

Imaging Service staff use hard copies of radiology orders to manage their exams. Orders may be marked as STAT, urgent or routine. Hard-copy orders are printed daily and are sorted by whether they are general radiology or specialty exams. Specialty exams require appointments to be scheduled in advance while general radiology exams are managed as walk-ins. Scheduling clerks schedule all specialty exam appointments except for Nuclear Medicine exams.

Nuclear Medicine exam orders are managed by Nuclear Medicine technicians in a separate filing system for scheduling. They perform their own scheduling in order to provide patients with specialized instructions and

[1] *Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times – VA Medical Center in Salisbury, North Carolina,* (October 4, 2016).

answer questions as needed. Nuclear Medicine technicians' primary responsibility is to administer scheduled exams so appointments are scheduled in between performing exams.

National and Local Guidance

VA issued Veterans Health Administration (VHA) Directive 2010-027, *Outpatient Scheduling Processes and Procedures*, on June 9, 2010, to update the scheduling policies for outpatient clinic appointments. However, VAMCs, including Salisbury, did not receive specific guidance on the scheduling of radiology exams until just before our review when VHA issued *Outpatient Radiology Scheduling Policy and Procedures and Interim Guidance* on February 25, 2016. During fiscal year (FY) 2014, Salisbury Imaging Service Policy 114-20, *Ordering, Scheduling, and Canceling Image Studies* required:

- Routine radiology exam requests to be completed within 30 days of the clinician's clinically indicated date (formerly known as the desired date)
- STAT studies to be completed within 24 hours unless otherwise indicated
- Did not provide guidance on urgent exam orders.

RESULTS AND RECOMMENDATIONS

Finding 1 VAMC Salisbury Imaging Service Did Not Effectively Manage Radiology Exam Workload To Ensure Patients Received Timely Exams

In June 2014, the OIG received a complaint regarding access to care in the Imaging Service at VAMC Salisbury. Specifically, the complainant made six allegations related to the existence of a large backlog of radiology exams. We substantiated the first allegation that VAMC Salisbury had a backlog of orders for radiology exams: there were more than 3,000 pending orders for radiology exams near the date identified by the complainant. The remaining five allegations were not substantiated and are discussed in Finding 2.

Alleged: Pending Radiology Backlog

We substantiated the allegation that VAMC Salisbury had a backlog of about 3,300 patients with pending orders for radiology exams. Our analyses of VAMC Salisbury's Imaging Service backlog data confirmed that the number of pending radiology exam orders reached a high of 3,205 as of January 9, 2014. This fact supported the complainant's general allegation that a large backlog of pending radiology exams existed at VAMC Salisbury at some point early in 2014. However, the data also showed that the pending exam backlog actually decreased to 1,451 by March 31, 2014 and averaged 1,358 pending orders during the period from January 1, 2014 through March 31, 2016.

We did not substantiate the second part of the allegation in which the complainant alleged that some patients had been waiting since 2007 for their radiology exams. System limitations prevented us from completing a point-in-time analysis of the pending orders that existed at the date specified by the complainant. However, VA OIG's review of the 3,126 pending radiology orders in the Veterans Health Information Systems and Technology Architecture (VistA) at the time of the April 12, 2016 site visit did not identify any pending orders dating back to 2007.

Although we did not find any patients who had waited since 2007, our review disclosed that Imaging Service may not be effectively managing pending orders and ensuring patients receive timely exams. We found that the 3,126 pending orders ranged from FY 2015 through FY 2016, year-to-date, with one order from FY 2012.

VHA policy requires radiology exams to be completed within 30 days of the clinically indicated date (CID). However, we found that 1,076 of the 3,126 pending orders (34 percent) were not timely because they had not been completed within 30 days of the CID.

This table shows a distribution of the pending radiology exam orders based

on the number of days they were past the CID.

Table. Orders More Than 30 Days Past the Clinically Indicated Date

Number of Days Past Due	Lower Limit
1–30	934
31–90	108
91–180	18
Over 180	16
Total	**1,076**

Source: VA Corporate Data Warehouse

Note: Includes pending exams that may be past due because the patient did not show for a scheduled exam.

