Department of Veterans Affairs

Office of Inspector General

Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services

VHA could resolve contract and security issues by using speech recognition technology to transcribe medical reports in-house.

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Contents

Page

Executive Summary i

Introduction 1

Purpose 1

Background 1

Scope and Methodology 1

Results and Conclusions 3

Issue 1: Using Speech Recognition Technology To Transcribe Medical Reports In-House Would Resolve Contract and Security Issues 3

Issue 2: Acquiring Contract Transcription Services Uniformly Nationwide Would Achieve Economies 5

Issue 3: Invoice Verification Practices Did Not Ensure that the Services Paid For Were Received 9

Issue 4: Management Controls Over Patient Privacy Needed Strengthening 13

Appendixes

A. Survey of Veterans Health Administration Facilities 17

B. The State of Speech Recognition Technology in the Industry and Within the Veterans Health Administration 23

C. Results of Site Visits to VHA Facilities Using Speech Recognition 27

D. Monetary Benefits in Accordance with IG Act Amendments 30

E. Under Secretary for Health Comments 31

F. OIG Contact and Staff Acknowledgments 37

G. Report Distribution 38

Executive Summary

Introduction

The VA Office of Inspector General (OIG) conducted an audit of the management controls relating to the acquisition of medical transcription services by the Veterans Health Administration (VHA). Medical transcription is the translation of patient health assessments, recorded by physicians and other health care providers, into text reports for documentation in the patients' medical records. The purpose of the audit was to determine whether applicable management controls were adequate and operating to ensure that VHA acquired transcription services economically, efficiently, and in compliance with applicable laws and regulations.

The audit was initiated after an OIG hotline evaluation, beginning in May 2002, disclosed that a contractor transcribing reports for several VHA facilities had submitted erroneous invoices for payment to some facilities by invoicing for reports that contained shorter lines of text than the line lengths defined in the contracts. A line of text was the predominant unit of measure used by VHA facilities to acquire medical transcription services. The audit disclosed other deficiencies relating to the acquisition of contract medical transcription services by VHA that may weaken program controls and result in unnecessary expenditures of VA resources.

In fiscal year (FY) 2004, VHA had 147 contracts, valued at about $30 million, with 43 contractors to acquire medical transcription services. VHA spent an additional $16 million in salaries for in-house and transcription-related support staff.

Results

VHA's processes and procedures for acquiring medical transcription services were deficient and needed improvement. The audit showed that: (1) using speech recognition technology (SRT) to transcribe medical reports in-house would resolve contract and security issues; (2) acquiring transcription services uniformly nationwide would achieve economies; (3) invoice verification practices did not ensure that the services paid for were received; and (4) management controls over patient privacy needed strengthening.

Using Speech Recognition Technology To Transcribe Medical Reports In-House Would Resolve Contract and Security Issues

VHA needs to develop the ability to perform its medical transcription function in-house because there is no practical way to ensure that contractors safeguard patients' protected health information (PHI). The inability to control confidential information in an era of global outsourcing leaves PHI unprotected and patients subject to identity theft.

VHA could ensure PHI security by using SRT to transcribe medical reports in-house. SRT is an emerging technology that is being used by some contractors to transcribe VHA reports. However, VHA had not issued policy or put forth a coordinated effort to study the benefits of using SRT. Implementation of SRT within VHA has been left to the discretion of individual facilities and, as a result, the technology was in use on a limited basis at only 52 facilities. Our survey showed that 79 other facilities were not using SRT, of which 48 reported no future plans to use the technology. SRT is an alternative to outsourcing that would allow health care providers to retain control over the documentation of patient records.

We did not conduct an analysis of the return on investment from a nationwide implementation of SRT because: (1) systems costs provided by VHA facilities using speech recognition programs were inconsistent and ranged from $300 to over $900,000, which means that facilities were using the technology to widely varying degrees and (2) gathering and analyzing departmental overhead and distribution costs, such as the cost of supervisors and other involved staff, dictation equipment, printers, fax machines, telephones, remote access for at-home work, as well as space costs and utilities were outside the scope of this audit.

