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VETERANS HEALTH ADMINISTRATION

Health Information
Management Medical
Documentation Backlog

AUDIT

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Executive Summary

VA healthcare staff rely on medical records to manage veterans' care. Since the Veterans Access, Choice and Accountability Act passed in August 2014, more than 70 million appointments with non-VA providers have been completed, generating at least as many medical documents.¹ Non-VA providers send medical documents to VA medical facilities for staff to scan or import into patients' electronic health records (EHRs), which helps ensure continuity of care by healthcare providers. Incorporating these non-VA medical documents into the patients' EHRs is critical to supporting patient care because it contributes to more complete, accurate, and readily accessible health records that guide clinicians' decisions.

An August 2017 site assessment summary by Cerner Corporation consultants and a VA team outlined VA staff concerns with document scanning backlogs.² In June 2018, the President signed the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, expanding opportunities for community care for veterans from non-VA providers. The MISSION Act has the potential to significantly increase the volume of documentation VA medical facilities will receive from outside providers for scanning, as well as any related backlog.

The VA Office of Inspector General (OIG) performed this audit to determine if Veterans Health Administration (VHA) medical facilities are scanning and entering medical documentation into patients' EHRs accurately and in a timely manner.

What the OIG Found

Significant medical documentation backlogs have occurred VHA-wide in part because VA medical facility staff did not scan documentation and enter electronic medical records into patients' EHRs in a timely manner. Based on data provided by the eight facilities visited and the 78 facilities interviewed, the audit team calculated that as of July 19, 2018, VA medical facilities had a cumulative medical documentation backlog of paper documentation that measured approximately 5.15 miles high and contained at least 597,000 individual electronic document files dating back to October 2016. The OIG team also found when medical facility staff scan medical documentation, they are not always performing the appropriate reviews and monitoring

¹ The Veterans Access, Choice and Accountability Act was intended to expand veterans' access to community care. The audit team utilized the VHA Support Service Center (VSSC) Non-VA Care cube to calculate the number of appointments with non-VA providers.

² In May 2018, VA signed a contract with the Cerner Corporation to modernize the VA's healthcare IT system and help provide seamless care to veterans as they transition from military service to veteran status, and when they choose to use community care. A Cerner consulting team and VA subject matter experts conducted site assessments with the intent of getting a broad look at the current state of systems, applications, integration points, reporting, and workflows being utilized at VHA facilities.

to assess the overall quality and legibility of the scanned documents. According to some VHA staff and a recent Comprehensive Healthcare Inspection Program Review published by the OIG Office of Healthcare Inspections, these issues put patients' continuity of care at risk because the lack of current medical documentation makes it challenging to ensure they receive accurate diagnoses and timely quality care.³

VHA needs to improve the management of scanning activities—including importing, indexing, and legibility checks—and ensure related resources and staffing are adequate. These steps would facilitate medical records being scanned and indexed to EHRs in a timely manner and support appropriate quality assurance monitoring throughout the scanning process. In addition, VHA needs to establish and implement an adequate training program for personnel performing scanning and indexing roles within medical facilities. These actions are necessary to help ensure veterans receive appropriately informed quality care in a timely manner.

Limited Monitoring and Oversight Contributed to Backlogs

The audit team found that VHA supervision and monitoring were limited for overseeing scanning activities and medical record backlogs at its medical facilities. VHA's Health Information Management (HIM) staff conduct an annual inventory requesting status details of facility HIM operations to determine future training needs and to identify medical facilities needing technical assistance.⁴ However, specific backlog details such as descriptions of the documents, size of the backlog, and age of unscanned records are not consistently addressed as part of this inventory, according to HIM leaders and VA medical facility staff. In addition, the OIG found HIM leaders do not use the annual inventory results to advise facility leaders on how to resolve or prevent backlogs. The HIM office's primary role in medical document scanning is creating policy. VHA facility directors are the designated authorities for enforcing that policy.

According to VHA Handbook 1907.07, VHA facility directors are responsible for developing and monitoring processes to ensure all health record filing and scanning duties are completed in a timely manner.⁵ In addition, facility directors are responsible for ensuring someone knowledgeable about health record file room management and scanning activities supervises these activities. However, during audit team site visits, neither the chiefs of HIM nor their

³ VA OIG Report, *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center*, Report Number 17-01757-50, published on January 28, 2019, states that "VHA requires timely filing or scanning of reports into patients' EHRs. The OIG found that 1,550 inches of paper patient reports dating back to 2014 had not been scanned into the EHR system. This prevented healthcare providers from accessing patient results to perform a comprehensive evaluation of the patients' healthcare needs and provide timely quality care."

⁴ HIM staff can be found at both the national program level as well as at the facility level.

⁵ VHA Handbook 1907.07, Management of Health Records File Room and Scanning, May 12, 2016.

designees responsible for supervising scanning activities always had direct knowledge of the scanning processes and backlog information within their facilities.⁶

Staffing shortages also were a factor in medical documentation backlogs. Facility directors are responsible for establishing policies and processes to ensure all duties associated with health record scanning are done in a timely manner, including that qualified and trained individuals work in health record file room and scanning departments. Staffing levels should be proportional to the volume of scanning to be completed; however, staffing levels and productivity standards varied significantly among the facilities reviewed, even between facilities with comparable veteran populations, demonstrating that VHA facility directors are not consistently assessing staffing needs based on scanning demand.

In response to this audit, the Office of the Acting Deputy Under Secretary for Health for Operations and Management issued a memo dated February 12, 2019, directing medical facilities with scanning backlogs to allocate the necessary additional resources to eliminate the backlogs. The memorandum requires VISN directors with active backlogs to implement action plans to include (1) using blanket purchase agreements, if available, or other contracting mechanisms; (2) shifting resources to assist those facilities with a significant backlog; and (3) authorizing compensatory time and overtime to staff who volunteer to assist. The memo also directs that technological issues affecting scanning productivity be addressed promptly.

Quality Assurance and Training Requirements Were Not Met

The chiefs of HIM at seven of eight medical facilities visited did not ensure compliance with mandatory quality assurance reviews after staff scanned medical records and indexed them to the EHRs. Facility site visits revealed that quality assurance monitoring by chiefs of HIM or their designees varied significantly. Quality assurance monitoring practices ranged from reviewing 0 percent of all scanned and indexed records at one facility to 100 percent at another facility.

Furthermore, staff at the eight VA medical facilities visited would scan, index, and place documentation in shred receptacles. The shred receptacles were emptied daily, weekly, or monthly without ensuring this documentation was available for quality assurance reviews that would identify and correct any errors.

The VHA medical facility chiefs of HIM or their designees did not establish or maintain training requirements to make certain medical facility staff had adequate instruction. The audit team found the eight medical facilities visited did not consistently follow training policy. In addition, chiefs of HIM at six of eight medical facilities did not train staff who conducted scanning duties

⁶ VHA Handbook 1907.07 states that facility directors may designate any individual to supervise health record file room and scanning activities as long as they are a qualified professional who is well-versed in all aspects of health record file room management and scanning activities. The handbook further states that the chief of HIM or other designee is preferred.

outside of the HIM department—such as staff assigned to other departments or offices—to ensure uniform scanning standards.

What the OIG Recommended

The OIG made nine recommendations to the executive in charge for VHA to address HIM Medical Document Scanning Program deficiencies in three key areas:⁷

- Define and promptly reduce backlogs
- Assess staffing resources to account for scanning demand
- Develop monitoring roles, controls, and procedures

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with Recommendations 1–9 and submitted acceptable corrective action plans for all recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified.



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⁷ The executive in charge has the authority to perform the functions and duties of the Under Secretary for Health.

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Abbreviations

EHR	electronic health record
FTE	full-time equivalent
FY	fiscal year
HCS	Health Care System
HIM	Health Information Management
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
OCC	Office of Community Care
OIG	Office of Inspector General
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Information Systems and Technology Architecture



Introduction

The objective of this audit was to determine if Veterans Health Administration (VHA) medical facilities are scanning and entering medical documentation into patients' electronic health records (EHRs) in a timely and accurate manner. The OIG audit team used the *HIM Annual Inventory* definition of a backlog as the standard for timeliness: any document not scanned within five days of receipt. The OIG used facility-reported quality assurance results, including error rates and common errors, as the measure for accuracy.

Medical document scanning activities are important for providing complete, accurate, clinically pertinent, and readily accessible health records to support patient care. Medical document scanning is a multistep process that begins when a medical facility receives documentation from another facility, the patient, or a community care provider. Medical documentation can be received electronically, such as by fax or email provided by third-party administrators for the Veteran's Choice program, or in paper format, such as documents mailed to the facility or hand-delivered by the veteran.⁸

A mailed or hand-delivered document requires scanning to incorporate into a patient's EHR. Scanning the document converts it from paper to an electronic version to both upload and index to the patient's EHR in VHA's Computerized Patient Records System. Indexing is the process of categorizing medical or administrative records by document or image type, specialty, procedure or event, and image description. Images must be indexed to the correct location in the EHR. Both paper and electronic formats require a check for quality and visibility. For example, these checks can determine if there are the correct number of pages, the document is positioned well, and whether it includes proper patient demographic information.

