DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records

AUDIT | REPORT #19-08658-153 | JUNE 17, 2021

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Executive Summary

The Veterans Health Administration (VHA) leverages non-VA healthcare providers in the community to help provide veterans with access to timely and quality services. To access care in the community, certain conditions must be met such as the veteran living a certain distance from a VHA facility, lengthy wait times for appointments at a VHA facility, or when community care is in the best interest of the veteran.[1] In fiscal year 2019, 1.2 million enrolled veterans completed over 23.7 million non-VA community care appointments.

For VHA physicians to promptly and properly follow up on medical needs or concerns identified during non-VA care appointments, they must have accurate documentation available in veterans' electronic health records (EHRs). Further, VHA providers need these medical records to provide continuity of care, such as ensuring all prescriptions and the history of care are available and accurate to inform treatment decisions. VHA employees update the EHRs following referrals for community care once they receive the non-VA medical records or, if documentation is not received, after the referring facilities' community care staff have confirmed the veteran received care.[2]

VHA assigns the responsibility of records management to VHA medical facility Health Information Management (HIM) staff, but allows facility directors to delegate scanning and indexing of non-VA medical records to the facilities' community care staff.[3] In August 2019, the Office of Inspector General (OIG) reported deficiencies with HIM staff scanning and indexing.[4] The OIG performed the audit described in this report to evaluate whether community care staff with scanning and indexing responsibilities accurately uploaded non-VA medical records to veterans' EHRs. The team reviewed the processes and procedures that encapsulate non-VA medical records for all non-VA services and tested the accuracy of following such procedures by reviewing a sample of non-VA medical records for mental health services, given the importance of closely monitoring suicide prevention, medication management, and other related concerns.

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[1] The Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act), Pub. L. No. 113-146 (2014); The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 132, (2018); "Community Care," accessed April 12, 2021, https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp#Appointments. The Choice Act established the framework for increasing veterans' access to care in their community through the Veterans Choice Program. The MISSION Act officially ended the Choice Program on June 6, 2019, but continued veterans' ability to seek care locally with some adjustments to eligibility requirements. The MISSION Act consolidated VA's many community care programs into a new Veterans Community Care Program.

[2] VA memorandum, "Clarification of Administrative Closure of Community Care Consults (VAIQ #7880748)," March 6, 2018.

[3] Community care staff include nurses and administrative staff.

[4] VA OIG, *Audit of VHA's Health Information Management (HIM) Medical Documentation Backlog,* Report No. 18-01214-157, August 21, 2019.

VHA Handbook 1907.01 establishes the overarching requirements for any staff involved in scanning and indexing medical records to the EHR, which includes the need for training, quality checks, quality assurance monitoring, and the development of local policies.[5] In June 2019, VHA released additional guidance specifically for scanning and indexing non-VA medical records.[6] Once a record is scanned, indexing is the process of categorizing it by document or image type, specialty, procedure or event, and image description. Images must be indexed to the correct location in the EHR. While the guidance addresses requirements from 1907.01, it also incorporates requirements from VHA Handbook 1907.07 related to the requirements for training, quality checks, and quality assurance monitoring of scanning and indexing activities.[7]

What the Audit Found

The OIG found that VHA medical facilities that opted for community care staff to conduct indexing of medical records did not sufficiently comply with VHA requirements.[8] The lack of local (facility-level) procedures contributed to community care staff lacking adequate training and oversight to accurately index non-VA medical records to veterans' EHRs. Inaccurate indexing of medical records poses a risk to veteran care and increases the burden on VHA staff who have to locate and correct the errors, reducing their time for other tasks. The finding is supported by the determinations, discussed more fully below, that

- community care staff did not always accurately enter non-VA records into VHA's system;
- VHA facilities lacked standard operating procedures with defined processes and staff responsibilities;
- training, quality checks, and quality assurance monitoring were inadequate for community care staff performing scanning; and
- lack of adequate procedures, training, quality checks, and monitoring adversely affected VHA operations.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[6] VHA HIM Office of Health Informatics, *Practice Brief*, *Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*, June 2019.

[7] VHA Handbook 1907.07, *Management of Health Records File Room and Scanning*, May 12, 2016.