Acquiring Contract Transcription Services Uniformly Nationwide Would Achieve Economies

VHA facilities agreed to pay significantly different line rates for medical transcription services. Some facilities paid up to 145 percent more than other facilities for the same line of transcription. If all VHA facilities had negotiated line rates at the lowest line rate contracted for, VHA could have saved an estimated $6.2 million in FY 2004.

These conditions occurred because the procurement process for medical transcription services was not coordinated VHA-wide, and 129 medical centers, healthcare systems, and Veterans Integrated Service Networks (VISNs) (collectively referred to as facilities) independently negotiated their own contracts. Additionally, VHA did not have a standard Statement of Work (SOW) concerning line length, formatting characteristics, and how the line length would be determined. As a result, some facilities agreed to pay for special characters, bolding, underlining, headers and footers, blank spaces separating words, or blank lines, while others did not.

Invoice Verification Practices Did Not Ensure that the Services Paid For Were Received

VHA facilities overpaid some contractors because facility Contracting Officer's Technical Representatives (COTRs) relied on supporting documentation provided by the contractors to approve invoices for payment, without verifying the accuracy of the information provided. Overpayments are under review by the OIG in coordination with

the Department of Justice (DOJ) for appropriate action. In addition, an employee at one VHA facility, who also provided transcription services after hours as a transcription contractor, recently pleaded guilty to a felony count of falsifying transcription line counts. The former employee was later sentenced in United States (U.S.) District Court and ordered to make restitution of $46,357. The COTR did not verify invoices submitted by the employee and retired after facility management recommended disciplinary actions. Also, a Combined Assessment Program (CAP) review performed at a facility in September 2002 showed that invoice verification practices were generally inadequate, and COTRs were not properly trained to verify invoice line counts.[1]

Management Controls Over Patient Privacy Needed Strengthening

VHA facilities did not have adequate controls to ensure that patients' PHI was secure against unauthorized access once the information was in the possession of the contractors. Some contractors were not required to transcribe medical information and patient identifiable information in the U.S. or its territories, and some were not required to meet basic security requirements necessary to protect PHI against unauthorized disclosure or misuse. Additionally, some facilities did not have Business Associate Agreements (BAA) with their transcription contractors, as required by the Health Information Portability & Accountability Act (HIPAA) of 1996 (Public Law 104-191).

During the audit, two U.S. Senators contacted the VA Congressional Liaison Service and expressed concerns that confidential VHA medical information was being transcribed overseas and that terrorists had access to medical data identifying U.S. service members and their families. While the scope of our audit did not include determining whether terrorists had access to VHA data, the audit showed that VHA's operating controls were incapable of controlling or detecting where the data was transcribed, or who had access to it. This deficiency in controls by VHA was illustrated in February 2005 when an offshore subcontractor in India threatened to expose personal and private information of about 30,000 VHA patients over the Internet.

Our discussions with staff in the VA Office of Information, Health Information Management Program Office indicated that, while VHA is aware of the conditions identified in this report and is studying several potential solutions, they acknowledged the conditions still existed as of February 2006.

Conclusion

Controls over the contract transcription process were inadequate, medical transcription services were not acquired economically, invoices were paid without verification, and

[1] *Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, Florida,* Report No. 02-03094-101, dated May 22, 2003.

PHI was vulnerable to unauthorized access. VHA could resolve these concerns by using SRT to transcribe medical records documentation in-house.

To improve the medical transcription process, we recommended that the Under Secretary for Health: (1) evaluate the various SRTs available and mandate the implementation of the SRT most suitable for VHA; (2) coordinate the acquisition of medical transcription services VHA-wide to ensure that comparable rates are paid for the same services and at the most economical rates; (3) ensure that facility COTRs are properly trained to monitor contractor performance, contracting officers appoint COTRs in writing, and COTRs verify the accuracy of invoice line counts to ensure that contractors are not overpaid; and (4) ensure that all contracts contain appropriate security provisions to protect PHI while in the possession of the contractors.