An August 2017 site assessment summary conducted by Cerner Corporation consultants and a VA team communicated key findings identified because of VHA facility site assessments.⁹ The site assessment outlined VA staff concerns with medical document backlogs, and the time required for a report or image to be associated with the veterans' EHR in Veterans Information Systems and Technology Architecture (VistA) Imaging. Those concerns take on even greater importance as access to community care is being expanded. In June 2018, the President signed the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, increasing access to veterans' care from non-VA providers. The MISSION Act has the potential to significantly increase the level of documentation VA medical facilities will receive from outside providers for scanning, as well as any related backlog.

⁸ This practice was confirmed by a scanning coordinator interviewed by the OIG audit team.

⁹ In May 2018, VA signed a contract with the Cerner Corporation to modernize the VA's health care IT system and help provide seamless care to veterans as they transition from military service to veteran status, and when they choose to use community care.

Health Information Management Requirements

The chief of Health Information Management (HIM) at a medical facility is responsible for the administrative management of health records, which includes planning, managing, advising, and directing the health information management program. HIM file room and scanning section staff at a facility provide customer service to health record users by retrieving and delivering health records that meet all applicable federal laws, rules, and regulations, as well as Joint Commission standards for the provision of health records.¹⁰

According to VHA Handbook 1907.01, *Health Information Management and Health Records*

Under Title 44 United States Code (U.S.C.) 3102(1), VHA, by statute, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements.

The health record must use standard content, creation, maintenance, management, processing, and expected quality measures. Healthcare practitioners and other authorized users must use electronic capture and storage of protected health information to improve access to patient data. Electronically stored and printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

VHA Handbook 1907.07 also requires each facility file room and scanning section to establish a quality assurance monitoring process. This process should include randomly selecting a quantity of indexed documents to be checked by an appointed quality assurance staff member.¹¹ Everyone who scans documentation must be monitored at least quarterly to ensure compliance with scanning requirements. The quality assurance monitoring process is necessary because medical documentation uploaded into EHRs may only be destroyed after data entry has been verified.

Office of Community Care Documentation

A December 12, 2016, memorandum of understanding between VHA's Office of Community Care (OCC) and all VA medical facilities and Veterans Integrated Service Networks (VISNs) directed compliance with H.R. 3230, *Veterans Access, Choice and Accountability Act of 2014*. The memo outlines procedures that allow OCC staff to receive, scan, and index medical documentation outside of the HIM department.¹² OCC receives the incoming documentation,

¹⁰ The Joint Commission, an independent not-for-profit organization, accredits and certifies nearly 21,000 healthcare organizations and programs in the United States.

¹¹ VHA Handbook 1907.07.

¹² OCC, the term used in this report, was also referred to by different names at facilities, such as Care in the Community or Non-VA Community Care.

reviews it, designates the appropriate consult (referral request) or non-VA hospitalization note to which it should be attached, and writes a summary note. OCC has the option to either send the medical document to HIM, where it will be scanned, imported, and indexed to the appropriate episode of care, or scan, import, and index the documentation directly to the appropriate episode of care in the patient's EHR.¹³ Responsibility for scanning, importing, and indexing OCC clinical records is a local facility decision and must be documented in facility policy.

¹³ At this step, medical documents may be either paper or electronic files.

Results and Recommendations

Finding 1: Medical Documents Were Not Entered into Patients' Health Records in a Timely Manner

VA medical facility staff did not scan paper documents and enter electronic information into patients' EHRs promptly, which created significant medical record backlogs. The national *HIM Annual Inventory*, completed December 2017, showed that 73 of the 140 medical facilities surveyed (52 percent) reported a medical documentation scanning backlog. From January through July 2018, the audit team visited eight VA medical facilities and interviewed staff at 78 other medical facilities. The OIG found that, as of July 19, 2018, these 86 facilities had a cumulative medical documentation backlog of paper documentation approximately 5.15 miles high and contained at least 597,121 individual electronic files.¹⁴ These totals do not include facilities that lacked quantifiable measures for their backlogs (i.e., those without paper document or electronic file calculations, such as facilities that only noted the age of the oldest document without calculating quantity).¹⁵

These backlogs occurred in part because facility directors did not ensure proper supervision or management of facility scanning activities, including not making sure resources were available to meet scanning demand. Furthermore, VHA and VISNs lacked mechanisms to ensure facility directors were properly managing and supervising the scanning and indexing of medical records. If medical facilities do not strengthen controls to scan and index medical records in a timely manner, patient care could be delayed or medical decisions could be based on incomplete documentation. In addition, care providers or administrative staff could spend time searching for necessary medical documents that were not indexed to the EHRs.

What the Audit Team Did

The team conducted site visits to eight VA medical facilities—four facilities that reported having a medical documentation backlog and four that reported having no backlog. While on site, the audit team observed scanning procedures and interviewed facility leaders and staff. The audit team also interviewed staff by phone or email at an additional 68 medical facilities that reported having a backlog in the *2017 HIM Annual Inventory* and an additional 10 facilities that reported having no backlog. In total, the OIG visited or interviewed 86 of the 140 facilities surveyed in

¹⁴ The cumulative medical documentation backlog was calculated using self-reported facility backlog information during eight site visits and from telephone and/or email interviews of 78 facilities. The 5.15 miles was self-reported and compiled in inches of paper backlog and converted to feet and then to miles. The electronic backlog of at least 597,121 was self-reported as measured per electronic file.

¹⁵ Details about the self-reported backlogs are available in Appendix C.

the *2017 HIM Annual Inventory*.¹⁶ For more information on the scope and methodology of the audit, see Appendix A.

This finding discusses the following issues:

- Facilities' medical document backlogs have been significant.
- VHA lacked oversight of medical document scanning.
- VA medical facilities inadequately managed medical documents.
- Facilities struggled with HIM vacancies and had varying authorized staffing levels.

Facilities' Medical Documentation Backlogs Have Been Significant

According to the director of VHA's Health Information Management Program Office, VHA medical facilities have received the *HIM Annual Inventory* survey for the last 20 years.¹⁷ Among its questions, the survey sometimes asks facilities to report on items such as scanning productivity, medical record backlogs, and planned actions to correct backlogs.¹⁸ The director said information from the survey is used to develop training to assist facilities in writing standard operating procedures and corrective action plans for reducing reported backlogs. However, responding to this survey is not mandatory. The questions related to backlogs were asked in only three out of the last six surveys, and facility respondents did not always answer the questions when they were asked. The December *2017 HIM Annual Inventory* received a 100 percent response, according to a HIM specialist with the Office of Health Informatics who reports to the director.

The 2017 inventory defined a medical documentation backlog as any records "pending scanning greater than five days after receipt by scanning staff." Seventy-three of the 140 medical facilities (52 percent) reported a medical documentation backlog in that survey.

During site visits, the audit team found paper and electronic forms of medical documentation that had not been scanned or indexed at four of the eight medical facilities visited. The backlog totaled approximately 1,219 inches of paper documents and an additional 47,248 electronic files. The age of medical records awaiting scanning varied significantly by facility—some facilities had medical records awaiting scanning that were less than a year old, while one facility had records dating as far back as October 2016.

¹⁶ The San Juan, Puerto Rico, facility, which reported having a backlog on the *2017 HIM Annual Inventory*, was omitted as a potential site due to hurricane damage and recovery during the information collection period. This omission then reduced the facilities available to be visited or interviewed from 140 to 139.

¹⁷ The audit team was only able to substantiate the HIM Annual Inventory being conducted since 2012.

¹⁸ The Office of Health Information Management's primary role for medical document scanning is policy creation. VHA facility directors are the designated authorities for enforcing the policy.

To supplement the site visits, the audit team interviewed staff by phone or email at the remaining 68 facilities that reported a backlog on the *HIM Annual Inventory*. Staff from all 68 facilities responded. Fifty-nine facilities reported combined backlogs of either paper or electronic files that measured 5.12 miles high and approximately 517,487 electronic files.¹⁹ Site-specific results are shown in Appendix C.

Sixty-three facilities reported not having a backlog on the *2017 HIM Annual Inventory*, and the audit team interviewed staff at 10 of them by phone or email. Of those 10, eight facilities reported no backlog, while two facilities reported current backlogs.

VHA Lacked Oversight of Medical Documentation Scanning

Chiefs of HIM and scanning supervisors at five medical facilities said no individual or office outside their medical facility routinely monitored scanning operations and backlogs. VHA's HIM Program Office director said the *HIM Annual Inventory* was the only time information about scanning backlogs was reported or captured. However, the director also said backlog specifics were not required on the inventory.