[8] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

Community Care Staff Did Not Always Accurately Enter Non-VA Records into VHA's System

The audit team determined that staff at six of seven VHA medical facilities reviewed did not always enter non-VA medical records into EHRs accurately. Community care staff within those facilities made errors in 44 percent of cases reviewed when indexing veterans' mental health medical records into their EHRs (108 errors identified for 92 of 209 veterans). These errors included when staff did the following: (1) used ambiguous or incorrect document titles, (2) indexed records to the wrong non-VA care referral, (3) entered duplicate records, or (4) indexed records to the wrong veteran.

VHA Facilities Lacked Standard Operating Procedures with Defined Processes and Staff Responsibilities

While VHA facilities have the option to use their community care department staff to manage non-VA medical records, they are also required to create standard operating procedures that detail the process, timeframes, and responsibilities for scanning, importing, and indexing non-VA clinical records into veterans' EHRs.[9] However, the audit team determined that two of the seven facilities assessed did not have written procedures, while five of the seven facilities had some written procedures that did not fully meet the standard operating procedure requirements. Without full compliance with required standard operating procedures, facilities may continue to experience challenges in ensuring that records added to veterans' EHRs are accurate.

Training, Quality Checks, and Quality Assurance Monitoring Were Inadequate for VHA Community Care Staff Performing Scanning

Facility chiefs of HIM at six of the seven sites assessed said they reviewed the work of the HIM scanning staff but did not provide oversight or assistance to their facilities' community care staff doing the same or similar work.[10] The OIG found deficiencies in the following areas:

- **Training**: There must be at least one full week of training, and employees must complete 100 consecutive document scans without error.[11] However, at the seven facilities assessed, the team found that HIM departments did not always train their facilities' community care staff as directed by policy.

[9] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

[10] VHA Handbook 1907.07, 4(b). The handbook states that HIM chiefs are responsible for ensuring all staff members with scanning responsibilities are properly trained and that scanning activities are completed accurately.

[11] VHA Handbook 1907.07.

- **Quality checks**: VHA facility staff that conduct scanning duties are required to perform quality checks on 100 percent of the documents they scan. Quality checks include making sure the document is not a duplicate, is legible, and the correct veteran is selected.[12] At all seven VHA facilities, the team observed that community care staff did not always complete the proper quality checks.
- **Quality assurance monitoring**: The chief of HIM, or a designee, is responsible for quality assurance monitoring. The monitoring requires selecting a random sample of scanned documents and assessing their quality.[13] At four of seven facilities assessed, no quality assurance monitoring of community care staff occurred. At the remaining three facilities, HIM leaders or designees did not consistently perform quality assurance monitoring in accordance with policy.

Lack of Adequate Procedures, Training, Quality Checks, and Monitoring Adversely Affected VHA Operations

When documents are identified as having been mislabeled or inaccurately indexed, the HIM chief or designee is required to review the error and take appropriate action, such as rescanning or re-indexing a document. If the document cannot be found, VHA facility community care staff must make and provide documentation of up to three separate requests for the medical record from the non-VA healthcare provider. If VHA still does not receive the medical record, facility community care staff must then confirm that the veteran received the requested care before they complete an administrative closure of the referral without the related record.[14]

What the OIG Recommended

The OIG recommended the under secretary for health improve non-VA medical records scanning and indexing by ensuring VHA facilities create and fully implement standard operating procedures. These procedures should clearly define all HIM and community care staff responsibilities and the procedures for accurately scanning, importing, and indexing non-VA medical records. The OIG also recommended the under secretary ensure HIM leaders provide or formally delegate training, quality checks, and quality assurance monitoring for facility community care staff responsible for medical record management.

[12] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.
[13] VHA Handbook 1907.07.
[14] VA memorandum, "Clarification of Administrative Closure of Community Care Consults (VAIQ #7880748)."

Management Comments

The acting under secretary for health concurred with the recommendations and provided corrective action plans that are responsive to the intent of the recommendations. Appendix B includes the full text of the acting under secretary for health's comments. The OIG will monitor the implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the identified issues.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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Abbreviations

EHR	electronic health record
HIM	Health Information Management
OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

As part of the Veterans Health Administration's (VHA) efforts to provide veterans with prompt, quality health care, VHA pays for healthcare services given by non-VA healthcare providers in the community. Access to community care is allowed when certain standards have been met. This includes access standards based on drive time to a specific VA medical facility and appointment wait times. More specifically, the standard is a at least a 30-minute average drive time for primary care and mental health, and at least 60-minute average drive time for specialty care. Access standards for appointment wait times are 20 or more days for primary care and mental health care, and 28 days or more for specialty care from the date of request. Additionally, the veteran may be referred to a community provider when both they and the referring VA provider agree that the referral is in the veterans best medical interest.[15] In fiscal year 2019 alone, approximately 1.2 million veterans enrolled in VHA's healthcare program completed over 23.7 million community care appointments.

