



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02195-381

Healthcare Inspection

Alleged Magnetic Resonance Imaging Order Deletion and Record Destruction VA Greater Los Angeles Healthcare System Los Angeles, CA

June 11, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoiqhotline@va.gov

Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to requests from Senators Susan Collins, Richard Burr, and Dean Heller and Representatives Mike Michaud, Bob Goodlatte, and Pete Olson to assess the merit of allegations regarding the deletion of magnetic resonance imaging (MRI) exam requests (orders) and the destruction of medical files at the VA Greater Los Angeles Healthcare System (facility), Los Angeles, CA.

We did not substantiate that MRI orders were deleted or mass purged (orders for multiple patients deleted at the same time) or that records were destroyed. We found that orders cannot be deleted or destroyed from the computer system, as we were able to view old orders in the electronic health record that had been canceled. Each MRI order we reviewed was canceled individually.

We did not substantiate the allegation that patients suffered adverse or clinically significant consequences as a result of the facility's action of canceling dated MRI orders (orders greater than 1 year) in late 2008. We reviewed 1,474 MRI orders and found sufficient evidence within the electronic health record to support that the process used to cancel orders did not impact patient care outcomes.

We identified quality of care concerns where a delay or inability to schedule MRIs placed patients at risk for more complicated and prolonged management. We concluded that providers needed to determine the status of ordered MRI studies to ensure timely completion and document relevant information in the electronic health record.

We identified 170 MRI studies ordered in 2008 that were still pending. We determined that the facility had not consistently implemented its process to cancel orders older than 1 year. We did not find any pending orders after 2008.

We determined that the facility should strengthen its view alert notification process. Surrogate physicians must be designated for providers who are absent or leave their positions, and supervising providers should be notified when an MRI order is canceled if the ordering physician is a trainee.

We concluded that radiology program managers needed to ensure that MRI exams are scheduled within 30 days from the date specified by the ordering provider. Additionally, clerks need to accurately annotate reasons for canceled orders and appointments.

We recommended that the Facility Director ensure that Radiology Department managers confirm that ordered exams are scheduled and completed within the Veterans Health Administration required timeframe, that they review pending lists of MRI exams at designated intervals to ensure timely scheduling of these exams and that compliance be monitored, and that they develop and implement a consistent procedure for canceling MRI orders. We also recommended that the Facility Director ensure that responsible providers are notified of canceled MRI orders and that radiology clerical

staff accurately annotate reasons for canceling MRI orders and appointments in the electronic health record.

COMMENTS

The Acting Veterans Integrated Service Network and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to requests from Senators Susan Collins, Richard Burr, and Dean Heller and Representatives Mike Michaud, Bob Goodlatte, and Pete Olson to assess the merit of allegations regarding the deletion (cancelation¹) of magnetic resonance imaging (MRI)² exams requests (orders) and the destruction of medical files so there would be no record of the requests, thus reducing a backlog of MRI orders at the VA Greater Los Angeles Healthcare System (facility), Los Angeles, CA.

Background

The facility is a 668-bed tertiary care facility that provides primary, specialty, outpatient, medical, surgical, psychiatric, rehabilitative, and long-term care services and serves a veteran population of approximately 86,000 in a primary service area that includes Los Angeles, Santa Barbara, San Luis Obispo, Ventura, and Kern counties in California. The facility is part of Veterans Integrated Service Network 22.

In February 2014, an audio recording of a facility system redesign meeting held in November 2008 was released to a media contact. On the recording, meeting participants debated whether actions of “mass order purging” or “order cancelation” were options to manage the MRI backlog of pending MRI orders.³ Team member A stated that all orders dating further back than April of 2007 should be canceled. Team member B questioned team member A to clarify the reason for canceling MRI orders and asked “schedule or cancel?” Team member A repeated “cancel” and went on to explain that the orders were dated and that the veterans may have had them done elsewhere and may not need them anymore or “may have died.” Team member A then asked team member C whether “a mass purge” of all orders dated greater than 1 year was possible. Team member C responded, “No, not unless someone wants to lose their job.”

The release of the recording gained widespread media coverage. Different versions of the story were published, and allegations ranged from destruction of disability files or destruction of medical records and files to mass purging of records for deletion. Veterans Health Administration (VHA) and the facility addressed the media reports and responded that no clinically inappropriate actions were taken with respect to imaging requests, that it was not possible to “destroy” records from the VA electronic system, and that there were no “group” close-outs (mass purging) of imaging studies. Further,

¹Although media reports used the term deletion, we found orders could not be deleted from the electronic health record and use the term cancelation in this report to describe the actions taken by the facility.