Furthermore, the *HIM Annual Inventory* does not include a description of the documents, size of the backlog, and age of unscanned materials. HIM leaders stated they use the reported information to train facility management and to write standard operating procedures and corrective action plans for reducing reported backlogs. However, HIM leaders acknowledged that they do not direct facility leaders to take corrective actions based on the results of the *HIM Annual Inventory*, nor are they authorized to do so.

The *HIM Annual Inventory* does not specify whether facilities should include backlogged documents from the OCC section in backlog measurements reported in response to the survey when local policy allows separation of scanning and indexing duties. However, during site visits and interviews, the audit team specifically requested each facility to include all HIM and OCC backlogged medical records in their responses, to fully capture the scope of scanning backlogs. The audit team found one instance in which a facility that separated HIM and OCC scanning duties had previously reported having no medical document backlog, when in fact the HIM staff member who responded to the inventory did not take into consideration that a backlog might exist in the OCC section. Once specifically asked for backlog totals including OCC documents, the facility's HIM chief reported a backlog of 26,786 electronic documents.

¹⁹ The approximate measurement of paper documents and number of electronic documents is a result of multiple facilities reporting estimated and unknown quantities of backlog. For example, one facility interviewed was unable to accurately determine its number of unscanned electronic files, so the facility provided an estimated range. Other facilities measured their backlogs by date only and did not physically measure their backlogged documents and so were excluded from the total. While the audit team did not include the facility's reported high-end range in the total, the audit team calculated the overall electronic backlog could be as high as 1,080,278 files.

VHA's HIM leaders said they provide guidance in the form of practice briefs, fact sheets, or "fireside chats" to medical facility HIM leaders.²⁰ This guidance is intended to provide potential solutions to track, monitor, define, and fix backlogs. The guidance is not distributed through official publication channels; therefore, it is not consistently implemented by medical facility directors. VHA policy lacks an official definition for medical document backlogs, although a suggested standard of scanning and indexing documents within five days of receipt is referenced in both the *2017 HIM Annual Inventory* and the *Fact Sheet, VistA Imaging Capture Indexing Reference Guide* released in May 2017. VHA's HIM leaders stated there is no policy in place that defines a backlog or makes the Office of Health Information Management responsible for holding facility directors accountable. During a project status update to the VHA HIM office in February 2019, the program office notified the OIG audit team that VHA is pursuing revisions to formalize the guidance and distribute it through official publication channels. The OIG team acknowledges this will aid in consistent implementation of policy by facility directors.

VHA has used the *HIM Annual Inventory* to capture some information about backlogs, but it has done so inconsistently. Without consistent data, VHA has been unable to provide effective policy guidance to medical facilities. If VHA standardized backlog data by defining what constitutes a medical documentation backlog—specifically the age of unscanned and unindexed medical documentation—it would be positioned to provide more effective guidance on keeping EHRs updated.

After the OIG audit team provided a project status update to the VHA HIM office in February 2019, the staff provided the team with results from the *2018 HIM Annual Inventory*. With a 100 percent completion rate, results of the inventory showed that 85 of 140 facilities (61 percent) reported a medical documentation scanning backlog. That is an increase of 12 facilities with a backlog, exceeding what was reported in the *2017 HIM Annual Inventory*. These results underscore the need for VHA to prioritize oversight of medical documentation scanning to ensure EHRs are updated in a timely manner.

As a result of this audit, VHA provided the OIG audit team with a memo dated February 12, 2019, from the Office of the Acting Deputy Under Secretary for Health for Operations and Management directing VISNs and medical facilities with scanning backlogs to allocate the necessary additional resources to ensure scanning backlog elimination. The memo requires VISN directors with active backlogs to implement action plans including (1) using blanket purchase agreements, if available, or other contracting mechanisms; (2) shifting resources to assist those facilities with a significant backlog; and (3) authorizing

²⁰ Fireside chats are employed to provide training and guidance to local HIM chiefs, who are also responsible for inviting the appropriate staff based on the topic (e.g., the coding staff attending any coding-related training). The topics can be derived from questions regarding practice briefs, fact sheets, and other guidance.

compensatory time and overtime to staff who volunteer to assist. The memo also directs that technological issues impacting scanning productivity be addressed promptly.

VA Medical Facilities Inadequately Managed Documentation

VHA relies on local HIM chiefs to adequately manage prompt EHR updates, including notifying medical facility directors when document backlogs exist. Medical facility directors, in turn, must take appropriate actions when significant or increasing volumes of unscanned medical documentation are identified. Facility directors also should ensure VISN and VHA leaders are made aware of the issues.

VHA policy establishes standards for HIM chiefs to ensure all duties associated with EHR scanning and indexing are done in a timely manner.²¹ Each VA medical facility the audit team visited had an approved facility policy for scanning medical records. However, the team observed instances in which HIM chiefs at facilities reporting a backlog did not always properly manage scanning and indexing activities to prevent medical documents from becoming backlogged or to eliminate existing backlogs:

- During a VA medical facility site visit the week of January 22, 2018, the facility’s scanning unit supervisor stated there was a paper scanning backlog of 944 stacked inches (79 feet) dating back to at least October 2016. Because this facility grouped and stored records based on the last two digits of patients’ social security numbers, the scanning unit supervisor was unable to determine the exact date of the oldest record included in the backlog without reviewing each individual stack within the scanning room’s storage area. Although the scanning unit supervisor prepared and sent weekly reports on the status of the medical documentation backlog to the facility’s chief business officer, no other actions were taken to reduce the scanning backlog.
- One acting HIM chief was not aware that there was a medical documentation backlog until the audit team visited during the week of March 12, 2018. When notified of the audit team’s visit, the acting chief visited the scanning room to learn that the facility had a medical documentation backlog of approximately 13,600 electronic records dating back to November 2017. The acting chief’s lack of awareness caused the facility to erroneously report not having a backlog on the *2017 HIM Annual Inventory*.
- During the audit team’s site visit the week of January 8, 2018, one medical facility had a backlog of approximately 1,600 emergency room and inpatient scanned medical records stored on a shared drive and 915 additional electronic records on a “Non-VA Care” provider portal. The facility’s chief of Health Administration Services had instructed the

²¹ VHA Handbook 1907.07.

HIM chief to prioritize specialty care records on the portal over the 1,600 emergency room and inpatient records because the emergency room and inpatient records were potentially too large for the scanning software to handle.²² The HIM chief acknowledged that the last time staff scanned the emergency room and inpatient records was in early December 2017.

Facilities Struggled with HIM Vacancies and Had Varying Authorized Staffing Levels

During the site visits and interviews, the audit team found that scanning supervision and other positions were not adequately staffed. According to VHA Handbook 1907.07, health record file room and scanning activities must be supervised by an individual knowledgeable in all aspects of health record file room management and scanning activities—preferably the chief of HIM or a designee. This handbook also states that scanning departments must be staffed with qualified and trained personnel, and that staffing needs must be assessed in relation to the volume of scanning to be completed.

Of the 78 facilities where the audit team interviewed staff remotely, 57 had staff who reported personnel shortages or turnover as a cause of their backlog. Some facility managers were actively trying to fill vacant positions, but one HIM chief told the audit team that facility leaders were hesitant to approve backfilling the positions and that the hesitation directly contributed to scanning delays. According to the same facility's chief of human resources, the facility had adopted a full-time equivalent (FTE) ceiling as the result of VISN budget concerns, which forced service-line chiefs to request approval to fill vacant positions through a monthly resource committee. The HIM chief said this competition for FTEs limited the ability to fill scanning positions because the committee prioritized healthcare providers and other direct patient care positions. At the time of the audit team's visit, the facility had stopped using the resource committee process and the HIM chief reported being able to successfully fill vacancies.

One of the facilities had a chief of HIM position that had been vacant for more than a year, with an acting chief in place for the duration of the vacancy. During interviews regarding this facility's scanning practices, the audit team found the acting chief's awareness of scanning operations was very limited—including being unaware of the significant backlog within the facility.

In addition to staffing shortages, staff at facilities reported wide disparities in authorized staffing levels, even between facilities with comparable veteran populations. One facility that provides services to more than 44,000 veterans was authorized 14 staff, while another serving almost 46,000 veterans was authorized only three.

²² The facility deemed electronic files were too large for the DocManager software to handle properly.

Finally, productivity standards for scanning staff also varied widely, ranging from 50 to 180 scans expected per person, per day, depending on the type of documents scanned. While VHA Handbook 1907.07 establishes daily minimum scanning standards, it allows facilities flexibility in setting local standards. Specifically, the handbook states that higher standards may be set by a HIM manager or scanning supervisor and that productivity and accuracy standards must be negotiated with local union representatives. Two facilities the audit team visited maintained the standards from the handbook, while the remaining six used different ranges. Because of the different scanning productivity expectations, the scanning productivity achieved by each site was also wide-ranging. The audit team reviewed local facility-approved productivity standards, authorized versus actual FTE, and fiscal year (FY) 2017 scanning workload and found a significant disparity among facilities in terms of workload, staffing, and productivity.