For VHA physicians to promptly and appropriately follow up on medical needs or concerns identified during non-VA care appointments, they must have accurate documentation about those visits within VHA's electronic health record (EHR) system for each patient. Further, VHA providers need these comprehensive medical records to ensure there is an accurate history of care to inform subsequent treatment decisions and to improve patient safety, such as ensuring all prescriptions are current and known. VHA employees update the EHRs once they receive the medical records for inclusion in VHA's system or, if documentation is not received, after the facilities' community care staff have confirmed the veteran received care.[16]

Records from veterans' appointments with care providers in the community must be scanned, indexed, and checked for quality. VHA assigns the responsibility of records management to VA medical facility Health Information Management (HIM) staff, but VHA-issued written guidance, called a practice brief, on non-VA medical records documentation activities states facility directors can delegate scanning and indexing of non-VA medical records to the facilities'

[15] The Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act), Pub. L. No. 113-146 (2014); The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 132, (2018); "Community Care," accessed April 12, 2021, https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp#Appointments. The Choice Act established the framework for increasing veterans' access to care in their community through the Veterans Choice Program. The MISSION Act officially ended the Choice Program on June 6, 2019 but continued veterans' ability to seek care locally with some adjustments to eligibility requirements. The MISSION Act consolidated VA's many community care programs into a new Veterans Community Care Program, described on the program's website.

[16] VA memorandum, "Clarification of Administrative Closure of Community Care Consults (VAIQ #7880748)," March 6, 2018. The memorandum defines a referral for community care as a consult request for a veteran to receive care from a non-VA provider. The memorandum also defines procedures for closing a consult request.

community care staff, which include nurses and administrative staff who coordinate VA-paid care in the community.[17]

In August 2019, the Office of Inspector General (OIG) reported deficiencies in HIM staff scanning and indexing.[18] The OIG performed the audit described in this report to evaluate whether community care staff with scanning and indexing responsibilities accurately uploaded non-VA medical records to veterans' EHRs. The team reviewed processes and procedures for non-VA medical records for all types of non-VA care and services. To test the accuracy of following such processes and procedures, the audit focused on records for mental health services, given the importance of closely monitoring veterans receiving services for suicide prevention, medication management, and other significant concerns.

Scanning and Indexing Process

VHA Handbook 1907.01 establishes the overarching requirements for staff involved in scanning and indexing medical records to the EHR. Scanning is the process of making electronic images of paper documents. Indexing is the process of categorizing medical records by document or image type, specialty, procedure or event, and image description. Images must be indexed to the correct location in the EHR. Handbook 1907.01 includes the need for training, quality checks, quality assurance monitoring, and the development of local policies.[19] In June 2019, the national HIM program office released a practice brief that specified requirements for scanning and indexing non-VA medical records.[20]

According to the practice brief's requirements for documentation, the scanning and indexing of non-VA medical records begins after assigned VHA staff receive medical documentation from non-VA providers. Documentation may be submitted either via mail or electronically through a portal. EHR documentation may include diagnoses, prescriptions, or other information necessary for effectively treating veterans.

Upon receiving medical records from non-VA providers, assigned staff

1. Identify the correct non-VA care referral, conduct a clinical review of either the paper or electronic medical records, and write a summary note;[21]

[17] VHA HIM Office of Health Informatics, *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*, June 2019.

[18] VA OIG, *Audit of VHA's Health Information Management Medical Documentation Backlog,* Report No. 18-01214-157, August 21, 2019.

[19] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[20] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

[21] Clinical reviews are performed on documentation related to the episode of care including the clinical response to the requested referral. The clinical reviewer must assess if requested care occurred and if any additional issues are present.

2. Scan any paper records or import any electronic records; and
3. Index the records into the appropriate veteran's EHR.

While VHA community care staff always complete step 1, the practice brief states VA medical facilities have the option to use either HIM staff or their community care staff for steps 2 and 3 when scanning, importing, and indexing non-VA health records. As defined in Handbook 1907.01, VHA requires facilities' policies to address how to scan external non-VA documents. The June 2019 practice brief further defined that facilities must document the responsibility in a local standard operating procedure that details the process, timeframes, and responsibilities of all parties.