²MRI produces images of body structures to aid in disease detection and confirmation of diagnosis.

³Pending orders are those for which appointments for exams have not yet been scheduled. In some instances appointments that are made but then cancelled or duplicated may continue in a “pending” status if not properly coded by the scheduling clerk.

the facility stated that the decision to administratively clear old imaging requests that were no longer clinically relevant was undertaken only after an extensive review of each MRI order.

Chronology of Events

In fiscal year (FY) 2007, VHA reported that many facilities were struggling to complete imaging exams within 30 days of a clinician's order, and access to imaging exam appointments became a high priority issue for VHA. On December 21, 2007, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) issued guidance⁴ on implementing various strategies to improve radiology/imaging exam wait times. The DUSHOM requested that Network Directors adopt the following strategies.

- If the desired date of the procedure is more than 30 days in the future, the ordering provider should always complete the "Date Requested" field of the computerized patient record system during order entry.
- All appointments should be made or mailed out within 7 days of entry of the order.
- If a patient does not show for an appointment and did not call to say they were unable to appear, and the lack of appearance cannot be explained by inclement weather or other circumstance, the order should be canceled, and the ordering provider should be notified to evaluate whether it should be re-entered.
- A person should be identified to routinely track the number of unscheduled orders, waiting times, and no shows.
- Imaging Service quality assurance (QA) minutes should reflect a discussion of waiting times and development of a correction plan.

In 2008, VHA introduced its system redesign program to improve patient access to appointments and patient flow. At the facility level, system redesign teams were formed to evaluate current operations within a department/service and to discuss and develop (or redesign) policies to improve performance outcomes.

In response to the DUSHOM guidance, the facility Interim Radiology Chief directed an evaluation of all pending MRI orders to assess the department's resources in July 2008 and determine whether purchasing additional MRI equipment was necessary to satisfy imaging demands. The study revealed an MRI "backlog" dating back more than 10 years; the Chief concluded that the backlog did not accurately represent the department's current demands. The facility's review revealed the following reasons as to why MRI orders were canceled.

1. Patients were inpatients when requests were submitted but did not follow up after discharge.

⁴DUSHOM Memorandum "Strategies to Improve Imaging Wait Times," December 21, 2007.

2. The Emergency Department ordered studies on patients who were from out of town and did not follow up with the facility.
3. Patients had other evaluations, so the requested studies were no longer clinically relevant.
4. Patients had not scheduled appointments or did not show for scheduled appointments.
5. Patients were no longer in the system.

In alignment with VHA's system redesign initiative, in 2008 Radiology Department staff formed a team with the Interim Chief as the team leader. Their first task was to address processes to reduce the backlog of pending MRI orders. The team included informatics leadership representatives and department scheduling managers. Scheduling clerks participated in the meetings at various times to offer their input as well as to receive direction as more specific plans were developed to improve access to MRI appointments and "work down the backlog."

The Interim Chief met with clinical service chiefs and members of the Medical Executive Committee (such as Medicine, Surgery, Neurology, and Primary Care) and presented initial review findings. A consensus was reached that pending MRI orders older than 1 year would no longer have clinical relevance and that patients would need to be re-evaluated by their providers prior to performing studies. The Interim Chief then instructed Radiology Department staff to review and cancel pending imaging orders (greater than 1 year) except for any follow-up studies that had future desired dates. Radiologists, technicians, and clerks canceled the pending orders. Cancellation of pending orders automatically triggered electronic alerts to the ordering providers notifying them that the pending orders had been canceled. The alerts afforded providers the opportunity to decide whether exams should be reordered.

In 2009, a complainant contacted the OIG alleging multiple "questionable practices," including cancelation of MRI appointments from 2000 through November 2008 without proper patient notification. Specific to MRI, the complainant reported that "valid requests for MRIs [were] being canceled and/or deleted from the system as a means of reducing the number of requests for pending MRIs." The OIG referred the allegations to the facility. In response, the facility cited guidance from the VHA National Radiology Director instructing Imaging Services to cancel orders older than 6 months when it was determined the exams were no longer needed.⁵ The facility explained that the alleged "mass purge" was undertaken with approval from the facility's Medical Executive Committee. The facility concluded that a majority of the pending MRI orders it had identified were no longer needed, as the patients had received alternative exams with other modalities or were no longer receiving their health care at the facility. The facility

⁵The facility elected to cancel orders that were older than 1 year, as they felt any orders older than 1 year would not have any clinical relevance.

addressed each allegation and provided reasonable responses. The OIG found the facility's responses adequate and considered the case closed.

