Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-02864-71

Healthcare Inspection

Delays in Processing Release of Information Requests
Bay Pines VA Healthcare System
Bay Pines, Florida

January 17, 2018

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations from a confidential complainant regarding the Release of Information (ROI) section at the C.W. Bill Young VA Medical Center (facility) of the Bay Pines VA Healthcare System (system), Bay Pines, FL. The complainant alleged that:

- The facility had a backlog of ROI requests, including one pertaining to a patient who died before the non-Veterans Health Administration (VHA) provider received the records.
- The Business Office Services (BOS) Chief took ROI requests "off-station" and lost requests.
- Staff working on ROI requests were not trained to complete ROI requests.
- BOS staff did not comply with policies and procedures to process ROI requests.

VHA requires that ROI requests be processed within 20 working days from the date of receipt of the request. Of the 10 patients identified by the complainant, one patient's records were released within 3 days of the ROI request, Patient A's (the deceased patient identified by the complainant) records were released 57 days after the ROI request was received and for the remaining 8 patients, the average release time was 159 days from receipt of the ROI request. Based on our review of available VHA electronic health records, OIG did not identify patient harm attributable to delays in processing the ROI requests.[1] This included not only Patient A, but the other eight applicable patients as well. OIG found that the facility Patient Advocate Office did not adequately capture and trend ROI complaints, as required. Rather, the Patient Advocate Office supervisor and staff handled the complaints personally and did not maintain documentation.

OIG substantiated a facility ROI request backlog of which system leaders[2] became aware in 2014. From October 2014 through April 2016, the average backlog was 2454 days. Then from May 2016 through February 10, 2017, the average backlog was 279 days. OIG found staff vacancies and equipment challenges to be the primary contributors to the backlog. In Q1 FY 2016, the average number of ROI staff in VHA's complexity level 1a facilities was 6 with a range from 1 to 16. During the same timeframe, the facility reported 11 ROI staff. Between June 2014 and February 2017, the number of medical record technician (MRT) vacancies fluctuated between two and seven. The backlog increased and remained high during the period of the most staff vacancies (July 2015 through April 2016) and diminished substantially during and after May 2016 when trained staff were in place. The ROI section relied upon compact disc

[1] Because of limited or no access to the medical records from the non-VA facilities that had requested the information, we reviewed only the information available in VHA electronic health records.
[2] For purposes of this report, "system leaders" refer to the system's Director and Associate Director; "managers" refer to Chiefs including system BOS and HIM Chiefs, and ROI supervisors.

(CD) burners and multifunction machines to copy, print, and fax. Imaging and dental records such as X-rays are placed on a CD. In May 2015, three of the four printer/copier machines were not functioning; at the time of OIG's May 2016 site visit, staff complained that CD burners and fax machines were frequently out of order, and that CDs were in short supply.

OIG also found that that the facility ROI staff did not communicate the backlog status to requestors as required. Further, OIG found that facility managers did not monitor staff productivity accurately. Following our May 2016 site visit, the facility ROI supervisor received training on how to generate valid productivity reports.

OIG substantiated that the BOS Chief approved transfers of hard copy ROI requests from the facility to the Largo BOS location in an effort to reduce backlog. For approximately 3 weeks starting in March 2015, the Largo Data Management Section staff were instructed to date-stamp and log in the requests. However, VHA policy authorizes Health Information Management (HIM) Chiefs (or designees such as the BOS Chief) to remove original health records from the facility. OIG substantiated that facility managers were unable to locate 547 hard copy ROI requests which were logged into the tracking system from approximately January 2014 through June 2016. However, due to the absence of other tracking mechanisms, OIG could not substantiate that the hard copy ROI requests were lost or misplaced while being transferred to Largo. Further, OIG found that the facility ROI managers did not fully implement corrective action plans in response to missing authorizations.

OIG did not substantiate that Data Management Section staff were not trained to complete assigned ROI tasks. OIG substantiated that, under the BOS Chief's direction, ROI staff did not comply with VHA's prioritization policy during the first quarter of FY 2015. VHA requires that requests be processed in the order in which they are received and prioritized based on urgency

During the course of our inspection, OIG also found that the ROI section workplace culture contributed to the challenges in resolving backlog and sustaining effective processes. These longstanding workplace culture challenges included Medical Record Technician and manager vacancies and turnover, interpersonal conflicts, lack of trust amongst staff and managers, and performance issues.

OIG recommended that the System Director ensure the:

- Strengthening of procedures for timely processing of ROI requests.
- Capturing and trending of complaints related to ROI requests.
- Evaluating of personnel issues negatively impacting staff retention and hiring in the ROI section and taking appropriate action.
- Monitoring of ROI staff productivity.
- Tracking and monitoring ROI request processing.

- Consulting with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action, if any, for managers' performance related to implementation of corrective action plans in response to privacy violations.
- Establishing and consistently implementing ROI standard operating procedures in accordance with VHA policy.
- Strengthening working relationships and communication processes within the facility ROI section and amongst staff and BOS managers.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 25–29 for the Directors' comments.) Based on information provided, we considered Recommendation 1 closed. For the remaining open recommendations, we will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations from a confidential complainant regarding the Release of Information (ROI) section at the C.W. Bill Young VA Medical Center (facility) of the Bay Pines VA Healthcare System, (system), Bay Pines, FL.

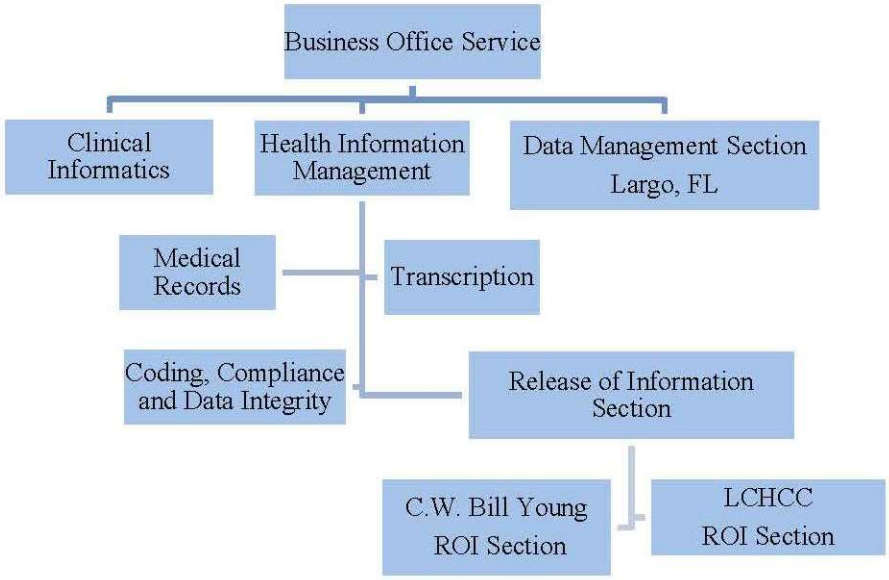
Background

The system, part of Veterans Integrated Service Network (VISN) 8, is comprised of the facility in Bay Pines, the Lee County Healthcare Center (LCHCC) in Cape Coral, and seven community based outpatient clinics located in Bradenton, Naples, Palm Harbor, Port Charlotte, St Petersburg, Sarasota, and Sebring, FL. The facility is a complexity level 1a[3] teaching hospital with 186 hospital beds, 112 community living center beds, and 99 residential care beds.

The system Business Office Service (BOS) Chief oversees three sections: the Data Management Section (DMS), Clinical Informatics, and Health Information Management (HIM). HIM is comprised of Coding, Compliance and Data Integrity, Medical Records, ROI, and Transcription. DMS is located at an off-site office in Largo, FL.[4] The system has two ROI sections–one located in the facility and one in the LCHCC. See Figure 1.

[3] Since 1989, the VHA Facility Complexity Model has categorized medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered to be the most administratively complex. Level 3 facilities are considered to be the least complex. VHA Office of Productivity, Efficiency& Staffing, http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx. Accessed April 12, 2017.
[4] The Largo, FL BOS location is 7.4 miles from the facility.