The practice brief details responsibilities such as training, quality checks, and quality assurance monitoring that help implement the requirements in both handbooks 1907.01 and 1907.07.[22] Handbook 1907.01 lays out specific requirements for scanning and indexing within the HIM department. While Handbook 1907.07 applies to staff within the HIM department, the practice brief extends the handbook requirements to facilities' community care staff with scanning and indexing responsibilities. Further, a VHA HIM fact sheet provided guidance on how staff should title notes used to close a non-VA care consult.[23] Taken together, the VHA handbooks, 2019 practice brief, and HIM fact sheet establish specific requirements:

- HIM staff are responsible for training all staff, which includes community care staff, in scanning and indexing.[24]
- Training must be at least one full week, and employees must complete 100 consecutive document scans without error.[25]
- Staff performing scanning are required to perform quality checks on 100 percent of the documents they scan. Quality checks include making sure the document is not a duplicate, is legible, and the correct veteran is selected.[26]
- The chief of HIM or a designee is responsible for quality assurance monitoring, which requires their selecting a random sample of scanned documents and assessing if all

[22] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

[23] VHA HIM Office of Informatics and Information Governance, HIM Fact Sheet Office of Community Care-Consult Closure, September 2017.

[24] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

[25] VHA Handbook 1907.07, *Management of Health Records File Room and Scanning*, May 12, 2016.

[26] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

documents captured are readable and retrievable.[27] This includes ensuring staff selected the correct related non-VA care referral with appropriate title for the summary note.[28]

- All documents must be scanned and indexed within five business days of receipt.[29]

When all requirements are not included in local standard operating procedures, facility managers lack assurance that community care staff receive adequate training or oversight to accurately index non-VA medical records to EHRs.

[27] VHA Handbook 1907.07.

[28] HIM Fact Sheet Office of Community Care-Consult Closure, September 2017. The fact sheet states staff will complete a clinical consult with a consult result note titled, "Community Care—Specialty Name CONSULT RESULT note."

[29] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

Results and Recommendations

Finding: Improvements Are Needed in Accurately Adding Non-VA Medical Records to Veterans' Electronic Health Records

VHA medical facilities that opted for community care staff to conduct indexing of medical records did not sufficiently comply with VHA's requirements. Community care staff at six of the seven VA medical facilities the audit team assessed did not always index medical records from non-VA providers into veterans' EHRs accurately.[30] The team reviewed 209 veterans' mental health medical records that VHA community care staff indexed in the third and fourth quarters of fiscal year 2019 (April 1, 2019, through September 30, 2019) and found 108 indexing errors for 92 veterans. Some veterans' records had more than one error. Errors included indexing to other veterans' EHRs, entering duplicate records, and using incorrect naming conventions. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, and lack of local facility-level policies. Inaccurate indexing of medical records poses an unnecessary risk to veteran care and patient safety and increases the burden on VHA staff who have to locate and correct the errors, taking their time away from other tasks.

This finding is supported by four determinations:

- Medical facility employees did not always accurately enter non-VA records into VA's system.
- VHA facilities lacked standard operating procedures with defined processes and staff responsibilities.
- Training, quality checks, and quality assurance monitoring were inadequate for VHA community care staff performing scanning duties.
- Lack of standard operating procedures, inadequate training, and inadequate quality checks and monitoring adversely affected VHA operations.

What the OIG Did

The audit team identified that 81 facilities self-reported in VHA's 2018 annual inventory that they were using their community care staff to scan and index non-VA medical documentation, and these facilities reported having scanning and indexing backlogs to VHA between

[30] Site visits were conducted from August through October 2019 at the following VA medical facilities: Memphis VA Medical Center, Minneapolis VA Health Care System, VA Western Colorado Health Care System, VA Pacific Islands Health Care System, Alaska VA Health Care System, Phoenix VA Health Care System, and the Hershel "Woody" Williams VA Medical Center in West Virginia.

January and March 2019.[31] The team selected six facilities within the 81 that reported the highest percentage of veterans receiving non-VA care services based on complexity level within their respective Veterans Integrated Service Network.[32] In addition, the team selected a seventh facility, the Minneapolis VA Health Care System, after reviewing an OIG hotline complaint alleging poor training of community care staff and inefficient processes for non-VA medical records scanning.[33]

The audit team conducted site visits to interview staff, observe processes, and assess policies and procedures. The team also obtained and analyzed backlog data that facilities reported to VHA's national HIM office. The team interviewed facility leaders, community care department leaders, and personnel responsible for scanning, importing, and indexing medical records received from non-VA providers. Further, to assess scanning accuracy, the team examined a sample of 209 veterans who had mental health non-VA care referrals completed in the third and fourth quarters of fiscal year 2019.