Conclusion

VA medical facility staff did not consistently scan and enter medical documents into patients' EHRs in a timely manner, resulting in significant backlogs. Facility directors did not ensure adequate oversight or resources to support the mission of medical document scanning and indexing for quality patient care. Inaccurate EHRs put patients at risk and compromise continuity of care because accurate medical diagnoses and treatment depend on complete and current documentation. VHA needs to improve supervision and management of scanning activities to ensure medical documents are indexed to patients' EHRs in a timely manner. This will help ensure veterans receive appropriate, thorough, and timely care.

Recommendations 1–6

The OIG recommended the Under Secretary for Health conducts the following:²³

1. Establish a policy that formally defines “medical document backlog”—specifically, the age of unscanned and unindexed medical documentation.
2. Implement formal controls to monitor medical document backlogs—specifically, the description of unscanned and unindexed documents, size of the backlog, and age of health records—as well as subsequent actions to reduce the backlogs.
3. Direct Veterans Integrated Service Networks and facilities with a backlog to allocate additional resources to help clear them.
4. Implement policy to require chiefs of Health Information Management to notify facility directors when a medical document backlog exists and to take appropriate action.

²³ The executive in charge has the authority to perform the functions and duties of the Under Secretary for Health.

5. Assess the scanning process, including staffing and productivity levels, within each facility to ensure authorized staffing levels can support future workload.
6. Ensure facility directors act on staffing level assessments and obtain the necessary resources within scanning departments.

Management Comments

The executive in charge, Office of the Under Secretary for Health, acknowledges the importance of incorporating medical record documents into the patients' EHRs. This critical step supports patient care by ensuring complete, accurate, and readily accessible health records that guide clinicians' decisions. The executive in charge concurred with Recommendations 1–6 and provided corrective action plans with anticipated implementation by July 2020.

In response to Recommendation 1, the executive in charge stated that the HIM Program Office is establishing policy that formally defines “medical documentation backlog”—specifically, the age of unscanned and unindexed medical documentation.

For Recommendation 2, the executive in charge stated that the HIM Program Office implemented formal controls during calendar year 2019 to monitor medical documentation backlogs, as well as subsequent actions taken to reduce backlogs.

For Recommendation 3, the executive in charge stated that on February 12, 2019, the Office of the Deputy Under Secretary for Health for Operations and Management directed VISNs and medical facilities with scanning backlogs to allocate the necessary additional resources to ensure scanning backlog elimination. He further stated that VHA will host a Scanning Backlog Stand-Down in July 2019 where facilities will focus on reduction and elimination of scanning backlogs.

For Recommendation 4, the executive in charge stated the HIM Program Office will formalize policy to require chiefs of HIM notify medical facility directors through their established chain of command when a medical documentation backlog exists and take appropriate actions.

For Recommendation 5, the executive in charge stated the HIM Program Office will analyze scanning workload and develop a staffing model to ensure appropriate staffing levels to support future workload.

For Recommendation 6, the executive in charge stated the HIM Program Office will analyze scanning workload and develop a staffing model to ensure appropriate staffing levels to support future workload. He further stated that chiefs of HIM will perform a staffing analysis and notify medical facility directors of staffing level deficiencies, and the HIM Program Office will continue to monitor medical facility action plans and address deficiencies with VISN points of contact for resolution.

OIG Response

The executive in charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified.

The executive in charge stated VHA completed actions to address Recommendation 2. The OIG audit team acknowledges VHA has implemented formal controls to monitor medical documentation backlogs—specifically the description of unscanned and unindexed documents, size of the backlog, and age of health records—as well as subsequent actions taken to reduce the backlogs. Prior to closing this recommendation, the OIG requests that VHA provides evidence that supports substantial, sustained improvement in the reduction of medical documentation backlogs. The OIG audit team addressed other concerns made by the executive in charge throughout the report. The full text of the responses from the executive in charge are in Appendix E.

The executive in charge also provided technical comments related to this finding, which are included in Appendix E and suggest that the information provided is anecdotal, not comprehensive, and not subject to HIM subject matter expert review. The OIG carefully considered these comments, but did not remove Footnote 1 that references the Cerner consulting team and VA subject matter experts conducting site assessments. The results of the site assessments were pertinent to the audit and the intent of the assessments was to get a broad look at the current state of systems, applications, integration points, reporting, and workflows at VHA facilities prior to contract finalization. Due to changes in this final report, Footnote 1 is now Footnote 2 in the executive summary and Footnote 8 in the main text.

Finding 2: Required Quality Assurance Monitoring and Training Were Not Adequate

Local HIM chiefs did not ensure staff complied with local policy and VHA Handbook 1907.07 quality assurance requirements for the medical records that were scanned or indexed at seven of eight sites visited (88 percent). The audit team observed wide-ranging quality assurance monitoring practices at the facilities visited, including one facility that reviewed 100 percent of scanned medical records and another facility that did not review any of its overall scanned workload. In addition, facilities visited did not have consistent training plans. The OIG found widely disparate training practices:

- Scanning staff reported receiving on-the-job training lasting from one to 30 days as the primary training method across the eight facilities.
- Training ranged from completing extensive, supervised training to being “thrown in” and learning on the job.

Beyond not meeting the VHA Handbook requirement to assess the quality of documents scanned, facilities failed to meet their own local standards for quality assurance monitoring (or set their standards so low as to limit the effectiveness of the monitoring process). As a result, there was a greater risk that scanned and indexed medical documents were incomplete, illegible, or possibly associated with the wrong EHR or episode of care. This can waste care providers’ time as they must track down the correct medical documentation. Without updated EHR documents, VHA also has little assurance that its care providers are treating veterans based on the most current and accurate information. According to some VHA staff and a recent Comprehensive Healthcare Inspection Program Review published by the OIG Office of Healthcare Inspections, these issues put patients’ continuity of care at risk because the lack of current medical documentation makes it challenging to ensure veterans receive accurate diagnoses and timely quality care. Additionally, if medical documents are scanned into the wrong patient files, this could result in unauthorized disclosure of personally identifiable information and protected health information.

What the Audit Team Did

During site visits to the eight VA medical facilities, the team compared the facilities’ policies and procedures to VHA Handbook 1907.07. While on site, the audit team interviewed quality assurance staff and observed scanning quality assurance monitoring and procedures. The audit team also interviewed facility staff and leaders on medical record scanning training procedures.

In this finding the following issues are discussed:

- Failures by scanning staff to comply with quality assurance procedures

- Inadequate training for scanning staff

Scanning Staff Did Not Comply with VHA Quality Assurance Procedures

At the VA medical facilities visited, scanning and indexing procedures were similar. However, the audit team observed, and scanning staff agreed, that facility staff did not always perform required first- and second-line quality reviews. VHA Handbook 1907.07 states

Documents are to be scanned and reviewed for quality by the person scanning. During the first quality check, the image will be checked for the overall quality and visibility of the document. The person scanning will be responsible for reviewing each image, to make sure that the demographic information is correct on every page, the image is positioned as correctly as possible, and that all pages of documents have been captured in VistA Imaging, which may include blank pages when applicable. The second quality check of the scanned document must be verified by logging into VistA Imaging Display. The responsible person scanning the document will perform both processes. These checks will be performed by the person responsible for scanning the document and will be performed on 100 percent of the documents scanned.

The audit team found that scanning staff at seven of the eight facilities visited were not aware of first-line quality reviews, and subsequently did not perform them. In addition, the audit team observed that scanning staff infrequently reviewed scanned images in VistA Imaging Display to ensure that the documents were attached to the appropriate veteran's record and linked to the correct consult or progress note in the Computerized Patient Records System. Staff often only looked to ensure a digital thumbnail was present to signify that a file had been associated.²⁴

Noncompliance with Local Quality Assurance Monitoring

The audit team found that VA medical facilities did not always perform quality assurance monitoring consistent with their own local policies. The team also found that one facility's quality assurance monitoring was not consistent with VHA policy. VHA Handbook 1907.07 states a "Quality Assurance Monitor must be performed to assess the quality of documents scanned. To determine which patients are selected for the monitor, the chief of HIM, and/or designee, picks a random sample of scanned documents."²⁵ The handbook further states that this type of oversight should be performed for all scanning staff at least quarterly, with frequency determined by the facility. The audit team reviewed local quality assurance policies for HIM

²⁴ A digital thumbnail is a small graphic representation of a larger image associated with a progress note in the veteran's medical record in the Computerized Patient Records System.

²⁵ A Quality Assurance Monitor is a review process to assess the quality of documents scanned.

scanning staff to determine if these policies were consistent with VHA Handbook 1907.07. The audit team also compared these local policies to the quality assurance monitoring being performed for scanning activities.