Figure 1. Organizational Chart, Bay Pines VA Healthcare System, Business Office Service



Source: Bay Pines VA Healthcare System

Each ROI section is staffed by Medical Record Technicians (MRTs),[5] Lead MRTs,[6] and an ROI Supervisor.[7] MRTs include General Schedule (GS) Levels 4, 6, and 7 employees. Employees' skill levels and responsibilities increase with grade level.[8] For example, GS-4 employees enter request information into computerized databases, GS-6 employees retrieve requested patient electronic health record (EHR) information, and GS-7 employees complete legal requests.

VHA ROI

ROI staff review and process requests for patient health information (PHI) including personally identifiable information (PII) consistent with pertinent Federal regulations and statutes.[9] Patients may request their own EHR information (known as a first party request) and/or can authorize other individuals including family members, private healthcare providers, attorneys, and/or entities such as hospitals and the Social Security Administration to receive their medical record information (known as third party

[5] VA Handbook 5005/79, *Staffing*, September 5, 2014. MRTs extract, compile, and disclose health information in accordance with all laws and regulations governing authorization and disclosure of health information.
[6] Ibid. Lead MRTs monitor the quality and quantity of work while ensuring compliance with requirements and balancing workload in the ROI Section. A Lead MRT is able to perform the functions of a MRT but may have additional responsibilities.
[7] Ibid. The ROI supervisor has full responsibility for the supervision, administrative management, and direction of ROI staff.
[8] GS is an Office of Personnel Management classification and pay system that covers the majority of civilian white-collar Federal employees. The GS has 15 grades—GS-1(lowest) to GS-15 (highest) which are based on level of job difficulty, responsibility, and required qualifications. https://www.opm.gov/policy-data-oversight/pay-leave/pay-systems/general-schedule, accessed May 31, 2017.
[9] VHA Handbook 1907.06, *Management of Release of Information*. January 18, 2013.

requests).[10] VHA requires facilities to establish a priority system for processing requests in which the most urgent requests are processed first and generally in the order in which they are received.[11] An urgent request, also referred to as a STAT[12] request, would be expedited for certain patients such as those waiting in a provider's office, receiving treatment in an Emergency Department, or receiving medical care while incarcerated. Requests can be submitted to ROI by mail, facsimile, or in person. Requests contain PII along with other information such as the name of requestor, the purpose and period of the request, and other items as required by VHA.[13] The MRT who receives the request determines if it is a first party or a third party request and confirms the validity of the request.[14]

VHA requires that requests be processed within 20 working (business) days from the date of receipt of the request.[15] ROI staff must notify the requestor within 10 business days if facility managers anticipate that staff cannot complete the request within 20 business days.[16]

ROI staff also process special requests such as tort claims[17] and Freedom of Information Act (FOIA)[18] requests. MRTs must have specialized knowledge to process such requests. These special requests may also require additional actions including reviews by the ROI supervisor, legal counsel, FOIA Officer, and Privacy Officer (PO).[19]

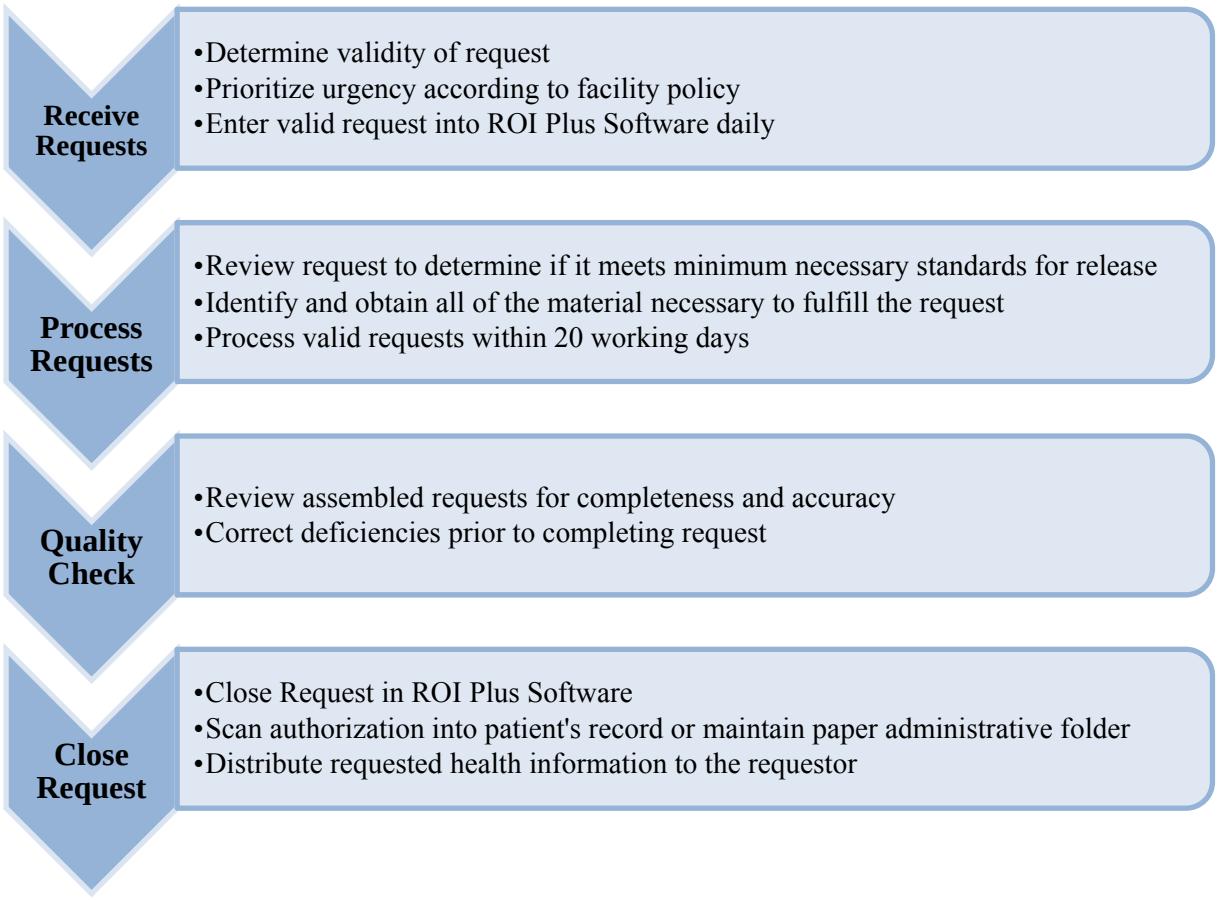
The HIM Chief must ensure that ROI processes support accuracy, completeness, and timeliness; comply with privacy requirements; and include continuous quality improvement. The ROI supervisor is responsible for managing daily operations, monitoring the quality and quantity of work, validating that staff participate in all applicable training, working with POs, and complying with ROI process timelines.

ROI technicians are required to enter incoming requests into the Document Storage System (DSS) ROI Manager Software (known as ROI Plus since July 20, 2016)[20] daily. Using ROI Plus, HIM and ROI managers are required to monitor productivity.[21] MRTs

[10] VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006. This Handbook was rescinded and replaced by VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.
[11] .VHA Handbook 1907.06, *Management of Release of Information*. January 18, 2013.
[12] STAT, from the Latin statim, means immediately or without delay. https://www.merriam-webster.com/medical/statim. Accessed June 13, 2017.
[13] VA Form 10-5345a-MHV, *Individual's Request For a Copy Of Their Own Health Information*, May 2012.
[14] VHA Handbook 1907.06.
[15] Ibid.
[16] VA Handbook 6300.4, *Procedures for Processing Requests for Records Subject to the Privacy Act*, August 19, 2013.
[17] "A tort is an act or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability." https://www.law.cornell.edu/wex/tort. Accessed on August 22, 2016.
[18] The Freedom of Information Act (FOIA), 5 USC 552, is a federal freedom of information law that allows for the full or partial disclosure of previously unreleased information and documents controlled by the United States government. In this context, FOIA requests often seek the production and release of patient medical records.
[19] VHA Handbook 1907.06.
[20] VHA Directive 1615, *Mandated Utilization of Release of Information (ROI) Plus Software*, July 20, 2016.
[21] VHA Handbook 1907.06.

must review requests for completeness and accuracy of the data entry before preparing hard copies of the requested information from the patient's EHR. Imaging and dental records such as X-rays are placed on a compact disc (CD).[22] Once a request is completed, the facility must either maintain a paper administrative folder or scan the original request form and any accompanying cover letters or documentation into the VistA Imaging system.[23][24] See Figure 2.