Community Care Staff Did Not Always Enter Non-VA Records Accurately into VA's System

The audit team determined that staff at six of seven VA medical facilities reviewed did not always enter non-VA medical records into EHRs accurately. The team found community care staff within those facilities made errors in 44 percent of cases reviewed when indexing veterans' mental health medical records into their EHRs (108 errors identified for 92 of 209 veterans). These errors, from highest to lowest occurrences, included instances when staff made the following mistakes:

- Used the incorrect clinical service name (83 occurrences)
    - Staff used ambiguous or incorrect document titles that did not allow clinicians to identify the specialty of the medical services provided without opening the document.
- Indexed records to the wrong non-VA care referral (12 occurrences)
- Entered duplicate records (11 occurrences)
- Indexed records to the wrong veteran (two occurrences)

[31] VA memorandum, "National Electronic Health Record Scanning Backlog Stand Down," June 5, 2019. The memorandum defines a backlog as any document not indexed within five business days of receipt.

[32] VHA Office of Productivity, Efficiency and Staffing, "Fact Sheet Facility Complexity Model," fiscal year 2017. The VHA Facility Complexity Model categorizes medical facilities based on factors including patient count, intensive care units, and number of physician specialists.

[33] Appendix A provides additional information about the audit team's methodology.

These errors increase the risk for privacy violations or delays for VHA providers making veterans' care decisions using the most current and complete medical information.

Incorrect Clinical Service Name

A VHA fact sheet on closing a consult (referral for care) directs that community care staff give indexed medical records the same clinical service name as listed on the non-VA care referral.[34] Correct naming helps clinical staff locate relevant records in the EHR. The audit team found 83 instances in which community care staff did not use the correct service name. Three of the seven facilities the audit reviewed accounted for 86 percent of the total errors (71 of 83), where they often used a generic document title. For example, a requesting medical facility care provider entered a non-VA care referral for psychology under COMMUNITY CARE-PSYCHOLOGY; however, the facility's community care staff indexed the medical records under the title SCANNED OUTSIDE MEDICAL RECORDS. One community care supervisor stated that VHA providers were "furious" about generic labeling because the failure to use descriptive titles made it difficult to locate non-VA medical records in a veteran's EHR.

Indexed to Wrong Referral

Community care staff index non-VA medical records to veterans' EHRs to document that they received the requested care and to close out the associated referral. When staff index records to the wrong referral, as the audit team identified in 12 instances, there is a risk that both community care department staff and the requesting clinical staff will not know whether the veteran received the requested non-VA care. Further, community care staff will continue to look for the non-VA medical records and potentially request documentation for medical records that were already provided. Indexing records to the wrong referral also introduces the risk that veterans will not receive care due to the referral being closed.

Duplicate Records

Duplicate records are created when community care staff index the same medical records into a veteran's EHR multiple times. Of the 209 veterans' records assessed, the audit team found 11 duplicate records at five of seven facilities reviewed. When duplicate records appear in veterans' EHRs, VHA medical staff may waste valuable time searching for and comparing all of them to ensure they have not missed new or different health information.

[34] HIM Fact Sheet Office of Community Care-Consult Closure, September 2017.

Indexed to Wrong Veteran

The audit team identified two instances in which community care staff indexed mental health medical records to the wrong veterans.

- On May 14, 2019, community care staff incorrectly added a veteran's medical record for mental health provided by a non-VA provider to another veteran's EHR. After the team notified the facility, facility staff reported that they removed the incorrect record on March 9, 2020, which was 300 days after the error was made.
- On September 30, 2019, community care staff incorrectly added a veteran's non-VA medical record for mental health to another veteran's EHR. After notification from the team, facility staff reported that they corrected the error on March 12, 2020, which was 164 days after the error occurred.

These errors potentially exposed the veterans' personally identifiable information and protected health information to other veterans and to medical staff accessing the other veterans' records. The OIG did not determine if the records were actually viewed by others prior to correction.