Based on these review results, we requested the OIG Office of Healthcare Inspections (OHI) review a judgement sample of medical records belonging to 15 patients (with 16 orders) who died within 6 months of their exam request date. The patients' dates of death ranged between March 6, 2014 and December 15, 2015. The OIG selected these patients' records for review because patients who had waited more than 30 days from their clinically indicated date for an exam, and who subsequently died, would likely represent the most seriously ill group of patients with pending radiology orders and would, therefore, be more likely than the average patient to have experienced harm from a delayed exam.

OHI reviewed these patients' records to validate whether the patients had received the test and, if they had not, whether any harm resulted to the patient. Each of these patients had orders for a myocardial perfusion scan with technetium$_{99}$, but 13 of the patients had not received the ordered scans. Two patients received the scans. One of these patients received the scan outside of VA during an emergent hospitalization. The other patient's scan was performed at VA. This patient was scheduled within 30 days of the consult; however, the patient did not show for the test as scheduled. It was rescheduled to a later date and completed 6-days before his death.

OHI physicians reviewed the patients' electronic medical records and obtained death certificates, as needed. They also noted that "no shows" for the scheduled scans were mitigating factors in many of the cases. The OHI physicians' review of the 15 patients with a total of 16 ordered exams did not determine that any patients died or had an adverse clinical outcome as a result of the delays.

Recommendations

1. We recommended the W.G. (Bill) Hefner VA Medical Center Director require staff to review all unscheduled radiology exam orders that are 30 days past the clinically indicated date and either cancel the orders if the exams are not needed or ensure the exams are scheduled.

2. We recommended the W.G. (Bill) Hefner VA Medical Center Director make unscheduled urgent and STAT (immediate) orders a priority in the staff's review of unscheduled radiology orders and ensure staff determine whether any potential harm has occurred to patients due to the delays in care.

3. We recommended the VA Mid-Atlantic Health Care Network Director ensure that the W.G. (Bill) Hefner VA Medical Center develops a plan to address existing demand for Radiology exams and ensures future patients receive access to exams in accordance with VHA policy.

Management Comments

The VA Mid-Atlantic Health Care Network Director and the VAMC Salisbury Director agreed with our findings and recommendations and stated that they have addressed all our recommendations. VAMC Salisbury staff reviewed all unscheduled radiology orders with a CID through July 2016 and canceled orders that were not completed within 60 days of the CID. All other unscheduled orders 30 days past the CID were reviewed to determine whether the exam needed to be canceled or scheduled. Furthermore, urgent and STAT orders were reviewed by the Acting Chief of Staff and the Assistant Chief of Staff, Imaging department to determine the status of the exam and take appropriate action.

A plan was developed to address the demand for Imaging services. The plan includes the addition of Imaging equipment and staff at VAMC Salisbury, as well as at the Charlotte and Kernersville HCCs. Imaging is further facilitating access through an increase in scheduling staff, and additional scheduling staff may be requested in FY 2017 if demand and subsequent workload warrant such a request.

OIG Response

The VAMC Salisbury Director provided a responsive action plan and comments to address our recommendations.

Finding 2 Alleged Practices In Nuclear Medicine Department Operations Did Not Cause the Radiology Exam Backlog

We did not substantiate five allegations regarding Nuclear Medicine department shifts, duration, and number of Nuclear Medicine scans performed each day, denial of overtime requests, and refusal to send patients to outside facilities because of cost concerns. The complainant alleged that these conditions had contributed to the Radiology exam backlog at VAMC Salisbury.

Alleged Use of 8-Hour Shifts Caused Backlog

Due to the lack of historical data and information, we could not substantiate the allegation and determine whether the 2014 backlog was caused by the operation of only one 8-hour shift in the Nuclear Medicine department, rather than multiple shifts or longer shifts. Several factors, such as staffing fluctuations or shortages, equipment issues, or problems in the maintenance of pending orders, could have contributed over time to the development of the backlog. We also noted that the Nuclear Medicine department could not unilaterally add multiple shifts or longer shifts because its hours of operation had to align with those of the VAMC's Imaging, Cardiology, and Pharmacy services.