Figure 2. Overview of the VHA Release of Information Process for Routine Requests



Source: VHA Handbook 1907.06, *Management of Release of Information,* January 18, 2013.

Training and Productivity Guidelines

VHA requires that the HIM Chief develop ROI standard operating procedures (SOPs) or other reference documents that are accessible to all staff involved in the ROI process. VHA does not specify a training program but considers ROI staff to be experienced:

[22] VHA Handbook 1907.06.
[23] The VistA Imaging system integrates clinical images, scanned documents, and other non-textual data into the patient's EHR. https://www.va.gov/health/imaging/overview.asp Accessed May 15, 2017.
[24] VHA Handbook 1907.06.

> *…once they have had the opportunity to review all available training aids, guides and Handbooks, develop a thorough understanding of the privacy requirements for releasing information and can independently and accurately release information based on a valid authorization. The timeframe may vary by facility, but at a minimum, developing trained staff requires 6 months of supervised training and experience.*[25]

VHA recommends that experienced MRTs complete a minimum of 18 routine requests per day. VHA allows facilities to establish flexibility for the productivity standards:

> *This is based on a 7.5 hour workday and does not include leave, educational hours, or activities the ROI technicians may be performing. Appropriate lower standards may be set for technicians in developmental positions. Standards must also be adjusted and lowered when issues beyond the employees control, such as system failures, excessive time spent searching for paper records, etc., impede the employee's ability to complete requests.*[26]

Due to the complexity of tort claims, VHA requires that only the "most experienced" MRTs complete these claims. VHA requires each facility to establish standards for "…accuracy, completeness of information and adherence to guidance outlined in the Legal Record Practice Brief" for the processing of tort claims.[27]

Privacy Violations

VHA requires privacy protection of the records of veterans, their dependents, and beneficiaries. VHA defines a privacy violation as an event with the potential to result in a loss of PII and/or PHI.[28,29] Given a potential privacy violation, VHA requires that ROI staff report missing requests to the PO immediately. The system policy further specifies that staff must report missing requests to the PO within one hour of discovery.[30] Managers then search for missing requests in a reasonable time period, which the Director, VHA Information Access and Privacy Office, defined as "…taking a few days or even a week." If the missing requests are not found in that time period, they are considered missing and constitute a loss of PII or PHI.

If PII or PHI is lost, VHA requires managers to take corrective actions such as education, reprimand, or sanction of employees. POs are required to enter all privacy violations into the Privacy and Security Event Tracking System (PSETS), a tool used to track potential or actual privacy violations involving lost ROI forms. VA requires that POs report immediately, notify appropriate entities and arrange credit protection services for individuals affected by a privacy violation.[31]

[25] VHA Handbook 1907.06.
[26] Ibid.
[27] Ibid.
[28] VA Handbook 6502.1, *Privacy Event Tracking,* February 18, 2011.
[29] VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006. This Handbook was rescinded and replaced by VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.
[30] Bay Pines VA HCS Memorandum 516-14-00-064, *Privacy Policy*, August 2014.
[31] VA Handbook 6502.1.

System policy reinforces VA requirements and "…identifies responsibilities and procedures for protecting privacy of information that is accessed, collected, maintained, used, disclosed, transmitted, amended and/or disposed of by staff and systems of this facility." Specifically, the policy states, "The facility PO will determine information privacy violations and provide evidence thereof. The employee's supervisor will determine appropriate actions…."[32] VHA requires system managers to develop, implement, and communicate SOPs relative to their respective roles.[33] System policy requires system leaders to create a "culture of privacy" and work closely with POs on strategic initiatives to ensure all federal privacy requirements are met.[34]

Veterans Access, Choice and Accountability Act of 2014

The Veterans Access, Choice and Accountability Act of 2014 (Choice) was enacted to allow certain veterans to receive care from eligible non-VA health care entities or providers.[35] The Choice program is one of VHA's Community Care Programs and is separate from and additional to VHA's existing program which provides medical care outside of the VHA system.[36] The Choice program further increases access to care for eligible veterans who are unable to schedule appointments with VHA providers. "The Choice Act allows certain eligible veterans, who are unable to schedule an appointment within 30 days of their preferred date or the clinically appropriate date, or on the basis of their place of residence to elect to receive care from eligible non-VA health care entities or providers."[37][38]

Health Net is the federal contractor that coordinates with eligible veterans to obtain authorization for all care under Choice.[39] Health Net staff work with veterans and enrolled providers to schedule appointments and coordinate efforts with VHA's Non VA Care Coordination (NVCC) services. The system's NVCC team includes providers and administrative personnel who review patient EHRs to ensure appropriate referrals, community provider selection, and exchange of pertinent medical information between the referring VHA and community providers. The system's NVCC teams and community providers exchange medical and administrative records using a software platform called DOMA Imaging Application.[40]

[32] Bay Pines VA HCS Memorandum 516-14-00-064, *Privacy Policy*.
[33] VHA Handbook 1907.06.
[34] Bay Pines VA HCS Memorandum 516-14-00-064.
[35] Veterans Access, Choice, and Accountability Act of 2014, (Public Law 113-146) ("Choice Act"), as amended by the Department of Veterans Affairs Expiring Authorities Act of 2014 (Public Law 113-175). https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf, accessed May 18, 2017.
[36] VHA Community Care Programs Overview. https://www.va.gov/COMMUNITYCARE/programs/overview.asp. Accessed May 18, 2017.
[37] Ibid.
[38] VHA Handbook 1601A-02, *Veterans Choice Act*, Eligibility, April 3, 2015.
[39] Health Net Federal Services, LLC (HNFS) coordinates with eligible Veterans to obtain authorization for all care under Choice and the PC3 program. https://www.hnfs.com/content/hnfs/home/company/company-information/va.html. Accessed May 18, 2017.
[40] DOMA Imaging Application (DIA) is a web-based imaging application. *One-VA Technical Reference Model v 17.4*. https://www.va.gov/TRM/ToolPage.aspx?tid=8188. Accessed May 17, 2017.

The system's NVCC office, located at the Largo site, is separate from the BOS and ROI sections and organizationally aligned under the Chief of Staff. NVCC personnel are responsible for the release of EHRs to non-VHA Choice providers and the receipt of medical information from non-VHA providers for VHA health records. The DOMA Imaging Application program is not capable of copying radiology imaging records (such as dental x-rays) that a non-VHA provider might request. Therefore, NVCC staff route these requests to the facility ROI section to create and mail a compact disc or digital versatile disc (DVD) of the requested images. Additionally, ROI MRTs release health information when a patient is physically at the non-VHA provider's office for care.

Related OIG Activity

On May 18, 2015, OIG received a patient complaint regarding the facility's delayed response to his non-VHA provider's ROI request. On May 27, 2015, OIG requested that system leaders review the complaint and provide a response. In July 2015, the system Director acknowledged that the ROI section had a backlog and poor communication with the patient. However, the Director opined that the backlog did not cause a delay in the patient's treatment. OIG reviewed the documentation provided by the Director and concluded that no further action was needed.

Prior Reports

A search of prior reports related to ROI at the facility did not identify relevant reports. See Appendix A for other relevant OIG reports published in the past 3 years.

Allegations

On February 29, 2016, a confidential complainant contacted the OIG by electronic mail. In two subsequent electronic mail communications and during our May 2016 site visit, the complainant provided a total of 10 names of patients allegedly impacted by the ROI backlog. Specifically, the complainant alleged that:

- The facility had a backlog of ROI requests, including one pertaining to a patient who died before the non-VHA treating provider received the records.
- The BOS Chief took ROI requests "off-station" and lost requests.
- Staff working on ROI requests were not trained to complete ROI requests.
- BOS staff did not comply with policies and procedures to process ROI requests.