In response to the media attention in early 2014, several Members of Congress requested the former VA Secretary and the OIG to conduct an investigation. We identified the following issues from the congressional request, as well as media sources, and conducted a review to determine whether:

- Patients experienced clinically significant consequences as a result of canceled MRIs.
- The facility performed acceptable alternate studies.
- MRI exams were scheduled as evidenced by appointments in response to orders.
- Patients had MRI studies done for the same indications as the original orders.
- Facility staff destroyed medical claims files and/or other records.
- If records were destroyed, to what extent were the records destroyed.
- The alleged destruction was done to misrepresent the backlog of medical records claims or other records.

Although not an allegation, during our review of patients' electronic health records (EHRs), we identified instances in which delays or inability to schedule imaging exams in a timely manner placed patients at risk for more complicated and prolonged management.

Prior to our site visit in April 2014, facility managers reported that they reviewed the EHRs of 103 randomly-selected patients from a list of 1,651 patients the facility had identified during its review of pending MRI orders in 2008. The facility found that 36 percent of orders for the patients reviewed were actually completed. The facility reported that it did not find evidence that the patients reviewed were harmed due to the canceled MRIs.

Scope and Methodology

We conducted our work from March through November 2014, including a facility site visit on April 14–16, 2014. We attempted to interview the source of the 2014 news story, but the individual declined our requests for a formal meeting.

We interviewed VHA's National Radiology Director, the facility Director, and the Chief of Staff. We also interviewed the facility Radiology Chief, a Patient Experience Specialist (also known as Patient Advocate), and other key facility staff. We reviewed VHA directives and handbooks, DUSHOM memoranda, issue briefs, patient advocate data, facility policies and procedures, and other pertinent documents. We listened to and reviewed a transcript of the subject audio recording and reviewed relevant media reports and social media entries.

The facility provided us a list of 1,651 pending MRI orders that were canceled as a result of the initiative to reduce the backlog in 2008. We reconciled this list with the 790 canceled pending MRI orders provided by another source to eliminate duplicate orders. Together, the lists contained the names of patients who had MRI orders dating back from 1999 through 2008; however, we focused our review on the most recent 3 years—2006 through 2008, as such a review would capture orders less than 3 years old at the time of the cancellation. Orders older than 3 years from the date of cancellation were considered too dated.

While on site, the inspection team identified an additional 170 pending orders from 2008 that had not been canceled at the time of the facility's initiative to reduce the MRI backlog. The total number of MRI orders from the reconciled list for the time period selected (1,304) plus the additional 170 pending orders was 1,474. We determined that the 1,474 orders were for 1,112 unique patients. We reviewed the EHRs of all patients with canceled and pending orders.

We also reviewed facility information regarding patient complaints related to access, timeliness, and coordination of care (appointment time/time concerns) for 2008–2013. We found 34 radiology related complaints; none were related to MRI orders.

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: Significant Clinical Consequences from Canceled Pending MRI Orders

