Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04898-290

Healthcare Inspection

Teleradiology Concerns
VA Roseburg Healthcare System
Roseburg, Oregon

October 12, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a confidential complainant regarding radiology services at the VA Roseburg Healthcare System (system), Roseburg, OR and teleradiology services with the Alaska VA Healthcare System, Anchorage, AK and the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA.

Specifically the allegations were:

- The practice of reading teleradiology studies for Anchorage occurred prior to signing a Memorandum of Understanding (MOU).
- Increased teleradiology workload is causing delays for local system patients.
- The system lacks a peer review process, which could result in a failure to detect decreased quality of image interpretation resulting from the increased workload.
- The system does not properly credential and privilege teleradiology providers.

We substantiated the allegation that the reading of teleradiology studies for Anchorage patients by system radiologists occurred prior to both sites signing a Memorandum of Understanding outlining the conditions for internal review of provider performance and quality of care concerns.[1]

We did not substantiate that delays in radiologic readings occurred for Roseburg patients as a result of providing teleradiology services to Anchorage and Walla Walla. We found no evidence of delays in radiologic interpretation, misinterpretation of studies, or reports of patient harm.

We substantiated that the system lacked an integrated peer review process for radiology. The system's Radiology Service level peer review program was not an integrated part of the system's overall peer review program for quality management. This could hinder the system's ability to detect misinterpretations of radiologic studies, if they occurred.

We did not substantiate that the system improperly credentialed and privileged teleradiology providers. All four of the system's staff radiologists providing teleradiology services were appropriately credentialed and privileged.

We recommended that the Veterans Integrated Service Network Director conduct a quality review of the imaging study interpretations completed during the time of the unsigned Memorandum of Understanding referenced in this report. We also

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

recommended that the System Director strengthen processes to ensure the Radiology Services is fully integrated into the system's formal peer review program.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 6–9 for the Directors' comments.) Based on actions already completed, we consider all recommendations closed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a confidential complainant regarding radiology services at the VA Roseburg Healthcare System (system), Roseburg, OR and teleradiology services with the Alaska VA Healthcare System, Anchorage, AK and the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA.

Background

System Profile. VA Roseburg Healthcare System is part of Veterans Integrated Service Network (VISN) 20. The system provides care for veterans residing in central and southern Oregon and northern California. The main campus includes an Emergency Department and community living center and provides primary care and hospital services in medicine, surgery, and mental health. The system has three community based outpatient clinics in the state of Oregon including one located in Eugene, one in Brookings, and one in North Bend.

The VA Roseburg Radiology Service provides both inpatient and outpatient services, which include radiography,[2] computed tomography,[3] magnetic resonance imaging (MRI),[4] and ultrasound.[5] At the time of our review, the Chief of Radiology supervised three part-time radiologists who were responsible for reading and submitting radiology reports for all imaging procedures completed at the system. These radiologists also provided teleradiology services. Teleradiology is the interpretation of imaging studies from a different location than the patient. The interpreting teleradiologist reads the images and submits a radiology report for that study.

The Alaska VA Healthcare System (Anchorage) located in Anchorage, AK, offers primary, specialty, and mental health outpatient care through the parent outpatient clinic as well as community based outpatient clinics in Fairbanks, Kenai, and Wasilla and an outreach clinic in Juneau, AK. Inpatient services for veterans in Alaska are provided through a Joint Venture with Joint Base Elmendorf-Richardson, adjacently located, as well as through Non-VA Care Coordination with community hospitals.

The Jonathan M. Wainwright Memorial VA Medical Center (Walla Walla), located in Walla Walla, WA, serves veterans residing in a 42,000-square-mile primary service area

[2] Radiography is an imaging technique that uses electromagnetic radiation other than visible light, especially x-rays, to view the internal structure of a non-uniformly composed and opaque object, such as the human body.
[3] CT is a noninvasive imaging procedure that uses specialized x-ray equipment to produce cross-sectional ("slices") images of the body. These sectional images are used for a variety of diagnostics and therapeutic purposes.
[4] MRI is an imaging procedure that uses strong magnetic field and radio waves to form images of the body. The technique is widely used in hospitals for medical diagnosis, staging of disease, and for follow-up without exposure to ionizing radiation.
[5] Ultrasound is an imaging study that uses high frequency sound waves to view soft tissues such as muscles, tendons, joints, vessels, and internal organs.

within the VISN 20 network. Services include outpatient primary care, mental health and specialty care, and substance abuse residential rehabilitation. The facility has three community based outpatient clinics located in LaGrande, OR and Richland and Yakima, WA.