Scope and Methodology

We initiated our review on April 11, 2016, and conducted a site visit to the facility from May 9–11, 2016. We also visited the Largo BOS on May 10, 2016 and LCHCC on May 11, 2016.

We interviewed the complainant; Director, VHA Information, Access, and Privacy; Director, VHA HIM; system personnel including the Director, Associate Director, BOS Chief and staff, HIM Chief, POs, Quality Systems Chief, NVCC Chief, Patient Advocate Supervisor, ROI supervisors, and ROI staff. We reviewed relevant VA/VHA handbooks and directives; ROI national data; consultants' reports; Government Accountability Office Standards; Patient Advocate Tracking System (PATS) reports; and the VHA EHRs and related ROI documentation of 10 patients whose care was allegedly affected by ROI delays. Because of limited or no access to the medical records from the non-VA facilities that had requested the information, we reviewed only the information available in VHA EHRs. We also reviewed the system's ROI and privacy policies and procedures; ROI data and documentation; PO memoranda and reports; applicable electronic mail and meeting minutes; issue briefs; performance improvement documents; and ROI staff training records. Although we requested ROI request backlog data dating back to April 2014, system managers did not "verify or validate" reported ROI data prior to October 2014.

We evaluated the facility's processes for tracking ROI requests within the context of Federal standards for control activities, which emphasize the need for management to establish processes to reliably evaluate performance against requirements and address noncompliance in a timely manner.[41]

We limited our review to the facility's ROI section and did not perform a detailed review of the LCHCC ROI section since the allegations pertained to the facility ROI section.

Although we received allegations of a hostile work environment during our site visits, the allegations were determined to already be the subject of internal review processes and beyond the scope of this review. When appropriate, we provided Office of Personnel Management resource information to employees.

With regard to internal guidance, VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005, expired September 2010 and has not been updated. However, we considered this policy to be in effect as it has not yet been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[42] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[43] The USH also tasked the Principal Deputy USH and Deputy USH with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[44]

[41] United States Government Accountability Office, *Standards for Internal Control in the Federal Government*, (GAO 14-704G 10.01 −10.08, September 2014).
[42] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[43] VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.
[44] Ibid.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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: Alleged Patient Harm and ROI Backlog[45]

Based on a review of VHA EHRs,[46] we did not identify patient harm attributable to the delay in processing of ROI requests for Patient A or any of the other patients whose names the complainant provided to us. We found that the facility Patient Advocate Office did not adequately capture and trend ROI complaints, as required by VHA.[47] We substantiated a facility ROI request backlog of which system leaders[48] became aware in 2014. We found staff vacancies and equipment challenges to be the primary contributors to the backlog. We also found that staff turnover was an ongoing problem and continued during the period of our review. We also found that, since at least June 2014, the facility ROI staff did not adequately communicate the backlog status to requestors.[49] Additionally, we found that facility managers did not monitor staff productivity accurately.

Alleged Patient Harm

Patient A. In fall, 2015, the facility received a STAT ROI request from a non-VA hospice/palliative care/home health care service. At the time of the request, Patient A, a male in his late 70's, was hospitalized. Patient A died at home 57 days after the ROI request was received. MRTs did not log this request until spring 2016. For approximately 5 months preceding the ROI request, Patient A received significant medical care at non-VA inpatient facilities. Based upon a review of the VHA EHR, it is doubtful that the provision of these records would have prevented the death of Patient A. Although release of the information should have occurred timely, we did not find evidence that the failure to fulfill the ROI request caused a delay in Patient A's medical care.

Other Patient Reviews. We found that of the nine other patient names provided, one patient's records were released 3 days after the MRT received the request. For the remaining 8 patients, the average delay in the release of medical information was 159 days. Two patients died prior to the processing of their requests. Based upon our VHA EHR reviews, we concluded that it was unlikely that the delay in delivery of medical records resulted in negative impact on care for any of these eight patients.

[45] For purposes of this report, backlog refers to ROI requests that have not been processed to completion by 20 days of receipt.
[46] Because of limited or no access to the medical records from the non-VA facilities that had requested the information, we reviewed only the information available in VHA EHRs.
[47] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005. This Handbook expired on the last working day of September 2010 and has not been updated.
[48] For purposes of this report, "system leaders" refer to the system's Director and Associate Director; "managers" refers to Chiefs including system BOS and HIM Chiefs, and the ROI supervisors.
[49] The staff's failure to communicate backlog status to requestors started sometime prior to June 2014. However, OIG could not determine exact start date since facility managers did not track this information.

Facility Review. In April 2016, one day after receiving notification of our pending inspection, system managers conducted a review. System managers evaluated the EHRs of 111 patients who died fewer than 30 days from the facility's receipt of an uncompleted ROI request.[50] The system managers concluded "…that there were no cases identified in which the likelihood of the delay having a negative impact on the Veterans' care and/or outcomes was more likely than not."[51]

Patient Complaint Data. VHA requires that "…patient complaint data are collected, trended, analyzed, and included along with other quality improvement data in the appropriate facility committees and forums."[52] Consistent with the findings of OIG published report, *Audit of the Patient Advocacy Program,* we found that the facility did not adequately capture and trend ROI complaints.[53] VHA's February 2015 Privacy Compliance Assurance Assessment Report noted that "…patient complaints related to delays were not forwarded to the Privacy Officer," as required by VHA.[54] In May 2017, the BOS Chief told us that BOS staff "forwarded all correspondence related to ROI complaints" to the PO. However, we did not receive evidence of a SOP or data to ensure that complaints were forwarded to the PO as required.

The facility ROI supervisor estimated that he/she spent 45 percent of his/her work day addressing complaints not including those from the Patient Advocate's Office. The facility Patient Advocate Office supervisor estimated receiving one or two ROI-related complaints per week. The supervisor also reported times when there were "a lot of [ROI] backlog complaints" from patients including 4–6 months prior to our site visit. The supervisor also told us that the ROI-specific information could not be isolated from the BOS complaints data and the categorizing of a complaint in PATS is "subjective." Using the PATS category, Obtaining Copies of Medical Records/Completion of Forms (IF07),[55] we found a total of only 14 complaints entered into PATS for FYs 2015, 2016, and Q1 and Q2 FY 2017. Further, the Patient Advocate Office supervisor and staff handled the complaints personally and did not maintain documentation. As such, patient complaints were not trended or analyzed.

ROI Backlog

The facility regularly exceeded the average in number of ROI requests received and processed compared to other complexity level 1a facilities. Of 39 1a facilities, the facility ranked seventh in number of first party requests processed and fifth for third

[50] Patient A and two other patients we reviewed were not included in the 111 EHRs reviewed since their deaths were beyond 30 days from the time the facility received the ROI request.
[51] OIG did not review the 111 patient cases independently.
[52] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005. This Handbook expired on the last working day of September 2010 and has not been updated.
[53] VA Office of Inspector General, Office of Audits and Evaluations, *Audit of the Patient Advocacy Program,* March 31, 2017.
[54] VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006. This Handbook was rescinded and replaced by VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.
[55] VHA Handbook 1003.4, *Patient Advocate Tracking System (PATS*). PATS "…is an application that tracks patient complaints and compliments at each medical center."

party requests processed for the FY 2015.[56] Specifically, the facility reported processing 45,571 total requests which exceeded the complexity level 1a national average of 29,250 total processed requests, respectively.

In the absence of data prior to October 2014, we were unable to determine when the backlog began.[57] Staff reported that while a backlog existed prior to October 2014, system managers did not "verify or validate" reported ROI data. We analyzed the system's combined first- and third-party requests backlog data for the period of October 2014 through February 10, 2017. We found that the backlog peaked at 3,423 in April 2016. Facility managers reported that as of June 1, 2017, the backlog was reduced to 37. See Table 1.