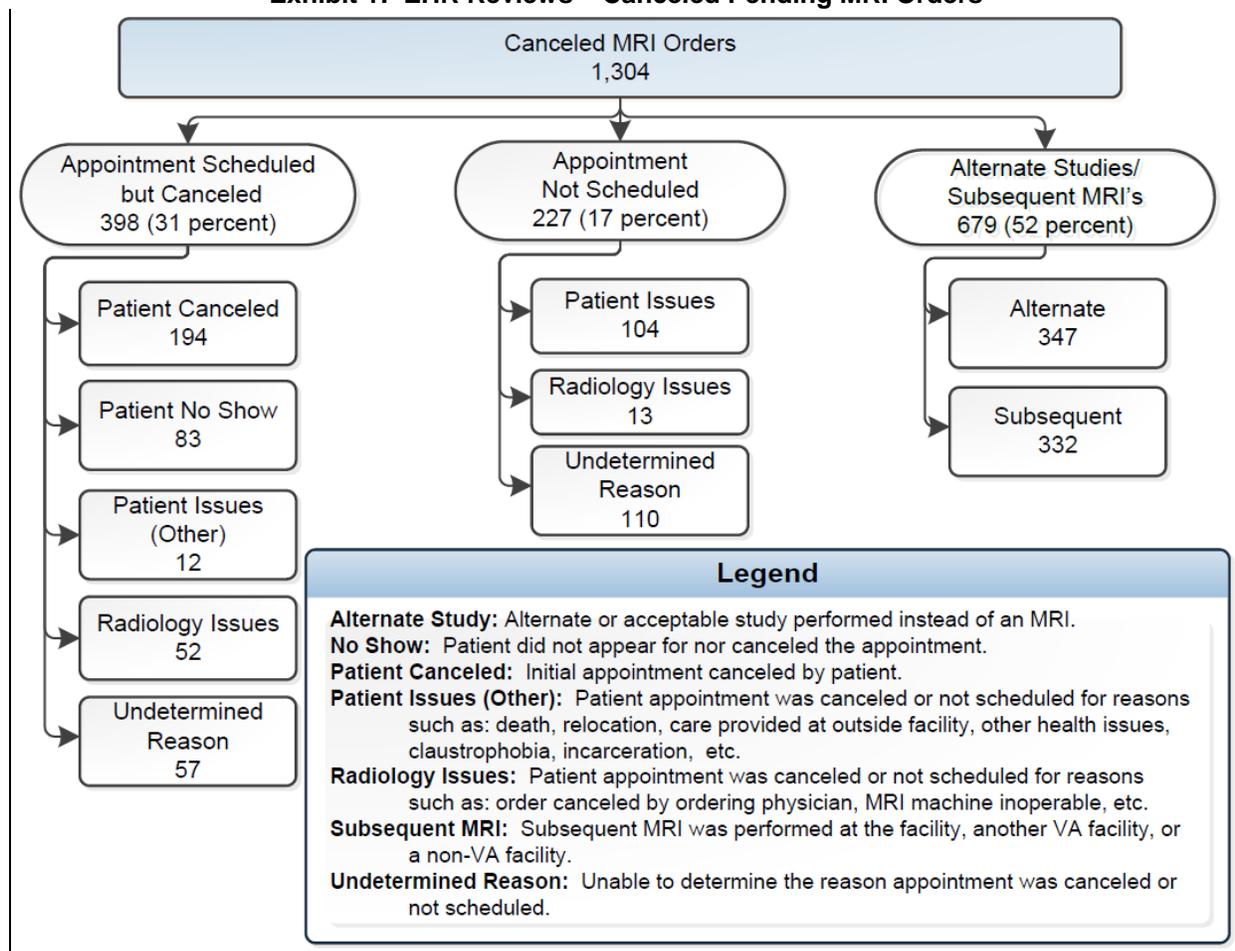
We did not substantiate that patients suffered adverse or clinically significant consequences as a result of the facility's procedure of canceling pending MRI orders older than 1 year (facility's definition of dated orders). The EHRs for the 1,304 cancelled orders that we reviewed contained sufficient evidence to support that the cancelation of pending MRI orders did not impact patients' health care management. As many of the orders were canceled 2 or more years (the average was 521 days) after the initial order was placed, scheduling dated MRI orders would have been inappropriate. Patients would need to be re-evaluated to determine current necessity.

Generally, we found insufficient documentation by providers related to original MRI orders. Frequently, a provider would order an MRI and multiple follow-up appointments over several months and years; however, there would be no documented discussion regarding the pending MRI order, no evidence of an attempt to get an exam scheduled, and no discussion of the clinical question that prompted the initial MRI order.

In some instances, patients' EHRs included documentation of specialty evaluations such as physical therapy and other rehabilitation services. Under these circumstances, we questioned the need for MRIs and determined them to be irrelevant in the overall care of these patients.

Our review of patient EHRs with canceled pending MRI orders is summarized in Exhibit 1. The exhibit includes 398 patients who had scheduled appointments canceled that resulted in the associated orders continuing to have a "pending" status.

Exhibit 1: EHR Reviews – Canceled Pending MRI Orders



Source: VA OIG

Issue 2: Alternate Therapy or Imaging Exams, Subsequent Appointments, or MRIs

A total of 332 patients either had adequate follow-up, such as alternative imaging exams or MRIs at other VA facilities, private facilities, or at the facility (as often the same imaging exams were ordered in duplicate). We found that 347 patients had alternative imaging exams. For example, an abdominal computed tomography (CT) scan might have been performed, which provided the needed information, making an abdominal MRI unnecessary.