The team found that quality assurance monitoring for all staff performing scanning duties ranged from no documents reviewed at one facility, to all scanned documents reviewed quarterly at another. While only one facility failed to perform any quality assurance monitoring, and therefore was not meeting the VHA Handbook requirement, other facilities failed to meet their own standards or set their standards low enough to limit the effectiveness of their process:

- One VA medical facility's policy required quality assurance monitoring on 30 percent of all scanned and indexed medical documentation. However, due to an ongoing vacancy within the HIM department, the chief failed to meet local policy and only conducted quality assurance monitoring on five percent of all scanned documents at the facility.
- One VA medical facility's policy only required weekly quality assurance monitoring on 10 randomly selected scanned and indexed documents for each person scanning, regardless of the quantity scanned. Scanning staff at this facility were responsible for scanning at least 100 records per day. Accordingly, reviewing the 10 records per week would only provide monitoring for two percent of a minimally productive full-time staff member's weekly workload. In addition, if scanners identified their own errors prior to completion of the quality assurance monitoring process, those errors would be counted as one of the documents under their quality assurance process and would therefore reduce the percentage of documents selected randomly.

To identify the types of errors found during quality assurance monitoring, the audit team reviewed monitoring reports at each of the eight facilities visited. The team found quality assurance monitoring error rates as low as 0.75 percent and as high as 23 percent for the first quarter of FY 2018. The common error types identified by FY 2018 quality assurance monitoring reports and by the audit team during site visit observations included the following:

- Documents associated with the wrong patient
- Improper indexing of documents to the wrong date
- Documents attached to the wrong note/episode of care
- Improper document orientation
- Duplicate scans—documents already indexed to patient
- Documents missing appropriate care provider signature
- Documents incomplete or missing pages
- Illegible documents

Follow-up actions varied when errors exceeded local quality assurance monitor thresholds, ranging from no action to verbal counseling and retraining. VHA Handbook 1907.07 states

Pertinent results of monitors must be discussed with the individual who performed the scanning. When consistent problems are identified on any of the reviews, focused reviews will be conducted that look at a higher volume of scanned documents. The errors must be investigated to determine the cause, scope, and seriousness and an action plan must be implemented.

Only one facility that the audit team visited had implemented a formal program for improving scanning performance when scanning staff exceeded an error threshold. The following examples reflect inadequate follow-up actions at other sites visited with excessive errors:

- An assistant HIM chief, the designee for quality assurance monitoring at one VA medical facility, was unaware of any policy that addressed the need to conduct follow-up actions when errors exceeded monitoring thresholds. HIM leaders used a spreadsheet to track the number and type of errors staff made but did not take corrective action when consistent errors were identified.
- Chiefs of HIM or their designees at six facilities the audit team visited did not take formal investigative or corrective action (such as retraining) when scanning errors were identified. Instead, errors were usually discussed with all staff during meetings or individually with the responsible staff member.

Inconsistent Destruction of Scanned Medical Documentation

VA Records Control Schedule 10-1 states that hardcopy versions of information manually input into EHR may be destroyed after verification of accurate entry. VHA Handbook 1907.07 further states that source documents may be destroyed only if the source document is indexed and imaged as an exact replica of the original document; quality control processes are in place; and there is assurance that the imaged document is stored, accessible, and retained according to VA and National Archives and Records Administration records retention requirements.²⁶

The audit team observed that VA medical facility staff would scan, index, and place documents in shred boxes or containers to be emptied daily, weekly, or monthly. If the documents are destroyed without adequate quality assurance reviews in place, and without a sufficient monitoring process, there are no means to retrieve them and make corrections. Original documents cannot be reproduced, and duplicates of copies can take excessive time to obtain, if possible. Destroying documents before quality assurance monitoring is completed to ensure

²⁶ Source documents are original documents with wet (i.e., physically marked) or electronic signatures, such as consent forms or patient advance directives, and copies of authenticated documents such as non-VA treatment records.

successful entry into the patients' EHRs could result in care providers' ordering redundant or inappropriate treatment or spending unnecessary time reaching out to community providers to request duplicate copies.

Training Was Inadequate for Scanning Staff

Without adequate staff training, VHA is at risk of missing important information, maintaining EHRs that contain errors and illegible documents, and storing sensitive records in the wrong patient files. Training for scanning staff was inadequate because VHA facility directors did not ensure training requirements were met. VHA Handbook 1907.07 states

Document scanning training is conducted for at least 1 week prior to allowing the employee to scan documents without direct supervision. Once the employee has reviewed the facility scanning policy, the supervisor, Chief of HIM, and/or designee, will train the employee on the computer functions of CPRS [Computerized Patient Records System] and VistA Imaging Capture & Display and then allow the employee to scan documents with direct supervision. After this training has been completed, the employee should be given the opportunity to scan documents without direct supervision. The Chief of HIM, and/or designee, will then monitor and review every document scanned by the employee until the employee has scanned a minimum of 100 consecutive documents error free for both administrative and clinical documentation.

The audit team found the eight medical facilities visited did not consistently follow training policy. Training variations for newly hired staff ranged from one week of on-the-job training to simply showing new staff a PowerPoint presentation before allowing them to scan and index documentation without direct supervision. The HIM chiefs at six of the eight medical facilities did not train staff with scanning duties outside of the HIM department (staff assigned to other departments or offices). In these instances, staff outside of the HIM department often trained one another on scanning duties.

The audit team found the range of training practices for scanning staff varied drastically by VA medical facility as reflected in these examples from sites:

- Being “just thrown in” and told how to do the job
- One week of formal training, followed by two to three weeks of informal training
- One-on-one training for a month

Conclusion

VA medical facility scanning staff are not performing appropriate quality assurance checks. In addition, HIM chiefs or their designees are not consistently conducting required retrospective quality assurance monitoring. Both deficiencies can allow errors to persist undetected, with

missed opportunities for advancing continuous quality care to patients. The audit team found that VHA needs to improve its supervision and medical facilities' management to ensure medical documents are accurately scanned and indexed, appropriate quality assurance monitoring occurs throughout the scanning process, and an adequate training program is established and implemented for personnel performing scanning or indexing roles throughout VHA facilities. These actions are necessary to ensure veterans receive coordinated, timely, and appropriate care.

Recommendations 7–9

The OIG recommended the Under Secretary for Health conduct the following:²⁷

7. Implement standardized quality assurance monitoring procedures to improve accurate updating of patients' electronic health records and completion of corrective actions when errors are identified.
8. Ensure original documents are retained until the scanning supervisor or designee verifies that scanning staff have met quality assurance monitoring standards established in Recommendation 7.
9. Develop procedures to ensure facility directors provide adequate document scanning/indexing training, consistent with Veterans Health Administration Handbook 1907.07, prior to allowing employees to scan/index documents without direct supervision and as needed for corrective actions.

Management Comments

The executive in charge concurred with Recommendations 7–9 and provided acceptable corrective action plans with anticipated implementation by July 2020.

In response to Recommendation 7, the executive in charge stated that the HIM Program Office will implement standardized quality assurance monitoring procedures to improve accurate updating of patients' electronic health records and completion of corrective actions when errors are identified.

In response to Recommendation 8, the executive in charge stated that the HIM Program Office will ensure original documents are retained until the scanning supervisor or designee verifies that scanning staff have met the previously mentioned, newly established quality assurance monitoring standards.

In response to Recommendation 9, the executive in charge stated that the HIM Program Office will develop procedures to ensure adequate scanning/indexing training is provided consistent with VHA Handbook 1907.07, prior to allowing employees to scan/index documents without

²⁷ Recommendations directed to the Under Secretary for Health were submitted to the executive in charge who has the authority to perform the functions and duties of the Under Secretary for Health.

direct supervision and as needed for corrective actions. He further stated that chiefs of HIM will be required to certify annually that staff performing scanning duties have been properly trained.

OIG Response

The executive in charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified. The full text of the responses from the executive in charge are in Appendix E.

Appendix A: Scope and Methodology

Scope

The OIG team performed audit work from January 2018 through May 2019, which included eight site visits to VA medical facilities, telephone and email interviews with staff at an additional 78 VA medical facilities, and a telephone interview with personnel from VISN 12 (Chicago, Illinois). The site visits were conducted from January 9 through March 14, 2018, at the following VA medical facilities: Harlingen, Texas; Salem, Virginia; Lebanon, Pennsylvania; Tomah, Wisconsin; Newington, Connecticut; Fargo, North Dakota; Fayetteville, Arkansas; and Las Vegas, Nevada. The eight site visits included four medical facilities that reported having a backlog and four medical facilities that reported not having a backlog. The audit team found backlogs at four medical facilities, including one facility that previously reported no backlog. Furthermore, one of the medical facilities that initially reported a backlog had eliminated the backlog prior to the audit team's visit. The audit team's telephone and email interviews with staff at the 78 VA medical facilities were conducted from April through July 2018. Staff at the 78 facilities were asked a series of questions regarding their current backlog as of the month noted in Appendix C for each facility. The telephone interview with personnel from VISN 12 helped to gather additional information related to the team's site visit at the VISN 12 facility in Tomah, Wisconsin. Finally, the audit team reviewed the results of the *2018 HIM Annual Inventory*, which was obtained after providing a project status update to VHA HIM staff in February 2019.