Table 1. Combined First- and Third-party Requests Backlog

Date Range	Average Number of Requests >20days
October 2014 –May 2016	2454
May 2016–February 2017	279
FY 2015	
Q1	1504
Q2	1673
Q3	2032
Q4	2866
FY 2016	
Q1	2827
Q2	2783
Q3	2514
Q4	359
FY 2017	
Q1	17
January–February 10, 2017*	38
June 1, 2017	37

Source: VA OIG analysis of facility-reported data
*Partial quarterly facility data was provided in response to OIG update request.

By Q2 FY 2016, the facility had the second highest backlog of first party requests and the highest backlog of third party requests amongst complexity level 1a facilities. In November 2015, the VHA HIM Director held national calls with HIM Directors and VISN and Medical Center Directors regarding the backlog and action plans. Additionally at that time, a VHA HIM specialist contacted medical centers that had a backlog (including the facility) to ensure leaders' awareness.

VHA requires that a requestor must be notified within 10 business days if the ROI staff anticipates a processing delay of more than 20 business days, along with the reason for

[56] VHA HIM collected data during the first quarter of FY 2016.
[57] The only data prior to October 2014 was an August 13, 2014, supervisory email string that reported a facility ROI backlog of 580 requests at that time.

the delay, and an expected date of completion of the ROI request.[58] We found that the facility ROI staff did not communicate the backlog status to requestors starting June 2014.[59] In October 2014, POs approved the mailing of a 10-day letter that acknowledged receipt of the request and advised the requestor that there would be a delay in processing due to the backlog. As of February 2017, this practice is still in use.

Beginning in 2014, system leaders and managers began to actively address the ROI backlog. Managers initiated multiple actions to address the backlog. The actions included increasing staff and mandating overtime; adjusting productivity goals; facilitating repair/replacement of faulty equipment; initiating system redesign (SRD); and obtaining subject matter expert consultation.

ROI Staffing

The BOS Chief started in the position in July 2014, a month after the prior Chief's retirement. The HIM Chief retired in February 2015 and the position was vacant for 9 months prior to being filled in November 2015. The BOS Chief assumed management of the ROI sections and then in May 2016 directed the new HIM Chief to assume oversight of ROI.[60] In January 2017, the HIM Chief left the position, which was still vacant in June 2017.

In Q1 FY 2016, the average number of ROI staff in VHA's complexity level 1a facilities was 6 with a range from 1 to 16. During the same timeframe, the facility reported 11 ROI staff. ROI staff described high turnover rates and delays in filling positions. Between June 2014 and February 2017, the number of MRT vacancies fluctuated between two and seven. The backlog increased and remained high during the period of the most staff vacancies (July 2015 through April 2016) and diminished substantially during and after May 2016 when trained staff were in place.

Detailing Staff. In October 2014, to address the "backlog and staff shortages," the BOS Chief approved overtime pay and detailed[61] a DMS staff member to the facility ROI section. A month later, the BOS Chief detailed six additional DMS staff to ROI, with five of them on rotations. During 2015, the BOS Chief detailed two additional DMS staff members to the facility ROI section. However, in December 2015, the Human Resources Management Services Chief informed managers that DMS staff could not be moved to ROI due to personnel rules restricting assignments based on employee classification. The Associate Director responded that they needed to increase ROI staff since "many" ROI positions "…have been vacant beyond a reasonable length of time due to several missteps that created delays in hiring." Human Resources and system

[58] VHA Handbook 1907.06, *Management of Release of Information*, January 18, 2013.
[59] The staff's failure to communicate backlog status to requestors started sometime prior to June 2014 but OIG cannot determine exact start date since facility managers did not track this information.
[60] This assessment was conducted by the LCHCC ROI Supervisor in June and July 2016.
[61] Detailed staff is the: "temporary assignment of employees under the intergovernmental personnel act." 27 SECTION C https://www.opm.gov/policy-data-oversight/hiring-information/intergovernment-personnel-act/. Accessed September 7, 2016.

leaders agreed that detailed DMS staff would perform basic ROI tasks such as monitor the file room, open mail, and date-stamp.

Tours of Duty. In early 2015, facility managers established two tours of duty to include an early morning tour that would "allow staff to work uninterrupted" on the backlog. Additionally, the number of ROI staff increased from 14 in 2014 to 16 full-time employees, including a supervisor, 3 ROI Lead MRTs, and 12 MRTs. At the time of our May 2016 site visit, ROI staff included a supervisor, three Lead MRTs, two experienced MRTs (with at least 6 months of supervised training and experience), and six recently hired MRTs who were undergoing training.

To address ongoing backlog concerns, system leaders requested consultation from other VA facility experts. In April 2016, the Miami VA Healthcare System HIM Chief (consultant) visited the facility to "identify opportunities…to address current backlog, ensure new incoming work is processed within required timeframes…" and accurately track requests. The consultant determined that the facility ROI section is "properly staffed to output the incoming workload." The consultant also noted that the "new" employees required additional training and experience before they could meet required productivity expectations. In May 2016, the MRTs received additional training and began to reduce the backlog significantly with notable progress made by Q4 of FY 2016.

Mandatory Overtime. In June 2016, a system leader reported that all but one position was filled in the facility ROI section; however, mandatory overtime was still being used to alleviate the existing backlog. During 2016, ROI staff participated in two Saturday (overtime) events (March and May) to work on the backlog. In February 2017, the facility ROI section was again understaffed with six vacancies due to reassignments and details.

Productivity Goals

System managers expected ROI staff to process a minimum of 18 requests per day, consistent with the VHA recommended productivity goal.[62] System leaders and managers told us that they adjusted productivity expectations based on ROI experience, competency, and staffing levels. In FY16, system managers implemented a tracking tool for monitoring productivity. However, we found that the facility managers did not include non-productive time including leave usage, performance of non-ROI activities, or equipment failures within the productivity tracking tool. Therefore, the tracking tool data did not accurately reflect staff productivity.

In October 2014, the BOS Chief proposed modifying productivity goals in an effort to improve productivity and reduce the backlog. Specifically, the BOS Chief directed staff to process 36 first party requests older than 20 days each day and to process other requests as able. In November 2014, the BOS Chief then proposed that staff process requests for 7 hours of the 8-hour work day, with daily productivity goals ranging from

[62] VHA Handbook 1907.06.

7 to 28 processed requests based on type of request. The ROI supervisors did not agree with the BOS Chief's proposed changes, which became a source of conflict. However, we found that the BOS Chief and ROI supervisors made efforts to reduce the backlog and discussed improvement opportunities with the ROI staff in meetings and huddles.[63]

Equipment Challenges

The ROI section relied upon CD burners and multifunction machines to copy, print, and fax. In May 2015, three of the four printer/copier machines were not functioning. System managers requested expedited action to repair the equipment and optimize the staff's use of technology. Replacement machines were installed approximately 7 months later. At the time of our May 2016 site visit, staff complained that CD burners and fax machines were frequently out of order, and that CDs were in short supply. In June 2016, facility leaders approved the purchase of Rimage, a CD publishing system.[64] However, installation was delayed until January 2017 because the required software was not included in the original quote. Additional scanners were delivered in January 2017.

System Redesign

The goal of VHA's SRD program is to promote a culture of safe and reliable healthcare for patients.[65] In 2014, system leaders recognized that the ROI section was not meeting VHA requirements related to privacy and productivity. The Associate Director tasked the system Compliance Officer to perform a detailed review of ROI functions. The Compliance Officer determined that the ROI staff were not processing requests properly, productivity levels were "questionable," and tracking measures were inadequate and did not allow for the assessment of ROI processes in real time. The report recommendations to improve ROI flow included encouraging patients to submit ROI requests through MyHealtheVet[66] and installing self-service kiosks to allow individuals to input requests. Also in 2014, system managers implemented several SRD initiatives, including educating patients on the use of MyHealtheVet to access personal medical records, implementing ROI section huddles and huddle boards,[67] and re-keying the file room to restrict access to stored documents and prevent loss of ROI documents.

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[63] A huddle is an informal staff gathering to discuss a day's work tasks, changes of procedures, or other work priorities.

[64] "Rimage disc publishing systems produce optical media with customized content and durable color or monochrome labels. In combination with our software solutions, Rimage systems can be tailored to any volume and workflow requirements." http://www.rimage.com/products-solutions/. Accessed May 3, 2017.