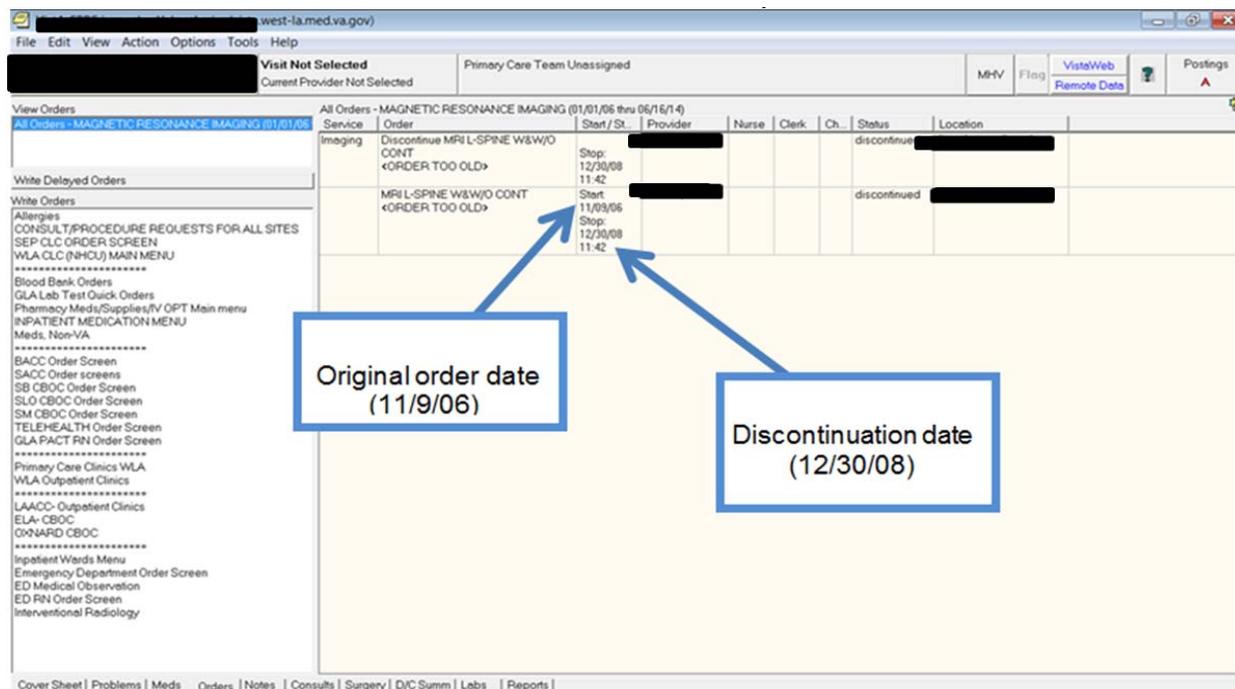
Issue 3: Deletion and Mass Purging of MRI Orders, Destruction of Records, and Intentional Cancellation of MRI Orders To Misrepresent Backlog

We did not substantiate that pending MRI orders were deleted or mass purged or that records were destroyed. We found all 1,474 MRI orders in the computer system. For the 1,304 canceled orders reviewed, we found information such as who canceled the order, the date and time the order was canceled, and the reason for the cancellation. We found that 846 orders were canceled by clinicians (providers, radiologists, nurse practitioners), and 805 orders were canceled by clerks or technicians. We did not find

evidence of “mass purging.” Instead, we noted (based on the date and time an order was canceled) that orders were canceled one by one. We confirmed that there was no option to mass purge/delete orders electronically.

Exhibit 2 shows a discontinued order on a patient from a list we received. The original order date was November 9, 2006; it was canceled on December 30, 2008. The screenshot shows how the cancellation is displayed in the patient’s EHR.

Exhibit 2: Discontinued Request



Source: VA OIG

We substantiated that backlogged pending MRI orders were intentionally canceled. However, we did not substantiate that cancelations occurred in order to misrepresent the backlog of MRI studies or that the facility intended that no record of the canceled order would exist.

The decision to cancel pending MRI orders was deliberate and based on a facility system redesign performance improvement effort. The cancelations were performed at the direction of the Chief of Radiology, after review of the orders, and in collaboration with the facility’s clinical service chiefs and after approval by facility leadership.

Issue 4: Quality of Care Concerns from Delayed Scheduling

Although we could not attribute adverse consequences to the facility’s cancellation of pending MRI orders, our review of patients’ EHRs revealed instances in which delays or inability to schedule imaging exams in a timely manner placed patients at risk for a more complicated and prolonged management. Below are two examples in which timely MRIs could have reduced the risk of serious harm or markedly improved a patient’s quality of life.