The Nuclear Medicine department relies on these services to prepare patients for the scans, provide support during the scans, perform the scans, and interpret the results. The VAMC Salisbury Imaging Chief also stated that the VAMC had not considered adding another shift because improved staffing levels, additional equipment, and the relocation of the cardiac stress lab had increased his service's efficiency and ability to meet workload demands.

Alleged Use of 4-Hour Scheduling Window Caused Backlog

We did not substantiate the allegation that Nuclear Medicine only scheduled patients and performed scans during a 4-hour window. We found no indications during our interviews or reviews that patients were only scheduled and scanned in the Nuclear Medicine department during a 4-hour window. According to the shift schedules, Nuclear Medicine technicians were available during the 10-hour period, 6:30 a.m.–4:30 p.m.

All of the Nuclear Medicine technicians we interviewed, including two who were employed in the service in 2014, stated (with slight variations due to their tours of duty) that they generally started scans between 7:30 and 8:00 a.m. and performed them throughout the day until 3:30 to 4:00 p.m. In addition, a review of the scheduled appointment logs for March 2014 and March 2016 in the VistA Clinic Availability Report showed that Nuclear Medicine had a 7.5-hour scheduling window for scans. The appointment logs showed that Nuclear Medicine typically scheduled patients for scans from 8:00 a.m. to 3:30 p.m.

Alleged Performance of Fewer Than 10 Scans Per Day

We did not substantiate the allegation that the Nuclear Medicine department performed fewer than 10 scans per day, which would have been insufficient to reduce the size of the patient pending list. Our review of the Nuclear Medicine department's FY 2014 workload disclosed that it completed an average of 22 scans per workday. We defined a workday as every business day, Monday through Friday, excluding Federal holidays. Our review and analysis of Nuclear Medicine's monthly FY 2014 workload showed that it consistently averaged 19 to 25 completed scans per workday each month. Thus, we found no evidence that Nuclear Medicine ever performed fewer than 10 scans per workday.

Alleged Refusal of Technicians' Requests for Overtime

We did not substantiate the allegation that the Radiological Administrative Officer told the Nuclear Medicine technicians' supervisor not to make any overtime requests. Based on interviews with the Chief of Staff and Nuclear Medicine department managers and technicians and our review of time and attendance overtime records, we did not identify any problems related to the request and approval of overtime in Nuclear Medicine. The Radiological Administrative Officer stated that he had not refused any Nuclear Medicine department overtime requests and Nuclear Medicine staff did not report any problems with making requests or getting them approved when we interviewed them regarding this allegation. However, we found 184 hours of overtime hours in calendar year (CY) 2014 and 117 hours in CY 2015 paid to the Nuclear Medicine Supervisor and four technicians for duties such as patient care, staff coverage, and scheduling.

Alleged Refusal To Refer Patients to Outside Facilities

We did not substantiate the allegation that Nuclear Medicine department administrators refused to refer patients to outside facilities because of cost concerns. The allegation was not substantiated based on our interviews with various VAMC Salisbury staff and our review of Nuclear Medicine authorizations for non-VA care. The Chief of Staff, chief of non-VA care, Imaging Service management and Nuclear Medicine technicians did not identify cost concerns as a barrier to referring patients to outside facilities through the non-VA care program. The VAMC Salisbury medical support assistant stated that when she scheduled appointments, she routinely offered non-VA care referrals if VAMC Salisbury radiology appointments exceeded a 30-day wait time. We also confirmed with the VAMC Salisbury chief of non-VA care that no policy prohibited the referral of Nuclear Medicine patients to non-VA care.

A review of non-VA care authorizations for the period from January 1, 2014 through April 11, 2016 showed that the Nuclear Medicine department made 165 referrals in CY 2014, 48 in CY 2015, and 5 as of April 11, 2016. Although we did not substantiate the complainant's allegation that cost concerns were a barrier to non-VA care radiology referrals, the Nuclear Medicine department's 1,076 past due pending exam orders indicated that increased use of non-VA care should be expanded to ensure that patients receive appropriate testing in a timely manner.

Conclusion

We substantiated the complainant's allegation that VAMC Salisbury had a backlog of about 3,300 patients with pending orders for radiology exams, but we did not substantiate the remaining five allegations. We confirmed the existence of a backlog of over 3,000 pending orders for radiology exams at a specific point in time in 2014 near the date identified by the complainant.