Methodology

The audit team methodology included reviewing applicable laws, regulations, and VA guidance. As mentioned above, the team interviewed national HIM management and VISN 12 personnel via teleconference and conducted site visits to interview managers and personnel at eight VA medical facilities.

The audit team randomly selected the medical facilities from four strata based on complexity (Level 1a, 1b, and 1c complexities were grouped together, as were Level 2 and 3 complexities)²⁸ and if they reported a scanning backlog on the *HIM Annual Inventory*.²⁹ The audit team also conducted telephone and email interviews with staff at medical facilities from April through July 2018:

²⁸ The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

²⁹ The audit team selected four facilities that reported having a backlog and four facilities that reported not having a backlog on the *2017 HIM Annual Inventory*.

- Staff at 68 medical facilities reported a backlog on the *2017 HIM Annual Inventory*.
- Staff at 10 of the 63 medical facilities reported having no backlog in the *2017 HIM Annual Inventory*.

Because VHA does not provide official guidance on how to define or measure backlog, the audit team did not validate or perform a detailed assessment of the backlog measurement methods at each visited or interviewed facility, such as whether facilities reporting in inches measured accumulated documents accurately and consistently. In addition, because facilities generally reported their electronic backlogs in total number of files and were unable to attest to number of pages or specific contents of each file, the audit team did not make any assessment of whether the reported electronic backlog total from each facility was based on comparable measurement.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by

- Conducting site visits to eight randomly selected medical facilities to evaluate policies, observe scanning procedures and physical areas, and interview the facility leaders and staff; and
- Interviewing staff at 78 additional medical facilities to assess the accuracy of previous backlog reporting.

The OIG did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

The audit team aggregated information on facility backlogs, assessed quality assurance and training practices, reviewed scanning productivity, and examined staffing levels based on facility-reported information. This information was obtained through the eight site visits, as well as telephone or email interviews with staff at the additional 78 facilities. The audit team did not obtain or rely on computer-processed data from any other sources, as there was no national mechanism for tracking the data related to the audit objectives.

During site visits, the audit team relied on interviews, direct observations, and staff-reported data to identify the presence and volume of medical record scanning backlogs. When backlogs were found, the audit team attempted to determine if the volume reported by facility staff appeared reasonable by observing each facility's process for receiving and storing incoming documents, physically viewing all locations where paper documents were stored, and observing scanning staff as they accessed digital storage locations.

During the audit team's interviews with staff at additional facilities, the team relied on facility representatives' responses to questions regarding the scanning process and potential medical records scanning backlogs. The audit team could not perform detailed field work to verify the accuracy of these responses because it did not visit these facilities to directly observe scanning processes or solicit responses from additional facility staff. The audit team calculated the amount of backlog based on facilities' self-reported information to estimate the backlog. Because the team was unable to verify the data provided, the total backlog could be somewhat higher or lower than presented in this report.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. The OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on the audit objectives.

Appendix B: Site-Specific Results for Eight Facilities

The table that follows presents the reported and observed backlogs, estimated size of the backlogs, and quality or training concerns, for each of the eight sites visited. As mentioned previously, these medical facilities represent various levels of complexity.

Table B.1. Reported Medical Facility Backlogs by Site

Medical facility	Backlog reported on 2017 HIM Annual Inventory	Backlog found by OIG	Quantity and type of backlog found*	Quality assurance issues found	Training issues found
VA Texas Valley Coastal Bend HCS	Yes	Yes	2,515 (E)	Yes	Yes
Salem, Virginia VAMC	No	No	0	No	No
Lebanon, Pennsylvania VAMC	No	No	0	Yes	Yes
Tomah, Wisconsin VAMC	Yes	No ³⁰	0	Yes	Yes
VA Connecticut HCS	Yes	Yes	944" (P)	Yes	Yes
Fargo, North Dakota VA HCS	No	No	0	Yes	Yes
Veterans HCS of the Ozarks	Yes	Yes	275" (P) 31,057 (E)	Yes	Yes
VA Southern Nevada HCS	No	Yes	13,676 (E)	Yes	Yes

Source: VA OIG staff site visits and interviews

*Note: P=paper (in inches), E=electronic (in files), HCS=Health Care System, VAMC=VA Medical Center

³⁰ As mentioned previously, this facility had eliminated its reported backlog prior to the audit team's visit.

Appendix C: Additional Facility-Specific Reported Backlogs

From April to July 2018, the audit team contacted each facility that reported a backlog on the *2017 HIM Annual Inventory* but was not included in site visits.³¹ The audit team conducted interviews to further assess the prevalence of scanning backlogs. All the data contained in Table C.1. was self-reported by each facility, and the audit team has not verified the information or the composition of each facility's backlog. The audit team further relied on each facility's definition of a backlog when requesting this information.

Table C.1. Responses from Medical Facilities with a Reported Backlog

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
Altoona, Pennsylvania VAMC	Yes	Unknown	0	377.25" of electronic documents	April
Anchorage, Alaska VA HCS	Yes	12,104	29	N/A	April
Ann Arbor, Michigan VA HCS	Yes	Unknown	Unknown	Measured by date (oldest from July 2017)	April
Asheville, North Carolina VAMC	Yes	0	150	N/A	April
Battle Creek, Michigan VAMC	Yes	0	25	N/A	April
Bay Pines, Florida VA HCS	Yes	0	271	N/A	April
Beckley, West Virginia VAMC	Yes	0	24.5	N/A	April
Big Spring, Texas (West Texas VA HCS)	Yes	0	Unknown	640 Data Saver Boxes	April
Boise, Idaho VAMC	Yes	8,311	342	N/A	April
Butler, Pennsylvania VA HCS	Yes	0	173.1	N/A	May

³¹ The San Juan, Puerto Rico, facility reported having a backlog on the *2017 HIM Annual Inventory* but was omitted as a potential site due to hurricane damage and recovery. This exclusion then reduced the reported backlog facilities available to be visited or interviewed from 73 to 72.

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
Canandaigua, New York VAMC	No	0	0	N/A	April
Captain James A. Lovell FHCC, (N. Chicago, Illinois)	Yes	5,767	18	N/A	April
Central Alabama Veterans HCS	Yes	0	Unknown	Measured by date (oldest from March 2018)	April
Cheyenne, Wyoming VAMC	Yes	2,000	0	N/A	July
Chillicothe, Ohio VAMC	Yes	1,770	730	N/A	April
Clarksburg, West Virginia VAMC	No	0	0	N/A	April
Cincinnati, Ohio VAMC	Yes	0	750	N/A	April
Columbia, Missouri (Harry S. Truman Memorial Veteran's Hospital)	Yes	0	72	N/A	April
Columbia, South Carolina VA HCS	Yes	0	469	N/A	April
Dallas, Texas VAMC	Yes	14,353	38	N/A	April
Dayton, Ohio VAMC	Yes	12,000	25	N/A	April
Durham, North Carolina VAMC	Yes	Unknown	216	Provided a range for electronic backlog	April
Eastern Kansas HCS	Yes	0	672.5	N/A	April
El Paso, Texas VA HCS	Yes	5	0	N/A	April
Erie, Pennsylvania VAMC	Yes	0	312	N/A	May
Fayetteville, North Carolina VAMC	Yes	2,054	345.4	Additional 19 boxes of paper	April
Gainesville, Florida (N. Florida/S. Georgia VA HCS)	Yes	0	1,671	N/A	April

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
Grand Junction, Colorado VA HCS	Yes	1,000	Unknown	File room has one week of paper and three days of electronic; The OCC has 1,000 paper records	April
Greater Los Angeles HCS	Yes	2,400	306,674	N/A	April
Gulf Coast HCS, Mississippi	Yes	3,586	0	N/A	July
Huntington, West Virginia VAMC	Yes	0	138	N/A	April
Iowa City, Iowa VA HCS	No	0	0	N/A	April
Iron Mountain, Michigan VAMC	Yes	0	152	N/A	April
Kansas City, Missouri VAMC	No	0	0	N/A	April
Lexington, Kentucky VAMC	Yes	Unknown	0	Recently found files on SharePoint	April
Manchester, New Hampshire VAMC ³²	No	0	0	N/A	July
Marion, Illinois VAMC	Yes	18,878	Unknown	Paper reported as 14,437 pages, not inches	April
Martinsburg, West Virginia VAMC	Yes	0	180	N/A	April

³² The original interview request was submitted to the facility April 3, 2018; however, the facility did not respond to the audit team's request until July 5, 2018. The facility indicated in their July response to the audit team they had eliminated their backlog by the end of April 2018.