Comments

Except for the monetary benefits, the Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans. The Under Secretary indicated that VHA will conduct a study to determine whether a national contract, SRT, or some combination of the two, is the best approach for acquiring medical transcription services VHA-wide. In the meantime, VHA has already inserted language into the VHA BAA template that forbids the transfer of veterans' PHI outside the jurisdiction of the U.S. and plans to issue a memorandum, through the VHA Prosthetics and Clinical Logistics Office (P&CLO), to medical facilities requiring that all contracts meet the security specifications recommended in the report. The Under Secretary deferred agreeing with the monetary benefits until October 1, 2006, in order to have an adequate opportunity to review the issues involved. *(See Appendix E, pages 31–36, for the full text of the Under Secretary's comments.)*

If VHA concludes that contracting is the best approach to acquiring medical transcription services VHA-wide, then technologies must be put in place to protect veterans' identities and PHI against inappropriate disclosure and misuse while the data is in the possession of the contractors.

(original signed by:)
MICHAEL L. STALEY
Assistant Inspector General
For Auditing

Introduction

Purpose

The purpose of the audit was to determine whether VHA acquired medical transcription services economically, efficiently, and in compliance with applicable laws and regulations.

Background

In May 2002, the OIG received a hotline complaint alleging that a contractor with multiple VHA contracts had submitted erroneous invoices for payment to VHA by billing some facilities for medical reports that contained lines of text with fewer characters than prescribed in the contracts. The complainant also alleged that the contractor violated the Privacy Act of 1974 (5 USC Section 552a, as amended) by subcontracting with offshore transcriptionists using an unsecured Internet website. In October 2002, another complainant made similar allegations against another contractor with multiple VHA contracts. The allegations resulted in inquiries from Members of Congress and led to reviews by the VA OIG that are still in progress in coordination with DOJ. In November 2004, following a probe launched by the Securities and Exchange Commission, one of the contractors publicly acknowledged overbilling clients. In February 2005, a subcontractor in India contacted the OIG and threatened to expose thousands of VHA patient records over the Internet due to a payment dispute with another subcontractor. These allegations suggested that contract transcription services, which are widely used by VHA to perform a vital administrative function, are carried out in a high-risk environment that lacks reliable security and regulatory controls.

Scope and Methodology

To assess the management controls over VHA's acquisition of medical transcription services, we conducted an Internet survey of VHA facilities on October 28, 2003, and requested follow-up information on November 24, 2004, to update facilities' initial responses.

In October 2003, we requested that VHA facilities complete an OIG Internet survey for purposes of gathering the information necessary to conduct the audit. The survey was distributed to 179 VHA facilities and resulted in 159 responses from 141 VHA facilities. Of the 141 facilities, 129 reported having 147 contracts; the other 12 either performed transcription services in-house or used sharing agreements with the Department of Defense (DoD) or other VHA facilities. In March 2004, the audit was temporarily suspended due to competing priorities and was reactivated in September 2004. In November 2004, we requested follow-up information for purposes of updating and supplementing the information obtained during the initial survey and completed our interviews with responsible managers and officials in February 2006.

In conducting the audit, we analyzed and summarized the survey responses received from VHA facilities and followed up with facility staff where necessary. We conducted site visits at six VHA facilities to evaluate invoice verification procedures. We reviewed applicable laws and regulations, transcription contracts, BAAs, contract transmission logs, monthly contractor invoices, transcribed reports from VHA's Computerized Patient Record System (CPRS), and pertinent OIG findings and reports of audits and investigations. We held discussions with VHA Central Office and field station staffs in Health Information Management Systems (HIMS), Management Review Service, Health Data and Informatics, and Information Resources Management. We interviewed representatives from several distributors of SRT and discussed the availability and applicability of SRT relative to capturing and organizing VHA patient data in report format.

We also conducted site visits at three additional VHA facilities to observe the use and performance of SRT in actual health care environments.[2] The audit covered the period October 1999 through February 2006 and was made in accordance with Generally Accepted Government Auditing Standards.

[2] The three VHA facilities were: VA Medical Center Atlanta (Decatur, Georgia); VA Medical Center Memphis, Tennessee; and Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin.