The VAMC Salisbury Imaging Service subsequently decreased that number, averaging 1,358 pending orders from January 1, 2014, through March 31, 2016, but did not eliminate the backlog. Although we did not identify any patients who had waited since 2007 for their exams, our review of the VAMC's current FY 2015 to FY 2016 year-to-date pending radiology exam workload indicated that the Imaging Service was not effectively managing its pending radiology exam workload to ensure patients receive timely exams. Furthermore, some patients had experienced significant delays in the completion of ordered exams. VA OIG's patient record reviews did not identify any patient harm associated with the delayed exams.

Appendix A Scope and Methodology

Scope

We performed our review and site visit during the week of April 11, 2016, to evaluate the allegations originating from VAMC Salisbury, North Carolina. The facility received notification of our visit two business days before the review began to ensure the availability of relevant personnel. We focused our review on validating the complainant's allegations.

Methodology

To gain a better understanding of the Imaging Service's overall operations, we interviewed VAMC Salisbury managers and staff, including radiologists, schedulers, and Nuclear Medicine technologists. On May 4, 2016, we interviewed the complainant by telephone to get a better grasp of the allegations; namely, that the complainant inadvertently became aware of the radiology order backlog after viewing routine Nuclear Medicine department reports in preparation for a weekly supervisors' meeting. The complainant also expressed opinions about Nuclear Medicine department staff and operations and provided emails that contained additional information and context for the allegations.

We analyzed pending radiology exam data and documentation from the facility's Imaging Service for the period from January 1, 2014 through April 8, 2016 to include outside fee-basis referrals. We reviewed information for the entire month of March 2014 once it was made available because the complainant specifically alleged that the 3,300 backlog of exams existed as of the end of March 2014. Our analysis included a judgmentally selected sample of pending radiology orders to determine the status of the patients' ordered exams and to identify patients who may have been potentially harmed by delays in care. OHI performed clinical reviews of the identified patients' records to determine any effect on their care.

We reviewed the following information:

- VHA policy regulations and requirements
- Complainants' allegations contained in OSC letter dated June 2014
- Imaging Service workload data and pending orders by modality
- VA time and attendance records
- Imaging Service scheduled appointment times
- Nuclear medicine fee-basis referrals and associated data
- Pending radiology orders from VistA

Government Standards

We did not perform this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.However, we believe the scope of our review and the work completed was sufficient to support the findings and recommendations in this report.

Appendix B Management Comments—VA Mid-Atlantic Health Care Network Director

Department of Veterans Affairs

Memorandum

Date: September 9, 2016

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subj: Response to VA Office of Inspector General (OIG) Review of Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VA Medical Center Network Adequacy (VAIQ 7636313)

To: Dr. Karen Rasmussen, Director Management Review Service

1. This memorandum is submitted by the Network Director, Veterans Integrated Service Network 6 (VISN 6) in response to the OIG Review of Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VA Medical Center.
2. VISN 6 concurs with the findings in this report and with the memo submitted by Ms. Kaye Green, VAMC Director at the W.G. (Bill) Hefner VA Medical Center.
3. With regard to recommendation three:

   "We recommended the VA Mid-Atlantic Health Care Network Director ensure that the W.G. (Bill) Hefner VA Medical Center develops a plan to address existing demand for Radiology exams and ensures future patients receive access to exams in accordance with VHA policy."

   We concur with Ms. Green's response that the action plan is completed and in the execution phase. VISN and Facility Leadership will track completion of these planned activities and monitor access to these services on a quarterly basis with Salisbury Leadership to ensure compliance with VA policy.

(Original signed by:)

DANIEL. F. HOFFMANN, FACHE

Appendix C Management Comments—W.G. (Bill) Hefner VA Medical Center Director

Department of Veterans Affairs

Memorandum

Date: September 8, 2016

From: Director, W.G. (Bill) Hefner VA Medical Center (659/00)

Subj: Healthcare Inspection – Review of Radiology Exam Backlog, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina Network Adequacy (VAIQ 7636313)

To: Director, VA Mid-Atlantic Health Care Network (10N6)

I have reviewed the draft report of the Office of Inspector General. I concur with the recommendations. I have included my response in the attached Director's Comments. Please contact me if you have any questions or comments.