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
Memphis, Tennessee VAMC	Yes	426	1,237	78 boxes approx. 10" each; 9,616 combinations of electronic and paper docs.; Streamfax qty. unknown	April
Middle Tennessee HCS	Yes	10,991	397	N/A	July
New Mexico HCS	Yes	8,997	254	N/A	April
Northern Arizona HCS	Yes	87,766	355	Paper reported as 125 documents, not inches	July
Northern Indiana HCS	Yes	0	10	N/A	July
Oklahoma City, Oklahoma VA HCS	No	0	0	N/A	April
Orlando, Florida VAMC	Yes	400	Unknown	Paper reported as 140,000 pages, not inches	April
Palo Alto, California VA HCS	No	0	0	N/A	April
Phoenix, Arizona VA HCS	Yes	33,760	100	N/A	April
Poplar Bluff, Missouri VAMC	Yes	0	143.2	CitC has an unclear amount and type of backlog	April
Portland, Oregon VAMC	Yes	48,822	159	N/A	April
Providence, Rhode Island VAMC	No	0	0	N/A	April

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
Reno, Nevada VA HCS	Yes	Unknown	Unknown	Paper reported as 189,440 pages, not inches; electronic reported as 100,000 pages, not files	April
Richmond, Virginia VAMC	Yes	0	175	N/A	April
Roseburg, Oregon VA HCS	Yes	56,935	1,055	N/A	April
Saginaw, Michigan VAMC	Yes	1,073	107.7	N/A	April
San Antonio, Texas VA HCS	Yes	2,852	28	N/A	April
Sheridan, Wyoming VAMC	No	0	0	N/A	April
Shreveport, Louisiana VAMC	Yes	0	105	N/A	April
Sioux Falls, South Dakota VA HCS	Yes	21,435	Unknown	Measured by date (oldest 1/21/2018)	April
Southern Arizona HCS	Yes	918	1,166	N/A	April
Spokane, Washington VAMC	Yes	52,543	0	N/A	April
St. Cloud, Minnesota VA HCS	Yes	0	Unknown	Paper reported as 146,836 documents, not inches	April
St. Louis, Missouri VA HCS	Yes	0	1,539	N/A	April
Togus, Maine VA HCS	Yes	0	180	N/A	April
VA Central Western Massachusetts HCS	Yes	0	61	N/A	April
Walla Walla, Washington VAMC	Yes	56,845	2,147.5	N/A	April
Washington, DC VAMC	Yes	0	1,445	N/A	April

Facility (reported "Yes" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Backlog (other than electronic or paper)	Month responses received (in 2018)
White River Junction, Vermont VAMC	Yes	0	52	N/A	April
Wilkes-Barre, Pennsylvania VAMC	Yes	0	100	N/A	April

Source: VA OIG staff telephone or email interviews

*Note: HCS=Health Care System, VAMC=VA Medical Center, FHCC=Federal Health Care Center

Appendix D: Facility-Specific Information with No Reported Backlog

From April to July 2018, the audit team contacted an additional 10 facilities that reported no backlog on the *2017 HIM Annual Inventory* and were not included in site visits. The audit team’s goal was to further assess the prevalence of scanning backlogs and the accuracy of the reporting in the *HIM Annual Inventory*.

Table D.1. Responses from 10 Medical Facilities with No Reported Backlog

Facility (reported "No" backlog on 2017 HIM Annual Inventory)	Facility backlog at time of interview	Backlog (electronic files)	Backlog (paper documents in inches)	Month responses received (in 2018)
Boston HCS, Massachusetts	No	0	0.00	July
Coatesville, Pennsylvania VAMC	No	0	0.00	April
Danville, Illinois VA HCS	No	0	0.00	April
Honolulu, Hawaii VA HCS ³³	Yes	26,786	0.00	April
Mountain Home, Tennessee VAMC	No	0	0.00	April
New York Harbor HCS, New York	No	0	0.00	July
Puget Sound, Washington VA HCS	Yes	5,600	576.00	July
Sacramento, California VAMC	No	0	0.00	April
San Francisco, California VA HCS	No	0	0.00	April
White City, Oregon RCC	No	0	0.00	April

Source: VA OIG staff conducted telephone or email interviews

*Note: HCS=Health Care System, VAMC=VA Medical Center. RCC=Rehabilitation Center & Clinics

³³ The Honolulu, Hawaii, VA Pacific Islands Health Care System reported “No” when asked if it had a backlog on the *2017 Annual HIM Inventory* because the facility did not consider the backlogged medical documents in the OCC section. The facility responded that it would have answered “Yes” on the inventory question regarding backlogs had the survey specifically included OCC.

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: June 21, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Health Information Management Medical Documentation Backlog (VIEWS 01116883)

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review the Office of Inspector General (OIG) draft report Health Information Management Medical Documentation Backlog. I concur with all 9 recommendations and provide the attached action plan and technical comments.

I appreciate OIG's concerns regarding incorporating these medical record documents into the patients' electronic health records (EHR). This critical step supports patient care by ensuring complete, accurate, and readily accessible health records that guide clinicians' decisions.

I am pleased that OIG did not find any cases of patient harm throughout the course of their review and found that facilities following Veterans Health Administration (VHA) policy regarding scanning resources, scanning/importing training, and quality assurance monitoring did not experience backlogs of medical documentation.

I am concerned that OIG's report does not account for some of the aggressive actions we've taken to ensure Veterans Integrated Service Networks (VISNs) and facility leadership resolve scanning backlogs:

A memorandum dated February 12, 2019 directed VISNs and medical facilities to assign a point of contact to oversee remediation of the scanning backlogs. (Attachment A). The VHA Health Information Management (HIM) Program Office meets weekly with these points of contact to review the status of scanning backlogs and remediation efforts. Additionally, I have directed a national stand-down for July to reduce scanning backlogs at all VHA facilities nationwide.

Since 2016, the HIM Program Office provided nine training opportunities to Chiefs of HIM, Assistant Chiefs of HIM, Scanning Supervisors, and Scanning Leads to address recommendations for reducing and eliminating scanning backlogs. (Attachment B)

HIM leadership implemented a performance improvement project which resulted in the dissemination of best practices, standardized processes and practice guides to all Chiefs of HIM and facility leadership to aid them in managing their scanning backlogs. VHA is pursuing revisions to policy to formalize guidance.

If you have any questions, please email Karen Rasmussen, M.D., Director for GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(Original signed by)

Richard A. Stone, M.D.

Attachments

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Health Information Management Medical Documentation Backlog

Date of Draft Report: May 20, 2019

Recommendations/Status	Completion Date
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Actions

Recommendation 1: Establishes policy that formally defines “medical documentation backlog”—specifically the age of unscanned and unindexed medical documentation.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) Program Office is establishing policy that formally defines “medical documentation backlog”—specifically the age of unscanned and unindexed medical documentation.

The policy update reflects that documents must be imported or scanned into VistA Imaging within 5 business days of receipt at the Department of Veterans Affairs facility and any documents over that threshold will be considered a backlog. Interim guidance was published in VHA HIM Fact Sheet VistA Imaging Capture Indexing Reference Guide and disseminated to all field facilities in May 2017.

Status:	Target Completion Date:
In Process	July 2020

Recommendation 2: Implements formal controls to monitor medical documentation backlogs—specifically the description of unscanned and unindexed documents, size of the backlog, and age of health records—as well as subsequent actions to reduce the backlogs.

VHA Comments: Concur

In calendar year 2019, the Veterans Health Administration (VHA) Health Information Management (HIM) Program Office implemented formal controls to monitor medical documentation backlogs—specifically the description of unscanned and unindexed documents, size of the backlog, and age of health records—as well as subsequent actions to reduce the backlogs.

The HIM Program Office at the VA Central Office meets weekly with Veterans Integrated Service Network (VISN) points of contact to monitor facility performance based on shared information from facility representatives to review the status of scanning backlogs and remediation efforts. The weekly meetings are utilized to facilitate communication and awareness of any facilities falling behind so additional guidance and support can be provided.

HIM provided the Inspector General with supporting documentation to demonstrate completion of this recommendation.

Status:	Target Completion Date:
Complete	May 2019

Recommendation 3: Directs Veterans Integrated Service Networks and facilities with a backlog to allocate additional resources to assist in its elimination.

VHA Comments: Concur

On February 12, 2019, the Office of the Deputy Under Secretary for Health for Operations and Management directed Veterans Integrated Service Networks (VISNs) and medical facilities with scanning backlogs to allocate the necessary additional resources to ensure scanning backlog elimination. The memorandum required Network Directors with active backlogs to implement action plans to include: (1) the use of blanket purchase agreements if available, or other contracting mechanisms, (2) shifting resources to assist those facilities with a significant backlog, and (3) authorizing compensatory time and overtime to staff who volunteer to assist. The memorandum also directed that technological issues impacting scanning productivity be addressed promptly.

The Veterans Health Administration (VHA) Health Information Management (HIM) Program Office initiated weekly backlog monitoring and meetings with Veterans Integrated Service Network points of contact. HIM provided an update on the scanning backlogs with details for corrective action on the Network Director Call on February 14, 2019, the HIM National call on February 20, 2019, and the VHA National call on February 15, 2019.