Allegations. In July 2014, the VA OIG's Hotline Division received allegations that the implementation of a new teleradiology program at the system was contributing to treatment delays and the program lacked quality oversight. Specifically the allegations were:

- The practice of reading teleradiology studies for Anchorage occurred prior to signing of the Memorandum of Understanding (MOU).[6]
- Increased teleradiology workload is causing delays for local system patients.
- The system lacks a peer review process, which could result in a failure to detect decreased quality of image interpretation resulting from the increased workload.
- The system does not properly credential and privilege teleradiology providers.

Scope and Methodology

The period of our review was July 2, 2014 to March 6, 2015. We reviewed system documentation, including Veterans Health Administration (VHA) handbooks and directives; The Joint Commission Standards; system policies and procedures; the MOUs at issue, quality management and staffing documents; scheduling, access, and performance data; and other relevant documentation.

To evaluate the quality and timeliness of interpretation of Roseburg patients' radiology studies, we randomly selected 25 of 886 patients who received diagnostic radiology care for a 2-week period in June and a second 2-week period in July 2014.

We conducted a site visit December 3–4, 2014. We conducted interviews with VISN leadership, system managers, radiologists, the Chief of Radiology, the Chief of Staff, and other clinical and administrative staff knowledgeable about the system's radiology and teleradiology programs.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

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.

[6] A Memorandum of Understanding is a formal agreement that defines the expectations of both the referring and interpreting facilities and outlines how services are to be rendered.

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: MOU Implementation

We substantiated that the reading of teleradiology studies for Anchorage patients occurred prior to both the system and Anchorage signing an MOU. VHA Handbook 1100.19, *Credentialing and Privileging*, requires organizations participating in the telemedicine services to have a formal agreement in place that includes internal review of provider performance and quality of care concerns.[7] On June 18, 2014, the system's Radiology Service Chief and Chief of Staff engaged in a cooperative effort to provide radiology services to veterans in VISN 20 and signed an MOU for staff radiologists to provide teleradiology readings for Anchorage patients. No evidence was provided that Anchorage leaders signed the document. Following a review of documentation, electronic health records, and interviews, we determined the system did provide teleradiology services to Anchorage patients through October 2014 without an MOU signed by both parties. We discovered that the system's teleradiologists performed under the assumption that the Anchorage MOU had been signed.

Concurrent to the system's MOU process with Walla Walla and Anchorage, the VISN 20 Teleradiology Program leaders were developing a VISN level MOU to include all eight facilities in the VISN. The MOU for Radiology Interpretation from VISN 20, dated July 11, 2014, standardized MOUs between all sites. The MOU was signed by all facilities and VISN 20 leadership on November 21, 2014.

Issue 2: Quality and Timeliness of Care

We did not substantiate that delays in radiologic readings occurred for Roseburg patients as a result of providing teleradiology services to Anchorage and Walla Walla. According to VHA Directive 2009-019, *Ordering and Reporting Test Results,* each facility must ensure that the facility has a policy regarding communication of test results that defines the acceptable length of time between the ordering of tests and the availability of results.[8] The system's local policy[9] clearly defines test priority and the acceptable timeframe for completing the imaging, including interpretation. Our review of the randomly selected electronic health records of 25 patients who received diagnostic radiology care during June–July 2014 showed no evidence of delay in interpretation of

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009. This VHA Directive, which was current at the time of the events discussed in this report, was rescinded and replaced by VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. The current Directive includes similar language regarding local policies for communication of test results.
[9] VA Roseburg Healthcare System, MCM1523, *Radiology General Policy, June 2011*.

results. The electronic health records were reviewed for the elapsed time from exam date to reading date and all records reviewed met local policy for timeliness.[10]

Issue 3: Quality Oversight

We substantiated that the system lacked a system integrated peer review process for radiology. VHA Directive defines peer review as "an organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals."[11] A peer review is a critical assessment of a provider's episode of care by a peer or group of peers for the purpose of quality management with the goal of improving the delivery of care and enhancing the provider's professional development. This ultimately contributes to organizational improvements and optimal patient outcomes. The VHA Directive further requires that each health care facility establish and maintain a program of peer review for quality management purposes.[12] The system's Medical Staff Bylaws require all medical staff members to participate in the system's protected peer review program. We found that the system's Radiology Service performed, at the service level, a peer review process for all radiologists. The data was tracked by the service chief but was not an integrated part of the system's overall peer review program and therefore did not meet requirements as outlined in local or VHA policy.

To assess for quality concerns with radiologic interpretation, we interviewed multiple staff members from the radiology department and reviewed patient advocate data. We found no evidence of delays in radiologic interpretation, misinterpretation of studies, or reports of patient harm. System managers reported that workload timeliness was not impacted by the additional work. Nevertheless, the absence of an appropriately integrated peer review program does create a vulnerability in which quality of care concerns could go undetected.