Results and Conclusions

Issue 1: Using Speech Recognition Technology To Transcribe Medical Reports In-House Would Resolve Contract and Security Issues

Findings

VHA needs to develop the capacity to perform its medical transcription function in-house where practicable. Current operating controls were inadequate to ensure that the transcription services paid for were received or to detect whether contractors safeguarded the confidential information VHA entrusted to them. As shown in the report:

- Variations in contract line rates resulted in VHA incurring an estimated $6.2 million in unnecessary costs in FY 2004 (*Issue 2: Acquiring Contract Transcription Services Uniformly Nationwide Would Achieve Economies, page 5*).
- Some contractors overbilled VHA based on inflated line counts (*Issue 3: Invoice Verification Practices Did Not Ensure That the Services Paid For Were Received, page 9*).
- Some contractors used offshore subcontractors to transcribe VHA patient data without VHA's knowledge or approval, which led to a recent incident whereby an offshore subcontractor with access to patient data for 5 VHA facilities threatened to expose about 30,000 patient records over the Internet (*Issue 4: Management Controls Over Patient Privacy Needed Strengthening, page 13*).
- Numerous VHA facilities cited poor workmanship on contractor-transcribed reports (*Appendix B, The State of Speech Recognition Technology In the Industry and Within the Veterans Health Administration, page 23*).

The potential damage and harm to veterans that could occur from unauthorized disclosure of their PHI needs to be addressed. Without adequate controls to ensure patient privacy, using contractors to transcribe confidential information in an era of global outsourcing leaves PHI unprotected and patients subject to identity theft. SRT is an alternative to outsourcing that would eliminate the contract and data security issues currently facing VHA. Additionally, maximum use of SRT would allow health care providers to retain control over the documentation of patient records.

We did not conduct an analysis of the return on investment from a nationwide implementation of speech recognition technology because: (1) systems costs provided by VHA facilities using speech recognition programs were inconsistent and ranged from $300 to over $900,000, which means that facilities were using the technology to widely varying degrees and (2) gathering and analyzing departmental overhead and distribution

costs, such as the cost of supervisors and other involved staff, dictation equipment, printers, fax machines, telephones, remote access for at-home work, as well as space costs and utilities was outside the scope of this audit.

Our discussions with VHA Central Office staff on July 28, 2005, disclosed that VHA did not have a specific policy on the use of SRT to transcribe VHA medical record documentation. However, as of February 8, 2006, according to staff from the VA Office of Information, Health Information Management Program Office, VHA Central Office had begun consulting with VHA facilities currently using SRT to study the methods in use.

Recommended Improvement Action 1. We recommended the Under Secretary for Health require VHA to follow through on efforts to evaluate the various SRTs available and mandate the implementation of the SRT most suitable for VHA.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the finding and recommendation.

Implementation Plan

The Under Secretary indicated that VHA is in the process of developing a data call to determine the extent to which SRTs are used within VHA and plans to convene an interdisciplinary VHA workgroup to review available SRTs and explore the feasibility of developing a standard technology for use throughout VHA. The review and exploration phase is expected to be completed by August 31, 2006, with recommendations made to the Under Secretary for Health on the feasibility of a national roll-out of SRTs in VHA by October 1, 2006. Implementation plans will be developed based on the decision of the Under Secretary for Health.

(See Appendix E, page 33, for the full text of the Under Secretary's implementation plan.)

Office of Inspector General Comments

The Under Secretary's implementation plan is acceptable. The Under Secretary indicated that VHA will conduct a study concerning the use of a national contract, SRT, or some combination of the two, to develop a common strategy for acquiring medical transcription services VHA-wide. If VHA's strategy is to continue using contractors, technologies must be put in place to protect veterans' identities and PHI against inappropriate disclosure while the data is in the possession of the contractors. We will follow up on planned actions until they are completed.

Issue 2: Acquiring Contract Transcription Services Uniformly Nationwide Would Achieve Economies

Findings

VHA agreed to pay transcription contractors an estimated $6.2 million unnecessarily in FY 2004 because the procurement process for medical transcription was not uniform and coordinated VHA-wide. VHA did not have a national contract to acquire medical transcription services, and as a result, 129 medical centers, healthcare systems, and VISNs acquired the services under 147 different contracts with 43 different contractors at line rates that varied from contract to contract and facility to facility.