[65] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

[66] My HealtheVet is an electronic portal allowing veterans to access personal health records, schedule appointments and perform other tasks related to VHA health care. Access is through the web or via kiosks located in VHA facilities. https://www.myhealth.va.gov/mhv-portal-web/web/myhealthevet/how-to-use-mhv. Accessed May 16, 2017.

[67] Huddle boards are white boards placed in a staff accessible area for two-way communication between managers and front line staff.

In August 2015, system leaders initiated another SRD project to identify and address process issues contributing to the backlog of ROI requests. The identified actions included improving staff recruitment, addressing equipment needs, and implementing process changes. However, the SRD project did not proceed beyond the planning stage. The former Quality Manager told us that the SRD team members had difficulty scheduling meetings and the BOS staff did not "buy-in."

In January 2016, the SRD team resumed the project. However, the team changed the focus from the backlog processes to reduced wait times. The SRD team's stated goal was the MRTs' completion of walk-in requests in less than 20 minutes, during which time the patient would be invited to wait. However, the SRD team found that the average wait time *increased* from 17 minutes in January 2016 to 29 minutes during the period of June through September 2016. In May 2017, system leaders reported a 22 minute average wait time which they attributed to implementation of Rimage and a sequential queuing system.[68]

In January 2017, the system launched a new SRD pilot project to implement the use of an ROI function at kiosks in primary care (and eventually community based outpatient clinics) to allow patients to request records without the need to wait for extended periods of time in the ROI lobby. In May 2017, system managers reported that kiosks would be implemented at the facility by August 2017.

Subject Matter Expert Consultations

In April 2015, per system leaders' request, a VISN 8 organizational development psychologist conducted a voluntary workplace assessment of BOS. Challenges identified included staffing vacancies, limited reliable equipment, constant change, negative culture and limited teamwork, and lack of written SOPs and productivity tracking processes.

Shortly after completing the workplace assessment, the psychologist left VA employment. In February 2016, a second psychologist initiated consultative work with facility BOS staff. This psychologist met with facility MRTs three times between February 2016 and August 2016. The psychologist then discontinued meetings because only three staff members participated in August. At the last meeting, the psychologist concluded that "…consistent policies and procedures and management are essential to fix this very important work area and team performance." The BOS Chief scheduled the psychologist for a July 2017 follow-up meeting with ROI staff.

After the assessment, the Associate Director reported following up on equipment problems, managers continued to establish ROI memoranda and SOPs,[69] and the ROI

[68] Per facility managers, the ROI lobby kiosk portals were reformatted to issue sequential numbers to waiting customers ("sequential queuing"), rather than the random number format previously used. The manager reported that this solution reduced confusion and improved customer service in the lobby.
[69] Managers established 8 ROI-relevant memoranda and SOPs in 2014; 12 in 2015 (7 of them after the workplace assessment); and 9 in 2016.

supervisor initiated regularly held huddles. Additionally, facility managers scheduled events such as pizza parties and potluck meals to "establish rapport" amongst ROI staff.

In April 2016, the Miami VA HCS consultant recommended establishing one team to work on current requests and a second team to process backlog; reducing the facility's 15-step ROI request processing to a 7-step workflow; and assigning requests to MRTs by either terminal digit or alphabet to increase accountability. The consultant estimated that the backlog would be eliminated in 3–6 months if managers implemented these actions. In response, facility managers immediately established three ROI teams each to cover either front desk customer service, backlog request processing, or incoming ("current") request processing. Each team included a Lead MRT and from two to four MRTs. The implementation of the teams decreased the number of workflow steps and the managers did not think it necessary to change the MRT assignment process.

In late June/early July 2016, the LCHCC ROI supervisor assessed the facility ROI section and made recommendations to address the identification of errors in date stamping, logging, and request processing; noncompliance with VHA process requirements; lack of organization; and MRT training needs. As a follow up, the LCHCC ROI supervisor worked with the facility ROI supervisor to ensure implementation of tracking tools including staff training monitors and the generation of valid reports.

Impact of Choice Program/NVCC

During our review, system managers described increased ROI staff burden as a result of the increase in Choice/NVCC utilization. While we identified challenges that affected both NVCC and ROI, such as staffing, duplicate requests, and availability of reliable equipment and software, we did not find that the increase in Choice/NVCC utilization contributed to the ROI backlog.

The facility ROI staff members provided support to NVCC staff by completing the requests for radiology imaging studies. Facility managers told us that non-VHA Choice program specialty care providers sometimes contacted ROI staff rather than NVCC staff for information needed. These requests sometimes occurred due to inaccessibility of medical information due to a DOMA Imaging Application software malfunction. However, since managers did not track such requests, we could not confirm the extent to which this software malfunction impacted the backlog.

In 2014, system leaders considered increased staffing for the NVCC service responsible for managing the Choice program; however, they did not expect that the ROI sections would require additional staff for this purpose. They anticipated that ROI staff workload would actually decrease as NVCC would assume responsibility for processing ROI requests for the Choice program appointments. In December 2015, system managers conducted an audit and found that only 2 of 30 records for ROI scanning were NVCC related. In March 2016, system managers streamlined the phone system to include key prompts to route incoming calls to either the facility ROI section or NVCC office based

on which location should handle the request. In June 2017, the BOS Chief told us that the streamlining improved incoming call routing but the telephone abandonment rate[70] was a concern. In response, system managers initiated a pilot to identify adequate staffing and training to improve clarification of caller needs.

Issue 2: Lost ROI Requests

We substantiated that the BOS Chief approved transfers of hard copy ROI requests from the facility to the Largo BOS location over approximately 3 weeks starting in March 2015. VHA policy authorizes HIM Chiefs (or designees) to remove original health records from the facility.[71] We also substantiated that facility managers were unable to locate 547 hard copy ROI requests logged in to ROI Plus from approximately January 2014 through June 2016. Due to the absence of tracking mechanisms, we could not substantiate that staff lost or misplaced ROI requests during the transfer of hard copy requests from the facility to Largo. Further, we found that facility ROI managers did not fully implement corrective action plans in response to missing authorizations.

Relocation of ROI Requests

In March 2015, to reduce the backlog, the BOS Chief authorized the transfer of an indeterminate number of requests from the facility to Largo DMS staff. The Largo DMS staff were instructed to date-stamp and log in the requests. DMS staff told us that they received stacks of requests that were undated, dated as far back as 2005, and/or without categorization of urgency or type of request (first party/third party). They also reported that no procedures were in place to ensure the security or tracking of requests transferred between the facility and Largo. The BOS Chief told us that documents were boxed up, sealed, and confirmed when received. Once DMS staff opened, stamped, and logged in the request, they were to reconcile the hard copy with the logged in information. DMS staff then sent the hard copies back to the facility with a cover sheet that listed the ROI requests. In the absence of a list of ROI requests sent to Largo, we were unable to determine the number of ROI requests relocated and whether any requests were misplaced or lost. After approximately 3 weeks, the system Compliance Officer discontinued the transfer of documents to Largo due to a "security concern."

Missing Requests and Privacy Violations

Between March 2015 and July 2016, facility managers reported that 547 hard copy requests received from around January 2014 through June 2016 were verified as missing. As a result, the PO submitted 10 violation memorandums to PSETS. From March 2015 through February 2016, the PO submitted 9 PSETS memoranda that accounted for 260 missing authorizations. A follow-on July 2016 PSETS memorandum

[70] Telephone abandonment rate is defined as "the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person." https://www.va.gov/QUALITYOFCARE/measure-up/SAIL_definitions.asp. Accessed July 25, 2017.
[71] VHA Handbook 1907.01, *Health Information Management And Health Records*, March 19, 2015.

reported 287 missing authorizations.[72] The total 547 missing authorizations affected 513 unique patients and resulted in 483 credit monitoring letters and 30 next-of-kin letters.[73] POs also submitted issue briefs and reported the information to the Privacy/FOIA/Information Security Office Subcommittee.