The chief of community care at one facility explained indexing records to the wrong veteran was a common error because non-VA providers sent medical records for multiple veterans at the same time. If staff did not check the entire document, they could mistakenly add multiple veterans' records to a single veteran's EHR.

VHA Facilities Lacked Standard Operating Procedures with Defined Processes and Staff Responsibilities

VHA guidance from June 2019 gives facilities the option to use their community care department staff to manage non-VA medical records and requires facilities to create standard operating procedures that detail the process, timeframes, and responsibilities for scanning, importing, and indexing non-VA clinical records into veterans' EHRs.[35] The audit team found that two of the seven facilities assessed did not have written procedures, while five of the seven facilities had some written procedures that did not fully meet the standard operating procedure requirements. The audit team did attempt to identify performance differences between facilities that did not have written procedures and those with some procedures.

For the five facilities with written procedures, three facilities defined responsibilities for training, quality checks, and quality assurance monitoring, but did not incorporate VHA's requirements for training, quality checks, and quality assurance monitoring.[36] The fourth facility had defined

[35] *Practice Brief, Office of Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements*.

[36] VHA Handbook 1907.07.

responsibilities for quality checks, but not for training and quality assurance monitoring. The fifth facility had limited written procedures that did not assign responsibilities for training, quality checks, or quality assurance monitoring.

The audit team concluded that the facilities did not follow VHA's policies when developing processes. Through interviews, the team found community care staff were generally unaware of VHA's scanning and indexing policies that required a standard operating procedure. Staff also appeared to lack knowledge of setup requirements such as training, quality checks, and quality assurance monitoring. Facility chiefs of HIM at six of the seven sites assessed said they reviewed their HIM staff's work but did not provide oversight or assistance to the community care staff in the facilities doing the same or similar work.

Further, without written procedures clarifying responsibilities, facilities run the risk of creating dysfunctional work environments. For example, community care staff at one facility complained about their working relationship with HIM staff. As evidence, the staff person provided a letter from a HIM employee indicating records from the community care employee would be shredded. The following is an excerpt of the communication from the HIM employee:

> The enclosed are not HIMS [*sic*] records. They were not requested by HIMS, not addressed to HIMS, and should not be forwarded to HIMS.
>
> HIMS respectfully returns these records to their intended and appropriate recipient; going forward, should HIMS continue to receive such records forwarded to us by [name removed], we will shred the records, as it appears the appropriate recipient neither wants, nor needs, nor has any interest in taking ownership or responsibility for them.

Recommendation 1 addresses the need for facilities to develop and implement standard operating procedures that clearly outline community care and HIM staff responsibilities and the procedures for working with non-VA medical records consistent with VHA policy.

Training, Quality Checks, and Quality Assurance Monitoring Were Inadequate for VHA Community Care Staff Performing Scanning

VHA requires the facility HIM leader or designee to train scanning staff, including community care staff in the facility who scan records. Before allowing staff to scan and index without direct supervision over every document, the leader or designee must train staff for at least one week and ensure staff have completed 100 consecutively scanned error-free records. As described earlier, staff who scan records must also conduct their own quality checks to ensure documents are not duplicates, are legible, and the correct veterans are selected. VHA policy requires quality checks on 100 percent of medical records scanned.[37] Lastly, VHA policy details oversight of the

[37] VHA Handbook 1907.07.

scanning process. The facility HIM leader or designee is required to perform quality assurance monitoring by randomly selecting and reviewing scanned and indexed documents from all staff, including community care staff.

Training

At the seven facilities assessed, the audit team found that HIM departments did not always train community care staff as directed by policy. During site visits, community care staff indicated that they had some training, but staff at all seven facilities did not describe their training lasting a week or including direct supervision of 100 error-free records as per VHA's requirements. While the chiefs of community care at two of the seven facilities stated supervisors were to review 100 records, one facility's supervisor admitted to not always reviewing 100 records, and the other facility's supervisor did not perform record reviews. The remaining five facilities either did not perform direct supervision of records or did not require the supervisors to review 100 records. For example, at one of these facilities, the training documentation required the review of only 20 consecutive error-free medical records before certifying staff were ready to scan without supervision, despite VHA's requirement of 100.

Quality Checks

The team determined that community care staff at all seven VA facilities visited did not always complete quality checks. At those seven facilities, the team observed 26 of 34 community care staff (76 percent) did not complete the proper quality checks. At four of the seven facilities, all 19 community care staff observed did not conduct the proper quality checks. At the remaining three facilities, seven of 15 community care staff observed did not complete quality checks.