Decentralized procurement activities left VHA's purchasing power fragmented and resulted in some facilities not obtaining the best prices available. Negotiating line rates that are consistent and based on a uniform line definition would ensure equitable line rates and reduce the cost of VHA's medical transcription services.

VHA Acquired Transcription Services from Numerous Contractors at Line Rates that Varied from Contract to Contract and Facility to Facility

In FY 2004, VHA acquired about 197 million lines of medical transcription services totaling about $30 million from 43 contractors. The audit showed that VHA acquired these services under 147 different contracts, which were negotiated at the following organizational levels:

Organizational Level	Contracts	Percent
Medical Center	70	48
VISN	68	46
Health Care System	9	6
Total	**147**	**100**

To determine whether contracts rates were reasonably consistent from contract to contract and facility to facility, we reviewed a sample of 78 medical transcription services contracts. These 78 contracts were from 76 facilities. The 76 facilities acquired about 118 million lines of text valued at about $17 million from 31 contractors during FY 2004. The audit showed that:

- Some facilities agreed to pay higher rates than others for lines of the same or shorter length.
- Some facilities agreed to pay for formatting attributes that others did not.

- Some facilities agreed to pay different rates for radiology and general medicine reports.
- Contractors with more than one contract negotiated different line rates for the same or similar services with different facilities.

Some Facilities Agreed to Pay Higher Rates for Lines of the Same or Shorter Length. The 78 contracts reviewed applied 12 different definitions to establish the length of a line of text for billing and payment purposes:

Variance in Cost Per Line of Text by Line Definition

	Line Definition	Contracts	High	Low	Average	Variance	Percent Variance
Keystrokes	85	1	$0.1300				
	80	10	$0.2600	$0.1200	$0.1771	$0.1400	117%
	75	3	$0.2200	$0.1403	$0.1946	$0.0797	57%
	70	1	$0.1600				
	66	1	$0.1200				
	65	6	$0.1700	$0.1200	$0.1453	$0.0500	42%
	Contracts	**22**					
Printable Characters	80	17	$0.2700	$0.1100	$0.1547	$0.1600	145%
	75	6	$0.2200	$0.1400	$0.1569	$0.0800	57%
	72	2	$0.1250	$0.1230	$0.1240	$0.0020	2%
	70	8	$0.2221	$0.1250	$0.1579	$0.0971	78%
	65	22	$0.2200	$0.1250	$0.1545	$0.0950	76%
	50	1[3]	$0.1500	$0.1200	$0.1350	$0.0300	25%
	Contracts	**56**					
	Total Contracts	**78**					

VHA facilities often agreed to pay more per line for lines based on keystrokes than lines based on printable characters of the same length. For example, some facilities agreed to pay an average of $0.1771 per line based on 80 keystrokes while others agreed to pay an average of $0.1547 per line based on 80 printable characters. Comparing keystrokes to printable characters showed that 80 keystrokes are equivalent to 65 printable characters. Therefore, the cost of 80 keystrokes should be less than the cost of 80 printable characters and close to the cost of 65 printable characters. How “lines” are counted or defined is a critical issue in transcription contracts.

The previous table showed that line rates varied from 2 percent to 145 percent for 9 of the 12 line definitions applied by VA staffs. Ten contracts defined a line of text as 80 keystrokes, with line rates ranging from $0.1200 to $0.2600 per line. Two facilities agreed to pay $0.1675 and $0.1700 per line for 65-keystroke lines, while 10 facilities agreed to pay the same or lower rates for longer line lengths. Similarly, the facility agreeing to pay $0.1100 per line for 80 printable characters had the lowest rate per line for printable characters but the longest line.

[3] This contract had different rates for radiology and general medicine reports.