Patient #1

At the time of our review, the patient was a man in his sixties with a history of schizoaffective disorder,⁶ diabetes mellitus, peripheral neuropathy, hepatitis C, cirrhosis,⁷ hypersplenism,⁸ and pancytopenia.⁹ In 2006, due to a full thickness ulceration at the left great toe and increasing pain that was interfering with his ability to walk, the patient was admitted to the facility for “intravenous (IV) antibiotics and debridement.” The patient received IV antibiotics for 1 day and was then changed to an oral antibiotic because of problematic IV access. Providers were concerned that the patient “may require long-term IV antibiotics for osteomyelitis¹⁰ therapy.” However, having displayed some improvement, he was discharged and placed on a brief course of oral antibiotics while clinicians awaited results of an “MRI as an outpatient to evaluate for osteomyelitis.”

The day prior to hospital discharge, the medical attending physician noted the patient’s foot “infection has improved only modestly on oral antibiotics and we hope to have a PICC line¹¹ placed today to continue IV antibiotics. MRI is still pending...once we have the MRI we can better outline the long term plan for this patient.” A podiatry team member also commented on the role of MRI and the reason for obtaining one, noting on the day prior to hospital discharge, “unclear if he has osteomyelitis...recommend MRI to rule out osteomyelitis.” The next day (the day of hospital discharge), another podiatrist corroborated the rationale for an imaging exam, saying: “MRI is recommended to rule out any deep abscess or any signs of osteomyelitis; can be performed on an outpatient basis.” Although the patient experienced eventual resolution of the left foot ulcer, the requested MRI of the foot was never performed.

Accurately diagnosing osteomyelitis is clinically important because its presence affects management decisions in the effort to lessen the ultimate risk of toe, foot, and limb amputations. Distinguishing between osteomyelitis and a superficial infectious process has relevance in antibiotic selection, duration, and mode of administration. When, as here, clinicians suspect possible osteomyelitis of the foot but are not successful in obtaining desired MRI imaging, a patient’s management becomes empiric and outcomes more uncertain.

⁶Condition in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms such as mania or depression.

⁷Late stage of scarring of the liver caused by many forms of liver diseases and conditions.

⁸Premature destruction of blood cells by the spleen.

⁹Abnormally low level of all blood cells produced by the bone marrow.

¹⁰Infection in the bone.

¹¹A PICC (peripherally inserted central catheter) is a long, slender plastic tube inserted into a vein and advanced to a large vein near the heart, facilitating intravenous access.

Patient #2

At the time of our review, the patient was a male in his late fifties with a history of post-traumatic stress disorder, depression, sleep apnea,¹² and bilateral knee pain. He sustained blunt force trauma to both knees during military service in the 1970s. Due to the patient's complaints of having difficulty in "getting up and down" and concerns about an internal knee derangement,¹³ the patient's primary care provider (PCP) placed an order for MRI exams of both knees in September 2006. The MRI exams were not scheduled. Eleven months later, the PCP documented chronic, worsening knee pain, and noted "laxity"¹⁴ of medial collateral ligaments" and re-entered the order for the MRI exams. The second set of MRI exams was not scheduled.

In subsequent months, the patient's progressive knee pain began to impact his ability to perform his job. Due to the progression of his knee symptoms and being aware that MRI exams had been ordered on two occasions, the patient contacted the facility several months later to inquire about the status of the PCP's imaging requests. He was informed that the MRI exams remained unscheduled. The patient then sought care outside the VA system and, within 2 months, underwent a right total knee replacement and, shortly thereafter, a left total knee replacement.

While the patient's knee pain first affected his performance of the routine daily movement of "getting up and down" it ultimately impacted his ability to perform required duties at work. With chronic, worsening knee pain and the finding of lax medial collateral ligaments, the MRI was essential for clarifying internal knee pathology and offering further insight as to whether a surgical referral was indicated.

Issue 5: Other Issues

Pending MRI Orders

While onsite in April 2014, we identified 170 MRI orders from 2008 that remained pending despite the facility's 2008 initiative to reduce the MRI backlog by canceling pending orders. Our review of the 170 patients' EHRs revealed sufficient evidence to support that the failure to timely schedule the 170 pending MRI orders did not impact the patients' health care management. We found that although 48 (28 percent) of the 170 patients had either alternate studies or subsequent MRIs completed, the associated orders had not been canceled. We did not find similar pending orders after 2008.

¹²Chronic disorder in which a person repeatedly stops breathing during the night.

¹³Chronic disorder of the knee due to damaged structures within the joint, such as cartilage and/or ligament tears.

¹⁴Cause of chronic pain characterized by loose ligaments.