The VHA Director, Information, Access, and Privacy told us that the multiple incidents of missing requests indicated a process problem and that the continued difficulties beyond the second PSETS memorandum were surprising. System leaders attributed the missing requests to a number of factors including a lack of organization, filing errors, and the practice of storing hard copies in desks.

For each PSETS memo, the BOS Chief identified corrective actions as required. In March 2015, the initial corrective actions included the establishment of a secured room "at the facility accessible only to ROI supervisor, Lead Clerk [MRT] or higher level BOS leadership" in which MRTs would store completed requests. However, we found that staff members were not securing the documents according to protocol. In February 2016, managers found a "stack" of requests dating back to the prior year in an employee's desk. In response, the facility ROI supervisor facilitated a huddle to review the system memorandum requiring specific steps to protect VA data from loss, including the storage of sensitive materials in the secured room.[74] Following the discovery of additional missing requests in May 2016, an administrative group including the Associate Director, the LCHCC ROI supervisor, and the Coding supervisor, searched facility ROI staff desks after hours and retrieved authorization information from unlocked drawers.

During our May 2016 site visit, the facility ROI supervisor told us that the secured room was locked unless a DMS staff member was present to monitor access. Then in June 2016, facility managers decided to further restrict access by keeping the room locked and only allowing managers to have keys but this caused work flow barriers. In late Fall 2016, the facility managers discontinued use of the room since the requests were scanned and preserved electronically.

Additionally beginning in March 2015, the facility ROI supervisor was expected to track logged requests and to review open/pending requests daily. In May 2016, the BOS Chief learned that the supervisor's tracking was "sporadic and inconsistent." The BOS Chief initiated weekly meetings with the facility ROI supervisor to review work flow, challenges, and sustained implementation of monitoring tools. In May 2017, the BOS Chief learned that the facility ROI supervisor did not arrange ongoing quality audits at the termination of the DMS staff auditor's detail almost a year prior (June 2016).

[72] The March 2015 through February 2016 memoranda covered lost authorizations from around December 2014 through April 2015. The July 2016 memorandum covered unique lost authorizations from January 2014 through March 2016.
[73] Included in the 547 missing authorizations were 2 instances where they were for the same veteran patient and 32 non-registered patients for whom there is not requirement for a letter; thereby resulting in 513 letters.
[74] Bay Pines VA Healthcare System Memorandum 516-14-0073, *Information Protection and Clean Desk Policy*, September 2014.

Issue 3: ROI Training

We did not substantiate that DMS employees were not trained to complete assigned ROI tasks. From September 2014 to June 2016, the BOS Chief detailed 14 DMS employees to the facility ROI section for various lengths of time to help relieve the backlog. Thirteen of the 14 DMS employees performed basic tasks that did not require special training, such as opening mail, date stamping documents, communicating with requestors to gather additional information, and doing "simple" quality checks on completed ROI requests prior to release. One GS-9 DMS employee was assigned to conduct more-in depth retrospective audits for accuracy, thoroughness, and policy compliance of released authorizations. This employee received training from a Lead MRT and a draft SOP for guidance. We also found that in April 2015, seven of nine DMS staff detailed at that time attended a MRT training on ROI staff responsibilities; federal privacy laws; VHA requirements; ROI Plus; and EHR guidelines.

Issue 4: ROI Policy and Procedure Compliance

We substantiated that under the BOS Chief's direction, ROI staff did not comply with VHA's required processing during Q1 FY 2015.[75] Specifically, we found that in October 2014 the BOS Chief directed ROI staff to process first party requests prior to more complex requests, therefore violating VHA's prioritization policy.

Priority Processing

VHA requires that requests be processed in the order in which they are received and prioritized based on urgency.[76] In October 2014, the BOS Chief initiated a pilot aimed to improve productivity and reduce backlog. The BOS Chief instructed ROI staff to process less complex requests first without consideration to chronology:

> *Each day staff should begin their day screening request [sic] to identify 36 complete requests that can be **closed**, setting aside request that are incomplete and need further action. The incomplete request should be reviewed the last hour of the day and necessary action taken.*

In November 2014, the BOS Chief eliminated the expectation of 36 requests but maintained that ROI staff members "begin their day screening their assigned request to identify complete requests that can be closed, setting aside request that are incomplete and need further action." The BOS Chief's direction did not provide an exception for staff to immediately process the STAT requests regardless of complexity.

Although we were unable to determine exactly when staff discontinued this practice, VHA and the February 2015 system policy direct that requests be processed in the order in which they are received. [77] Beginning in May 2016, the facility ROI section included a designated "current team" to process the requests as they were received.

[75] VHA Handbook 1907.06.
[76] Ibid.
[77] Ibid.

During our site visit, the BOS Chief told us that ROI staff processed requests daily consistent with VHA requirements. However, in June 2017, the BOS Chief told us that staff continued to be unsure of procedures and that they were creating additional SOPs to clarify policy.

Issue 5: Workplace Culture

We found that the facility ROI section workplace culture contributed to the challenges in resolving backlog and sustaining effective processes. We found longstanding[78] workplace culture challenges including MRT and manager vacancies and turnover (discussed earlier), interpersonal conflicts, and lack of trust amongst staff and managers. We also found that leaders and managers did not effectively communicate with each other or with staff to ensure compliance with VHA requirements and the establishment of a culture of privacy.[79][80]

During our site visit, system leaders and managers cited multiple barriers to improving the facility ROI section staff's compliance with VHA requirements, including work place culture issues, ineffective communication, low morale, and perceived lack of support. The psychologist reported that BOS staff identified challenges related to leadership approach, constant change, a negative culture, and very low trust.

Leaders and managers made efforts to improve the workplace culture through a number of mechanisms including administrative actions and the engagement of subject matter experts as discussed earlier. We found that facility managers followed up on the recommendations to improve communication and morale. Further, starting in January 2016, system leaders established regular meetings with facility managers to monitor and support the ROI section. In spite of these efforts, at the time of our May 2016 site visit, we found ongoing impaired communication processes amongst managers as well as between managers and staff due to negative working relationships, confusion about protocols, and frustration with the frequency of policy changes. We found that the BOS Chief sometimes made changes without the awareness of or input from ROI supervisors. We also found that facility ROI managers communicated inconsistent information about policy and procedural changes to staff leading to morale problems, perceived conflicts in supervisory direction, misunderstandings, and poor policy implementation.

Conclusions

Based on a review of VHA EHRs, OIG did not identify patient harm attributable to the delay in processing of ROI requests for Patient A or any of the other patients whose

[78] For example, we found current and prior ROI staff members inappropriately accessing a fellow staff member's EHR recurrently beginning in 2004.
[79] VHA Handbook 1907.06, *Management of Release of Information,* January 18, 2013.
[80] Bay Pines VA HCS Memorandum 516-14-00-064, *Privacy Policy*. System leaders are responsible for "maintaining a culture of privacy, and ensuring that the facility meets all the privacy requirements mandated by VA and VHA policies and other federal legislation."

names the confidential complainant provided to us. OIG found that the facility Patient Advocate Office did not adequately capture and trend ROI complaints, as required. OIG substantiated a facility ROI request backlog of which system leaders became aware in 2014. OIG found staff vacancies and equipment challenges to be the primary contributors to the backlog. OIG also found that the facility ROI staff did not communicate the backlog status to requestors starting June 2014. Further, OIG found that facility managers did not monitor staff productivity accurately.

OIG substantiated that the BOS Chief approved transfers of hard copy ROI requests from the facility to the Largo BOS location over approximately 3 weeks starting in March 2015. However, VHA policy authorizes HIM Chiefs (or designees such as the BOS Chief) to remove original health records from the facility. OIG substantiated that facility managers were unable to locate 547 hard copy ROI requests logged in to ROI Plus from approximately January 2014 through June 2016. However, due to the absence of tracking mechanisms, OIG could not substantiate that staff lost or misplaced requests during the transfer of hard copy requests from the facility to Largo. Further, OIG found that facility ROI managers did not fully implement corrective action plans in response to missing authorizations.

OIG did not substantiate that DMS staff were not trained to complete assigned ROI tasks. OIG substantiated that under the BOS Chief's direction, ROI staff did not comply with VHA's required processing during Q1 FY 2015. Specifically, OIG found that in October 2014, the BOS Chief violated VHA's prioritization policy by directing ROI staff to process first party requests prior to more complex requests.