Some Facilities Agreed to Pay for Formatting Attributes. Our review of the 78 contracts showed numerous inconsistencies in line definitions applied by VA staffs other than line length. For example:

- Spaces between words were counted for billing purposes in 22 contracts, but not in the remaining 56 contracts.
- Headers and footers were included in the line lengths for 42 contracts, but not for 31 contracts. There were no responses to our survey for 5 contracts.
- Blank lines were countable for billing purposes in 4 contracts, but not for 70 contracts. There were no responses to our survey for 4 contracts.
- Other formatting inconsistencies identified during our review were related to character spacing; font styles, sizes, and types; margins; and paper size. For example:
  - Character spacing was specified in 51 contracts, but not in 27.
  - Font styles were specified in 44 contracts, but not in 34.
  - Font sizes were specified in 54 contracts, but not in 24.
  - Font types were specified in 47 contracts, but not in 31.
  - Margins were specified in 42 contracts, but not in 36.
  - Paper size was specified in 22 contracts, but not in 56.

Facilities Agreed to Pay Different Rates for General Medicine and Radiology Reports. In 41 of the 78 contracts, the contractors were required to transcribe general medicine and radiology reports. In all 41 contracts, the contract line lengths were the same for the 2 types of reports. For 21 contracts, the cost was the same for both types of reports. However, the cost per line for the 2 types of reports was different for the remaining 20 contracts:

- In seven contracts, the line rates for general medicine reports exceeded the line rates for radiology reports by as much as 46 percent.
- In 13 contracts, the line rates for radiology reports exceeded the line rates for general medicine reports by as much as 57 percent.

Our review of the contract SOWs found no valid reasons, such as requirements relating to formatting, turnaround times, or other complexities that supported different line rates for lines of the same length. The inconsistencies in line rates appeared to be the result of

uncoordinated procurement processes and ineffective price negotiations by VHA contracting officers, rather than more complex work requirements.

Contractors with more than One Contract Negotiated Different Line Rates for the Same or Similar Services with Different Facilities. We identified 13 of 32 contractors that had contracts with more than 1 VHA facility. These 13 contractors had from 2 to 14 contracts with 59 VHA facilities to transcribe medical records documentation. VHA agreed to pay these contractors about $15 million to transcribe about 98 million lines of text in FY 2004. Our review showed that several contractors negotiated higher rates with some facilities, regardless of the service provided. For example:

- One contractor had three contracts with three facilities totaling $679,662. All 3 contracts required the contractor to transcribe reports formatted in 80-printable character lines, and all 3 facilities paid different rates per line ($0.2286, $0.2300, and $0.2700, respectively) for general medicine reports, a variance of 18 percent. One contract required the contractor to also transcribe radiology reports for only $0.1800 per line, which was significantly lower than the rate for the general medicine reports.
- Another contractor had two contracts with two facilities in the same metropolitan area totaling $895,974. Both contracts required the contractor to transcribe reports formatted in 70-printable character lines. However, the contracts provided that one facility was charged $0.1960 per line, while the other was charged only $0.1550 per line, a variance of 26 percent.
- One contractor had four contracts with four facilities totaling about $1.9 million. The contractor charged a facility $0.1100 per line to transcribe an 80-printable character line of text, while charging another facility $0.1500 per line to transcribe a shorter 70-printable character line of text. As a result, 1 facility agreed to pay $1.38 for every 1,000 printable characters, while the other paid $2.14 for every 1,000 printable characters, a variance of 55 percent.
- Another contractor had 14 contracts with 14 facilities totaling about $2.5 million. Four contracts required 80-keystroke lines of text; however, the contractor charged each facility a different rate. The rates ranged from about $0.1700 to $0.2600 per line, a variance of 53 percent. Further review showed that 7 contracts requiring 65-printable character lines had line rates ranging from $0.1400 to $0.2200 per line, a variance of 57 percent. Had each facility agreed to pay the lowest line rate for each line length in FY 2004, the 11 facilities could have saved a total of about $280,000.

Similar calculations for all 78 contracts included in our review showed that VHA could have saved about $6.2 million (22 percent) in FY 2004. As of February 8, 2006, VHA was planning to develop a Blanket Purchase Agreement (BPA) for the acquisition of transcription services that would address equity in pricing by delineating standard line definitions.