Issue 4: Credentialing and Privileging Process

We did not substantiate that the system failed to properly credential and privilege teleradiology providers. VHA Memorandum *Credentialing and Privileging of Telemedicine Practitioners in VHA* outlines the requirements for credentialing and privileging teleradiologists.[13] It specifies the referring site can accept the credentialing and privileging of the site providing the services. We found that all of the system's staff radiologists providing teleradiology services were appropriately credentialed and privileged at the providing site.

[10] VA Roseburg Healthcare System, MCM1523, *Radiology General Policy, June 2011*.
[11] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This VHA Directive expired June 30, 2015, and has not been updated.
[12] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[13] VHA Memorandum, *Credentialing and Privileging of Telemedicine Practitioners in VHA*, September 16, 2010.

Conclusions

We substantiated the allegation that the reading of teleradiology studies for Anchorage patients occurred prior to both sites signing an MOU. This occurred because the system's teleradiologists performed under the assumption that the MOU had been signed. In November 2014, VISN 20 implemented an MOU for Radiology Interpretation which standardized MOUs between all sites including Anchorage.

We did not substantiate that delays in radiologic readings occurred for Roseburg patients as a result of providing teleradiology services to Anchorage and Walla Walla. We found no evidence of delays in interpretation of results for Roseburg patients who received diagnostic radiology care during the time in which the system provided teleradiology services to Walla Walla and Anchorage. In addition, we did not find evidence of quality of care issues or receive reports of specific patient harm related to the provision of teleradiology services.

We substantiated that the system lacked an integrated peer review process for radiology. The system's Radiology Service level peer review program was not an integrated part of the system's overall peer review program for quality management. This could hinder the system's ability to detect misinterpretations of radiologic studies, if they occurred.

We did not substantiate that the system improperly credentialed and privileged teleradiology providers. All four of the system's staff radiologists providing teleradiology services were appropriately credentialed and privileged.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director conduct a quality review of the imaging study interpretations completed during the time of the unsigned Memorandum of Understanding referenced in this report.

2. We recommended that the System Director strengthen processes to ensure the Radiology Services is fully integrated into the system's formal peer review program.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 21, 2016

From: Acting Director, VA Northwest Health Network Director (10N20)

Subj: Healthcare Inspection—Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to review and concur with the report: Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon.

2. If you have any additional concerns or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Michael J. Murphy

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 Veterans Integrated Service Network Director conduct a quality review of the imaging study interpretations completed during the time of the unsigned Memorandum of Understanding referenced in this report.

Concur

Target date for completion: Completed

Facility response: Between June 2014 and October 2014, Radiology studies originating at the Anchorage VA were read via Teleradiology by other VISN20 facilities. This was an emergent situation. Teleradiology MOUs were being circulated across the VISN and were already signed by all VISN20 facilities except the Anchorage VA and the Roseburg VA by the end of July 2014. A total of 283 Radiology examinations were read by three Radiologists at two VISN20 facilities, Roseburg VA and Southern Oregon Rehabilitation Center and Clinics in White City. A total of 45 Radiology study interpretations will be reviewed for accuracy of the interpretations, 15 for each Radiologist who read studies for the Anchorage VA during this time period.

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: January 19, 2016

From: Director, VA Roseburg Healthcare System (653/00)

Subj: Healthcare Inspection—Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

To: Director, VA Northwest Health Network Director (10N20)

1. On behalf of the VA Roseburg Healthcare System, Roseburg, Oregon, I would like to provide a status update to the findings from the Teleradiology Concerns VA Roseburg Healthcare System Roseburg, Oregon.

2. Please feel free to contact us if you have any concerns or questions regarding the information included in our responses.

(original signed by:)
Douglas V. Paxton, Sr., MSW
Director, VA Roseburg Healthcare System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. We recommended that the System Director strengthen processes to ensure the Radiology Services Department is fully integrated into the system's formal peer review program.

Concur

Target date for completion: Completed

Facility response: Radiology Service is fully integrated into the system's formal protected peer review program. Any case referred for protected (formal) peer review includes a review of all providers involved in the case, including Radiologists. Protected peer review statistics for Roseburg Radiologists during FY15 are:

Number of Radiology protected peer reviews in FY15 = 2. One of these cases was referred to the National Teleradiology Program for a protected peer review. The outcome for both protected peer reviews [Information protected by 38 U.S.C. § 5705].

"Peer reviews" are also done for the purposes of Focused Professional Performance Evaluation (FPPE) and Ongoing Professional Performance Evaluation (OPPE). These are unprotected peer reviews for the purpose of performance evaluation and are reviewed and approved at the Service Chief level or by the Chief of Staff for Service Chiefs. If an issue were to be identified during these processes the case would be forwarded to the facility's Peer Review Committee for a formal protected peer review. The FPPE and OPPE processes are separate processes and are not intended to be "fully integrated" with the formal protected peer review process that is done by the facility's Peer Review Committee.

Appendix C

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 D

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