Quality Assurance Monitoring

The audit team determined that HIM leaders or designees did not always perform required quality assurance monitoring. At four of seven facilities, no quality assurance monitoring of community care staff occurred. For example, the chief of HIM at one facility reported not being aware if quality assurance monitoring was being done for community care staff. At the remaining three facilities, HIM leaders or designees did not consistently perform quality assurance monitoring in accordance with policy. At one facility, the chief of community care stated they had stopped quality assurance monitoring due to other priorities. HIM supervisors were either unaware of the requirements to oversee community care staff performing this function, or only focused on their HIM staff when performing quality assurance monitoring. Further, community care leaders were either unaware of the requirements or said they did not have the time to complete the task.

Recommendation 2 focuses on ensuring HIM leaders or designees train, oversee that quality checks are done, and conduct quality assurance monitoring for community care staff responsible for non-VA mental health medical record management, as required by VHA guidance.

Lack of Adequate Procedures, Training, Quality Checks, and Monitoring Adversely Affected VHA Operations

To close non-VA care referrals, staff may spend additional time searching for non-VA medical records. This burden can be significant if documents cannot be found and community care staff are required to make additional requests—up to three additional documented attempts—for medical records from the non-VA provider.[38] At one facility, a community care leader stated these additional requests are the biggest reason for duplicate records and a community care nurse manager estimated that about 40 percent of records received were duplicates. If, after multiple requests, the medical records are still not received, community care staff must then confirm that the veteran received the requested care prior to completing an administrative closure of the referral without the records. In addition, when documents are mislabeled or inaccurately indexed, the HIM chief or designee is required to review the error, take appropriate actions, and staff must make corrections that may require rescanning or re-indexing a document.

Conclusion

At six of the seven sites reviewed by the audit team, the VA medical facilities did not always ensure community care staff accurately indexed non-VA mental health medical records into veterans' EHRs. Facilities that opted for community care staff to conduct this important function did not fully comply with VHA's requirements for creating standard operating procedures, training staff, performing quality checks, and monitoring quality. As a result, these facilities had errors while indexing and did not subsequently detect those errors. Until VHA improves the accuracy of indexing non-VA medical records, veterans are at heightened risk of privacy violations and receiving care based on incomplete or out-of-date information. VHA community care staff will also continue to spend unnecessary time and effort to close referrals.

Recommendations 1–2

The OIG made two recommendations to the under secretary for health:

1. Ensure facilities create and implement standard operating procedures that clearly define all Health Information Management and community care staff responsibilities, and the procedures for accurately scanning, importing, and indexing non-VA medical records.

[38] VA memorandum, "Clarification of Administrative Closure of Community Care Consults (VAIQ #7880748)."

2. Require facility directors to ensure that Health Information Management leaders provide or formally delegate training, quality checks, and quality assurance monitoring for community care staff responsible for medical record management.

Management Comments

The acting under secretary for health concurred with recommendations 1 and 2. To address the recommendations, the executive in charge reported VHA's HIM program office will ensure facilities create and implement standard operating procedures and require facility directors to delegate formal training, quality checks, and quality assurance monitoring for community care staff. HIM leaders will do this in coordination with VHA operations and the Office of Community Care. VHA comments may be found in full in appendix B.

OIG Response

The 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 VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The team performed the audit work from June 2019 through April 2021, which included site visits to eight VA medical facilities. To address the audit objective, the team conducted the site visits from August through October 2019 at VA medical facilities in Memphis, Tennessee; Minneapolis, Minnesota; Grand Junction, Colorado; Big Spring, Texas; Honolulu, Hawaii; Anchorage, Alaska; Phoenix, Arizona; and Huntington, West Virginia. The site visits specifically included facilities that self-identified community care staff as responsible for scanning, importing, and indexing non-VA medical records. The team conducted sample reviews of completed non-VA mental health care referrals during the third and fourth quarters of fiscal year 2019.

Methodology

The audit team's methodology included reviewing applicable laws, regulations, and VHA's guidance. The team conducted site visits to interview facility leaders, managers, and staff at the eight facilities mentioned above, with an analysis of seven of them as discussed below. Additionally, the team reviewed sampled completed non-VA mental health care referrals from the facilities visited.