VHA will host a Scanning Backlog Stand-Down in July 2019. Medical facility participation is required. During the month of July, facilities will focus on reduction and elimination of scanning backlogs. In preparation for the stand-down, materials will be developed with recommendations for corrective actions.

Status:	Target Completion Date:
In Process	October 2019

Recommendation 4: Implements policy to require Chiefs of Health Information Management to notify facility directors when a medical documentation backlog exists and to take appropriate action.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) Program Office will formalize policy to require Chiefs of HIM to notify medical facility directors through their established chain of command when a medical documentation backlog exists and take appropriate actions. The HIM Program Office will continue to provide routine feedback to Veterans Integrated Service Network points of contact on medical facility action plans.

The target completion date for the policy reflects the expected publish date of the directive and subsequent communication to the field.

Status:	Target Completion Date:
In Process	July 2020

Recommendation 5: Assesses the scanning process, including staffing and productivity levels, within each facility to ensure authorized staffing levels can support future workload.

VHA Comments: Concur

Veterans Health Administration will host a Scanning Backlog Stand-Down in July 2019. Medical facility participation is required. During the month of July, medical facilities will focus on reduction and elimination of scanning backlogs. In preparation for the stand-down, materials will be developed with recommendations for corrective actions. The Health Information Management (HIM) Program Office will continue to provide feedback to Veterans Integrated Service Network points of contact and Chiefs of HIM.

The HIM Program Office will analyze scanning workload and develop a staffing model to ensure appropriate staffing levels to support future workload. The model will be added to policy and communicated by a Deputy Under Secretary for Health for Operations memorandum in the interim.

Status: In Process Target Completion Date: July 2020

Recommendation 6: Ensures that facility directors act on staffing level assessments and obtain the necessary resources within scanning departments.

VHA Comments: Concur

The Health Information Management (HIM) Program Office will analyze scanning workload and develop a staffing model to ensure appropriate staffing levels to support future workload. The model will be added to policy and communicated by a Deputy Under Secretary for Health for Operations memorandum in the interim.

Chiefs of HIM will perform a staffing analysis and notify medical facility directors through their established chain of command of staffing level deficiencies. The HIM Program Office will continue to monitor medical facility action plans and address deficiencies with Veterans Integrated Service Network points of contact for resolution.

Status: In Process Target Completion Date: July 2020

Recommendation 7: Implements standardized quality assurance monitoring procedures to improve accurate updating of patients' EHRs and completion of corrective actions when errors are identified.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) Program Office will implement standardized quality assurance monitoring procedures to improve accurate updating of patients' electronic health records and completion of corrective actions when errors are identified. HIM will convert VHA Handbook 1907.01 Health Information Management and Health Records into a directive and add information regarding the minimum sample size required for the Quality Assurance Monitor.

VHA's HIM Program Office provides guidance for the facilities to perform for a standardized Quality Assurance Program including proper procedures. Quality assurance reviews must be conducted by a third party (i.e., supervisor, quality coordinator) on a sample of the scanned documents.

HIM collaborated with VHA's Office of Compliance and Business Integrity to determine an appropriate standardized minimum sample size for the Quality Assurance Monitor. The standardized minimum sample for the Quality Assurance Monitor is listed below is based on medical facility complexity. This will be formalized in VHA Policy and communicated to the field.

Level 1 medical facilities	150 scans/imports per month
Level 2 medical facilities	100 scans/imports per month
Level 3 medical facilities	50 scans/imports per month

If a medical facility's accuracy rate is found to be less than 95 percent, the medical facility will perform an additional comprehensive review of 50 additional cases and provide remedial training to Chiefs of HIM, Assistant Chiefs of HIM, Scanning Supervisors, and Scanning Leads.

The sample size will be added to policy and communicated via a memorandum in the interim.

Status: In Progress Target Completion Date: July 2020

Recommendation 8: Ensures original documents are retained until the scanning supervisor or designee verifies that scanning staff have met quality assurance monitoring standards established in Recommendation 7.

VHA Comments: Concur

The Veterans Health Administration Health Information Management Program Office will ensure original documents are retained until the scanning supervisor or designee verifies that scanning staff have met quality assurance monitoring standards established in Recommendation 7.

The policy will be updated to include a standardized process to ensure original documents are retained until the quality assurance monitoring process is completed.

The document retention requirement will be added to policy and communicated via memorandum in the interim.

Status: In Progress Target Completion Date: July 2020

Recommendation 9: Develops procedures to ensure facility directors provide adequate document scanning/indexing training, consistent with Veterans Health Administration Handbook 1907.07, prior to allowing employees to scan/index documents without direct supervision and as needed for corrective actions.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) Program Office will develop procedures to ensure adequate scanning/indexing training is provided consistent with VHA Handbook 1907.07, prior to allowing employees to scan/index documents without direct supervision and as needed for corrective actions.

Chiefs of HIM will be required to certify annually that staff performing scanning duties have been properly trained.

A comprehensive Scanning Training Checklist to ensure proper training of scanning staff has been available on the HIM SharePoint site since 2016. The VHA HIM Program Office Director will reiterate the guidance on the HIM National call, Network Directors conference call and VHA Hotline call.

The certification requirement will be added to policy and communicated via a memorandum in the interim.

Status: In Progress Target Completion Date: July 2020

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Technical Comments

OIG Draft Report: Health Information Management Medical Documentation Backlog

Suggested change: Page i and footnote 1

VHA requests that the reference to the site assessment be removed from the report.

“In May of 2018, VA signed a contract with the Cerner Corp. to modernize the VA’s health care IT system and help provide seamless care to Veterans as they transition from military service to Veteran status, and when they choose to use community care. A Cerner consulting team and VA subject matter experts conducted site assessments with the intent of getting a broad look at the current state of systems, applications, integration points, reporting, and workflows being utilized at VA facilities.”

Justification: The Office of Inspector General uses an anecdotal reference from a VA-Cerner site assessment in this report. The assessment did not include a comprehensive analysis of scanning processes at the facility or input from Department of Veterans Affairs VA HIM subject matter experts on the team.

**Department of
Veterans Affairs**

Memorandum

Date: FEB 12 2019

From: Acting Deputy Under Secretary for Health for Operations and Management

Subj: Electronic Health Record Scanning and Importing Backlog

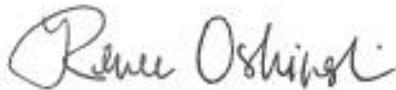
To: Veterans Integrated Service Network Directors (10N1-23)
Medical Center Directors (00)

1. During Fiscal Year 18, the Office of the Inspector General (OIG) identified that the increase in clinical documentation from community providers has contributed to an increased backlog at field sites. A backlog is defined as any document that is not scanned or imported into the VA patient electronic health record system (EHR) within five days of receipt.
2. VHA directive 1907.01 requires timely filing or scanning of reports into the EHR system. Untimely scanning or filing of documents prevents health care providers from accessing needed test results or performing comprehensive medical evaluations of Veteran patients. Facility and VISN Directors are charged with ensuring that all clinical documentation is entered timely into the EHR system and ongoing compliance is monitored.
3. VISN Directors with active backlogs at their facilities are urged to immediately implement action plans to include: (1) the use of blanket purchase agreements if available, or other contracting mechanisms, (2) shifting resources to assist those facilities with a significant backlog, and (3) authorizing compensatory time and overtime to staff who volunteer to assist. Issues with compliance due to iMED Consent, Direct Entry into CPRS, and any other technological issues must be concurrently addressed to ensure staff have needed resources.
4. The Office of Health Information Management will monitor this effort. VISN Directors are requested to ensure the VISN POC attend weekly calls that will be scheduled with the Office of Health Information Management and provide updates regarding the number of document sets scanned, document sets that remain outstanding, and any issues preventing timely completion of this task.

Page 2

Electronic Health Record Scanning and Importing Backlog

5. If you have any questions, please contact Janet W. Wilson, Office of Health Information Management by email at Janet.Wilson@va.gov.



Renee Oshinski

Attachment B

Appendix A

VHA HIM Program Office Trainings:

1/23/19 - [Working Remote Best Practice for Scanning](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors and Scanning Leads

12/12/18 - [Scanning Backlog Monitoring](#)

HIM Chief, OCC Managers and BIMS

9/2018 - [HIM and Community Care](#)

AHIMA VA Day, HIM Chiefs

8/22/18 - [Quick Wins Reducing Scanning Backlog](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors and Scanning Leads

3/2018 - [HIM Staffing Needs](#)

HIM Professional Week; HIM Chiefs, HIM Assistant Chiefs, HIM Supervisors

2/28/18 - [Improving Scanning Timeliness](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors and Scanning Leads

9/27/17 - [HIM and Community Care](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors and Scanning Leads

7/26/17 - [File Room and Scanning BPA](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors and Scanning Leads

4/6/16 – [Scanning Quality Assurance](#)

HIM Chiefs, HIM Assistant Chiefs, Scanning Supervisors, Scanning Leads, Any staff doing Scanning/Importing.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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