Provider Notification of Canceled MRI Orders – “View Alerts”

We were informed that an ordering provider automatically receives a “view alert” email notification when a pending MRI order is canceled. This electronic alert is a mandatory field and must be “on” at all times in the computer system. While onsite, we verified that this field was mandatory and it was “on” at the facility.

The view alert allows the ordering provider the opportunity to determine the necessity of the exam and whether it should be reordered. Once the alert is “viewed” or read by the ordering provider, it is no longer visible and cannot be saved or recalled. If a supervising physician or surrogate (alternate) provider is not designated for an ordering provider who is a trainee or no longer affiliated with the facility, the “view alert” is not reviewed. Facility leadership informed us that a failure to designate a surrogate is a VA-wide issue and is often not done. Because the view alert system is a one-time notification, we were unable to verify if ordering providers were notified of the MRI orders that were canceled from 2006 through 2008.

MRI Wait Times

In order to ascertain current timeliness of scheduling MRI orders, we reviewed the facility’s more recent MRI scheduling data. A VHA performance measure for MRI requires exams be scheduled within 30 days from the date specified by the ordering provider, with a 90 percent goal for compliance. We found that the facility did not meet the goal for this performance measure for FY 2013 and FY 2014. Table 1 below shows the facility’s quarterly MRI wait times within 30 days. On average, 55 percent of MRIs were scheduled within 30 days in FY 2014.

Table 1: MRI Wait Times: Number of MRIs Scheduled Within 30 Days/Number of MRIs Ordered

FY	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
2013	1214/2002 (61 percent)	1189/1927 (62 percent)	1545/2150 (72 percent)	1366/2122 (64 percent)
2014	1343/2037 (66 percent)	1106/1839 (60 percent)	1121/2457 (46 percent)	1318/2585 (51 percent)

Source: VA OIG, VHA

Annotation of MRI Appointment Cancellation

While conducting EHR reviews, we found instances of incorrect or inadequate documentation regarding MRI orders and appointments. During our review of the 398 MRI orders with appointments that had been canceled in late 2008, 194 appointments were canceled by the patient, 83 were canceled because the patient did not appear for the appointment, 52 were canceled by radiology, and 12 were canceled for other reasons. For the remaining 57, we could not determine the reasons for cancellation because radiology clerical staff did not consistently annotate reasons.

Conclusions

We did not substantiate that MRI orders were deleted or mass purged or that records were destroyed. We found that orders cannot be deleted or destroyed from the computer system, as we were able to view canceled orders in the EHR orders. Each MRI order that we reviewed was canceled individually.

We did not substantiate the allegation that patients suffered adverse or clinically significant consequences as a result of the facility's action of canceling dated MRI orders in late 2008. Of the 1,474 MRI orders reviewed (1,304 canceled pending orders and 170 pending), we found sufficient evidence within the EHR to support that the process the facility used to cancel the orders did not impact patient care outcomes.

We did, however, identify quality of care concerns where delays or inability to schedule MRIs timely put patients at risk for more complicated and prolonged management. We concluded that Radiology Department managers should monitor the status of MRI orders to ensure timely completion and document relevant information in the EHR.

We identified 170 MRI studies ordered in 2008 that remained on the pending list. We determined that the facility had not consistently implemented its process to cancel orders older than 1 year. We did not find pending orders after 2008.

We determined that the facility should strengthen its view alert notification process. Surrogate physicians must be designated for providers who are absent or leave their positions, and supervising providers should be notified when an MRI order is canceled if the ordering physician is a trainee.

We concluded that radiology program managers should ensure that MRI orders are scheduled within 30 days from the desired date as required by VHA. Additionally, clerks must accurately annotate reasons for canceled orders and appointments.

Recommendations

1. We recommended that the Facility Director ensure that Radiology Department managers confirm that ordered magnetic resonance imaging exams are scheduled and completed within the Veterans Health Administration required timeframe.
2. We recommended that the Facility Director require Radiology Department managers to review pending lists of magnetic resonance imaging exams at designated intervals to ensure timely scheduling of these exams and that compliance be monitored.
3. We recommended that the Facility Director ensure Radiology Department managers develop and implement a consistent procedure for canceling magnetic resonance imaging orders.

4. We recommended that the Facility Director ensure that responsible providers are notified of canceled magnetic resonance imaging orders.
5. We recommended that the Facility Director ensure that radiology clerical staff accurately annotate reasons for canceling magnetic resonance imaging orders and appointments in the electronic health record.