(original signed by:)

KAYE GREEN, FACHE

Director, W.G. (Bill) Hefner VA Medical Center (659/00)

Attachment

W.G. (Bill) Hefner VA Medical Center
Action Plan

OIG Draft Report, Review of Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VA Medical Center

Date of Draft Report: September 8, 2016

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

OIG Recommendation

Recommendation 1. We recommended the W.G. (Bill) Hefner VA Medical Center Director require staff to review all unscheduled radiology exam orders that are 30 days past the clinically indicated date and either cancel the orders if the exams are not needed or ensure the exams are scheduled.

Concur

Target date for completion: Completed

Facility response: A list of Imaging orders was generated using the VistA Pending option that includes the Clinically Indicated Date (CID) of orders through July 2016. Upon review, some unscheduled orders were categorized as "walk-ins" which places the responsibility on the patient to report to the Imaging Department for the test. Orders that are not completed within 60 days of the CID were canceled per the "VHA Outpatient Radiology Scheduling Policy and Interim Guidance" memo dated August 12, 2016. All other unscheduled radiology test orders that were 30 days past the CID were reviewed by a team of physicians to determine whether to cancel the order if the exam was no longer needed, or schedule the exam as necessary. A total of 411 orders were reviewed. Of the 411, there were 50 determined to warrant priority scheduling. As of August 30, 2016 all 50 patients warranting priority scheduling were contacted by telephone. Those patients who were unable to be reached by phone were sent a letter, in effort to continue attempts to schedule per "VHA Outpatient Radiology Scheduling Policy and Interim Guidance" memo dated August 12, 2016.

Recommendation 2. We recommended the W.G. (Bill) Hefner VA Medical Center Director make unscheduled urgent and STAT (immediate) orders a priority in the staff's review of unscheduled radiology orders and ensure staff determine whether any potential harm has occurred to patients due to the delays in care.

Concur

Target date for completion: Completed

Facility response: The list of unscheduled urgent and stat orders were reviewed by the Acting Chief of Staff and the ACOS, Imaging Department on August 15, 2016. There were a total of twenty-three (23) orders on the unscheduled urgent/stat list. The 23 orders involved 15 unique Veterans.

17/23 orders had no clinical indication warranting stat orders and the patient did not show for the exam, therefore the order was cancelled with a note to the provider.

- 1 order – Six month follow-up that is scheduled as such
- 2 – Same patient, MRIs ordered as stat but patient had no acute injury. Patient no-showed, orders cancelled.

- 6 orders - were for one patient who was seen by a primary care provider in the morning and subsequently admitted to the inpatient acute mental health unit that afternoon. The patient had no evidence of acute injury requiring stat x-rays.
- 8 orders - no shows for plain x-ray films and cancelled by imaging with a note to the provider.
- 4/23 were completed the same day as ordered.
- 2/23 were duplicate orders.

As a result of the facility's review of the records it was determined that no harm occurred to any patient on the unscheduled stat/urgent list. Of note, the facility requires direct provider to radiologist interaction for all STAT imaging requests with the exception of plain films. In effort to improve coordination of care this direct provider interaction facilitates not only communication but comprehensive care planning.

Recommendation 3. We recommended the VA Mid-Atlantic Health Care Network Director ensure that the W.G. (Bill) Hefner VA Medical Center develops a plan to address existing demand for Radiology exams and ensures future patients receive access to exams in accordance with VHA policy.

Concur

Target date for completion: Completed

Facility response:

A plan was developed to address the demand for Imaging Services. The plan includes the addition of Imaging equipment and staff at the Salisbury VAMC as well as the Charlotte and Kernersville HCCs. This includes the addition of two complete Nuclear Medicine departments at the HCCs as well as four MRI units, which will essentially triple capacity in both modalities. Additionally, two CT units were added at the HCCs.

Imaging is further facilitating access through an increase in scheduling staff from seven to thirteen schedulers and one MSA supervisor. Additional Imaging scheduling staff may be requested in FY17 if demand and subsequent workload warrants such request.

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Janet Mah, Director Rhiannon Barron Gregory Gladhill Andrea Lui Andrea Sandoval Leslie Yuri

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