The site selection methodology began with the first site selected, the Minneapolis VA Health Care System, as the audit team was made aware of a prior hotline complaint expressing concerns about community care staff scanning processes. The remaining facility selections were determined by leveraging data from the VHA Support Service Center and examining the highest percentage of veterans that used non-VA care for fiscal year 2019 until the date of data retrieval (May 2019); facilities that self-identified in a VHA annual survey that they had community care staff responsible for scanning, importing, and indexing non-VA medical records (per question number 103 on the *2018 HIM Annual Inventory*); and facilities that self-reported a non-VA medical records backlog anytime from January through March 2019 on HIM's Monthly Scanning Monitor. These site selections were made to ensure all facility complexity levels were encompassed, and the team did not choose facilities within the same Veterans Integrated Service Network.

The audit team addressed findings from seven sites visited instead of eight. When the team arrived at the Big Spring, Texas, medical facility, the team determined staff incorrectly reported on the *2018 HIM Annual Inventory* that community care staff performed scanning duties. As a result, the information obtained during the site visit at Big Spring, Texas, was excluded as they no longer met the site selection methodology.

The audit team conducted sample reviews of completed non-VA mental health care referrals from the third and fourth quarters of fiscal year 2019. Specifically, the team reviewed documents indexed to each veteran's EHR, consult history, medical notes, and other available data to determine whether staff made indexing errors. The team determined whether staff entered non-VA medical records in the correct veterans' EHRs, entered duplicate copies, indexed to the correct consults, and used the correct clinical service names when indexing.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators within its data analysis, to include soliciting the OIG's Office of Investigations for indicators. The OIG did not identify any instances of fraud during this audit.

Data Reliability

The audit team used computer-processed data from VHA's Corporate Data Warehouse. To test the reliability of data used for the team's review of completed non-VA mental health care referrals, the team compared elements of data obtained through the Corporate Data Warehouse to records available in the EHR. Specifically, the team confirmed elements for 10 sampled documents, including that each consult: (1) was included in the correct veteran's record, (2) had the correct clinical service name, and (3) was completed during the third or fourth quarter of fiscal year 2019. The team did not identify any inaccuracies or inconsistencies between the obtained data and the EHR; therefore, the data were sufficiently reliable for this audit.

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 the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Management Comments

Department of Veterans Affairs Memorandum

Date: May 11, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, VETERANS HEALTH ADMINISTRATION: Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records (2019-08658-R5-0002)

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

1. Thank you for the opportunity to review and comment on the subject Office of Inspector General (OIG) draft report. The Veterans Health Administration (VHA) concurs with the two recommendations and provides an action plan in the attachment.

The OIG removed point of contact information prior to publication.

(Original signed by)

Richard A. Stone, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

VETERANS HEALTH ADMINISTRATION: Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records

(2019-08658-R5-0002)

The OIG made two recommendations to the Under Secretary for Health:

Recommendation 1. Ensure facilities create and implement standard operating procedures that clearly define all Health Information Management and community care staff responsibilities and the procedures for accurately scanning, importing, and indexing non-VA medical records.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) program office will, in coordination with VHA Operations and Office of Community Care, ensure facilities create and implement standard operation procedures that clearly define all HIM and community care staff responsibilities. VHA facilities will be notified in writing of the requirement to have a standard operating procedure that addresses accurately scanning, importing and indexing non-VA medical records.

Status: In progress Target Completion Date: September 2021

Recommendation 2. Require facility directors ensure that Health Information Management leaders provide or formally delegate training, quality checks, and quality assurance monitoring for community care staff responsible for medical record management.

VHA Comments: Concur

The Veterans Health Administration (VHA) Health Information Management (HIM) program office will, in coordination with VHA Operations and Office of Community Care, require facility directors ensure that HIM leaders provide or formally delegate training, quality checks, and quality assurance monitoring for community care staff responsible for medical record management. VHA medical center directors will be notified in writing to provide HIM with a memorandum verifying designation of staff who are responsible for training, quality checks, and quality assurance monitoring for medical record management.

Status: In progress Target Completion Date: July 2021

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Audit Team	Daniel Morris, Director Ken Myers, Director Alicia M. Allen Tony Barnes Josh Belew Jenniffer Corriea Brad Lewis Eric Sanford
Other Contributors	Kathryn Berrada Kim Cragg Tamara Schulman Rasmi Simhan

Ken Myers passed away recently. Ken was a valued member of the Office of Audits and Evaluations who worked diligently to serve veterans and the public. He will be missed.

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