Acting VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 6, 2015

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

Subj: Draft Report – Healthcare Inspection—Alleged Records Destruction, VA Greater Los Angeles Healthcare System, Los Angeles, California

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

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Attached is VA Greater Los Angeles Healthcare System's response to the Alleged Records Destruction Healthcare Inspection Report recommendations 1,2,3,4 and 5.
2. If you have any questions or require information, please contact Jimmie Bates, Quality Management Officer at 562-826-5963.

*(original signed by
Jimmie Bates for:)*

Skye McDougall, PhD
Acting Network Director

Acting Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 6, 2015

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Draft Report – Healthcare Inspection—Alleged Records Destruction,
VA Greater Los Angeles Healthcare System, Los Angeles, California

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

1. VA Greater Los Angeles Healthcare System (GLA) concurs with the Department of Veterans Affairs Office of Inspector General Healthcare Inspection performed at GLA April 14–16, 2014. We appreciate the professionalism by the OIG Team demonstrated during the review process.
2. If you have any questions regarding this report, please contact Joan Lopes, GLA Chief of Quality Management, at (310) 268-3585.

(original signed by:)

Stephen R. Bauman
Acting 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 Facility Director ensure that Radiology Department managers confirm that ordered magnetic resonance imaging exams are scheduled and completed within the VHA required timeframe.

Concur

Target date for completion: September 30, 2015

Facility response: GLA currently stands at 55-68% completion within the time frame. The following actions are currently in process:

- Medical Support Assistants (MSA) print pending lists daily and call patients to schedule appointments.
- MRI MSA's have been trained to use Veterans Choice List (VCL) when needed or requested.
- Chief of Imaging reviews consults for non-VA fee care and approves based on criteria.
- MR scheduling grids have been opened to CBOC's. MSA's instructed to schedule at point of care.
- Imaging scheduling SOP is under revision to reflect new VACO guidelines.

Recommendation 2. We recommended that the Facility Director require Radiology Department managers to review pending lists of magnetic resonance imaging exams at designated intervals to ensure timely scheduling of these exams and that compliance be monitored.

Concur

Target date for completion: May 30, 2015

Facility response: The pending lists are printed daily by MSA's at two hour intervals. Wait times are monitored monthly by Chief of Service for analysis and recommendations for improvement. Currently have approval for an additional 4 MSA's which should result in improvement in timeliness.

Recommendation 3. We recommended that the Facility Director ensure Radiology Department managers develop and implement a consistent procedure for canceling magnetic resonance imaging orders.

Concur

Target date for completion: March 30, 2015

Facility response: A written procedure for canceling magnetic resonance imaging orders will be developed.

Recommendation 4. We recommended that the Facility Director ensure that responsible providers are notified of canceled magnetic resonance imaging orders.

Concur

Target date for completion: June 30, 2015

Facility response: The review of pending orders that can be discontinued according to VA policy generates an alert for the ordering physician. In cases where the patient has been referred for non-VA fee care, that status is noted in CPRS as reason for discontinuing. If there are other specific reasons such as other testing being done, a note is generated to the ordering provider.

Recommendation 5. We recommended that the Facility Director ensure that radiology clerical staff accurately annotate reasons for canceling magnetic resonance imaging orders and appointments in the electronic health record.

Concur

Target date for completion: June 30, 2015

Facility response: Imaging has been allocated 4 MSA positions which should increase the efficiency of this recommendation. Chief of Imaging is retraining clerical staff about the need to have a reason for discontinuing, as well as providing another accepted menu for reasons.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Pete Aguilar, Karen Bass, Julia Brownley, Xavier Becerra, Ami Bera, Ken Calvert, Lois Capps, Tony Cárdenas, Judy Chu, Paul Cook, Jim Costa, Jeff Denham, Mark DeSaulnier, Susan Davis, Anna G. Eshoo, Sam Farr, John Garamendi, Bob Goodlatte, Janice Hahn, Mike Honda, Jared Huffman, Duncan D. Hunter, Darrell Issa, Stephen Knight, Doug LaMalfa, Barbara Lee, Ted Lieu, Zoe Lofgren, Alan Lowenthal, Doris O. Matsui, Kevin McCarthy, Tim McClintock, Jerry McNerney, Grace Napolitano, Devin Nunes, Pete Olson, Nancy Pelosi, Scott Peters, Dana Rohrabacher, Lucille Roybal-Allard, Ed Royce, Raul Ruiz, Loretto Sánchez, Adam Schiff, Brad Sherman, Jackie Speier, Eric Swalwell, Mark Takano, Norma Torres, Mike Thompson, David Valadao, Juan Vargas, Mimi Walters, Maxine Waters

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