We also found that the facility ROI section workplace culture contributed to the challenges in resolving backlog and sustaining effective processes. OIG found longstanding workplace culture challenges included MRT and manager vacancies and turnover, interpersonal conflicts, lack of trust amongst staff and managers, and performance issues.

Recommendations

1. We recommended that the System Director ensure strengthening of procedures for timely processing of Release of Information requests.

2. We recommended that the System Director strengthen the process to adequately capture and trend complaints related to Release of Information requests in accordance with Veterans Health Administration policy.

3. We recommended that the System Director ensure an evaluation of the personnel issues negatively impacting staff retention and hiring in the Release of Information section and take appropriate action.

4. We recommended that the System Director ensure accurate monitoring of Release of Information staff productivity.

5. We recommended that the System Director ensure accurate and effective tracking and monitoring processes of Release of Information requests.

6. We recommended that the System Director ensure consultation with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action, if any, for managers' performance related to implementation of corrective action plans in response to privacy violations.

7. We recommended that the System Director ensure Release of Information standard operating procedures are established in accordance with VHA policy and implemented consistently.

8. We recommended that the System Director strengthen working relationships and communication processes within the facility Release of Information section and amongst staff and Business Office Service managers.

Appendix A

Prior OIG Reports

April 1, 2013 through April 1, 2017

System Reports

Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths
3/27/2017 | 16-00252-137

Audit of VA's Recruitment, Relocation, and Retention Incentives
1/5/2017 | 14-04578-371

Healthcare Inspection – Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida
4/13/2016 | 15-01432-264

Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida
8/28/2014 | 14-01292-258

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Bay Pines VA Healthcare System, Bay Pines, Florida
8/8/2014 | 14-00904-226

Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015
6/22/2016 | 16-01040-324

Combined Assessment Program - Evaluation of Coordination of Care in Veterans Health Administration Facilities
3/31/2015 | 15-01809-163

Topic Related Reports

Audit of VHA's Patient Advocacy Program
3/31/2017 | 15-05379-146

Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VARO
9/15/2016 | 16-00623-306

OIG reports are available on our website at www.va.gov/oig

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 5, 2017

From: Acting Network Director, VA Sunshine Healthcare Network (10N8)

Subj: Draft Report: Healthcare Inspection—Delays in Processing Release of Information Requests, Bay Pines VA Healthcare System, Bay Pines, Florida

To: Director, Baltimore Office of Healthcare Inspections (54BA)

1. Thank you for the opportunity to respond to the Healthcare Inspection of the Bay Pines VA Healthcare System. I have reviewed and concur with the response, comments, and proposed actions submitted by the Director, Bay Pines VA Healthcare System.

2. The Network will be monitoring the progress towards full compliance with all recommendations. If you have any additional questions or need additional information, please contact Mr. Ken Massingill on behalf of the VISN 8 Quality Management Officer at 727-575-8014.

Verana E. Richardson, Health Systems Specialist to the VISN 8 Network
for and in the absence of
Timothy W. Liezert

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: December 5, 2017

From: Director, Bay Pines VA Healthcare System (516/00)

Subj: Healthcare Inspection—Delays in Processing Release of Information Requests, Bay Pines VA Healthcare System, Bay Pines, Florida

To: Acting Network Director, VA Sunshine Healthcare Network (10N8)

1. I have conducted a thorough review of the Office of Inspector General (OIG) report titled "Delays in Processing Release of Information Requests, Bay Pines VA Healthcare System, Bay Pines, Florida." We concur with all recommendations provided in the report. It is important to note that several improvement efforts have been successfully carried out during the period of review. Several other recommendations are already in-progress.

2. Please find attached our formal response. We appreciate your review and comment. If you have a need for additional information, please contact Ms. Kristine M. Brown, Deputy Director, at 727-398-9301, or via email at kris.brown@va.gov .

3. We appreciate your support in improving our operations and service to Veterans. Thank you.

Suzanne M. Klinker

SUZANNE M. KLINKER
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 System Director ensure strengthening of procedures for timely processing of Release of Information requests.

Concur

Target date for completion: December 4, 2017

Facility response: Release of Information (ROI) processes have stabilized over the last 6 months. Service managers provide additional oversight through the development of a weekly standardized reporting tool specific to open and pending requests. Total Open/Pending ROI requests have dropped from 593 on March 31, 2017 to 50 on November 27, 2017 with only 4 ROI requests pending >20 days.

Weekly ROI Tracking Logs are provided to the Deputy Director detailing the number of pending ROI requests to include those greater than 20 days. Over the previous 24 months, the total number pending request has decreased significantly and the total number of request pending >20 days has remained at less than 25 for the last 120 days.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 2. We recommended that the System Director strengthen the process to adequately capture and trend complaints related to Release of Information requests in accordance with Veterans Health Administration policy.

Concur

Target date for completion: December 4, 2017

Facility response: The Service will develop and implement a tracking tool to track and trend ROI complaints made to the Service in coordination with the Patient Advocates Office and use of PATS as appropriate. Complaints specific to ROI section will be collated with the healthcare systems' electronic Controlled Correspondence Tracking System (CCTS) that has been in place since 2012.

Recommendation 3. We recommended that the System Director ensure an evaluation of the personnel issues negatively impacting staff retention and hiring in the Release of Information section and take appropriate action.

Concur

Target date for completion: December 15, 2017

Facility response: In an effort to promote team building and improve retention of existing ROI staff, VISN 8 Organizational Development (OD) Psychologist will continue to provide Service managers with employee feedback from quarterly workplace assessments. Information will be incorporated with All Employee Survey (AES) results from 2016 and 2017 and work groups will be established within the ROI section accordingly.

Recommendation 4. We recommended that the System Director ensure accurate monitoring of Release of Information staff productivity.

Concur

Target date for completion: December 15, 2017

Facility response: In June 2016, the service updated the performance plans for ROI staff to include productivity standards as a critical element. The productivity standards were developed on a graduated basis for each MRT grade level and utilized to monitor daily productivity. Daily reports are generated on open, closed and pending requests to provide a snapshot of staff productivity. Weekly reports will be provided to Service Chief for appropriate follow up.

Recommendation 5. We recommended that the System Director ensure accurate and effective tracking and monitoring processes of Release of Information requests.

Concur

Target date for completion: December 15, 2017

Facility response: In May 2017, the Service implemented a standardized checklist to improve the audit process and ensure consistency across both ROI locations. Daily quality reviews are conducted with new staff members throughout their training period and monthly with seasoned staff. A revised version of the audit tool was implemented on November 1, 2017.

Recommendation 6. We recommended that the System Director ensure consultation with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action, if any, for managers' performance related to implementation of corrective action plans in response to privacy violations.

Concur

Target date for completion: December 15, 2017

Facility response: Deputy Director will consult with HRMS and OGC to determine the appropriate administrative action, if any, for managers' performance related to implementation of corrective action plans in response to privacy violations. This will

occur in accordance with recent guidance addressing Disciplinary Actions for Privacy Violations (VAIQ #7813157), HR policy and table of penalties

Recommendation 7. We recommended that the System Director ensure Release of Information standard operating procedures are established in concordance with Veterans Health Administration policy and implemented consistently.

Concur

Target date for completion: April 28, 2017

Facility response: In April 2017, the Service developed a template for writing SOPs to include purpose, responsibilities and references to national policy that govern processes. The Service has developed a library of SOPs and is available to all staff. As new SOPs are developed, they are added to the library and notification occurs to ROI staff through email and weekly staff huddles.

Recommendation 8. We recommended that the System Director strengthen working relationships and communication processes within the facility Release of Information section and amongst staff and Business Office Service managers.

Concur

Target date for completion: December 15, 2017

Facility response: The Service Chief will continue to provide high-level oversight of ROI operational areas and processes as well as continue the transition to a single unified process for logging, tracking and completing ROI request between the two ROI locations utilizing best practices. Continuing education and formal training will be emphasized for supervisors, leads and all MRTs.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix E

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