Conclusion

VHA facilities did not acquire contract transcription services economically. Decentralized procurement methods left VHA's purchasing power fragmented and uncoordinated, resulting in facilities not obtaining the best prices available. We estimate that VHA could have saved about $6.2 million in FY 2004 if all facilities had agreed to pay comparable rates for the same services.

Recommended Improvement Action 2. We recommended the Under Secretary for Health require VHA to coordinate the acquisition of medical transcription services VHA-wide to ensure that comparable rates are paid for the same services and at the most economical rates.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the finding and recommendation, but deferred agreeing with the estimated monetary benefit until October 1, 2006, in order to have an adequate opportunity to review the issues involved.

Implementation Plan

The Under Secretary indicated that the data call mentioned in response to Recommended Improvement Action 1 will include a request for information on rates paid across the country for similar services. After review of the rates and related information, an interdisciplinary VHA workgroup will make recommendations to the Under Secretary for Health on whether developing a national contract for transcription services is the most economic and effective method for securing PHI and providing medical transcription services VHA-wide.

(See Appendix E, page 34, for the full text of the Under Secretary's implementation plan.)

Office of Inspector General Comments

The Under Secretary's implementation plan is acceptable. We will follow up on planned actions until they are completed.

Issue 3: Invoice Verification Practices Did Not Ensure that the Services Paid For Were Received

Findings

Overbilling based on inflated line counts by contractors is a significant problem for VHA. Two contractors used by VHA are currently under review by OIG in coordination with

DOJ for allegedly overbilling VHA. In addition, an employee of one VHA facility, who was also providing transcription services for the facility after hours as a transcription contractor, recently pleaded guilty to a felony count of overbilling VHA based on inflated line counts.

Contractor overbilling is often not detected by VHA because facility COTRs frequently rely on information provided by the contractor to verify invoice accuracy. Additionally, COTRs used contractor-provided software to verify invoice line counts without determining the reliability of the software, were not familiar with contract requirements, and some COTRs were not properly trained in invoice verification practices.

VHA Overpaid Some Transcription Contractors

Our review of a sample of reports transcribed by three contractors used by VHA disclosed that the line counts invoiced to five VHA facilities by two of the contractors were inconsistent with contract terms, were overbilled, and resulted in overpayments. In FY 2004, the 3 contractors provided transcription services to 80 VHA facilities, at a cost of about $14.8 million. Our review showed the following:

- A contractor who provided services to several VHA facilities overstated the line counts invoiced to 4 facilities by 34 to 70 percent, resulting in overpayments.
- Another contractor providing services to several VHA facilities overstated the line counts invoiced to a VHA facility by about 15 percent. The contractor incorrectly included blank lines in the invoice line count, which was not consistent with contract terms, resulting in overpayments.
- The third contractor also provided services to multiple VHA facilities. Our review of invoices at one VHA facility disclosed that the invoice line counts were accurate. However, our review showed that the invoice verification practices in place at the facility were deficient and relied on manual line counts by the COTR without regard to the length of the lines. Because the invoice line counts were invariably lower than the COTR's line counts, the COTR accepted the invoice line counts as accurate without determining if they were consistent with contract requirements. Our line counts showed that the invoice line counts were not overbilled; however, had they been, the COTR might not have detected the inaccuracies due to deficient invoice verification practices.

Invoice Verification Practices Were Not Independent

COTRs frequently did not identify contractor-inflated line counts because they certified invoices without verifying that contractor-provided information was accurate. Additionally, some COTRs were not knowledgeable of contract terms and specifications, and some were not adequately trained in invoice verification procedures.

Responses to our survey from 147 respondents with contracted transcription services showed that 35 respondents did not verify contractor invoices before paying the contractors. Although 112 respondents reported that they verified invoices before payments were made, descriptions of the verification processes provided by 75 of the 112 respondents showed that the actions taken did not represent independent verifications. For example:

- In 41 responses, COTRs compared the number of lines reported in the contractors' transmission logs with the monthly invoices without testing the validity of the contractors' line counts, such as sampling the transcribed reports to verify that the line counts claimed were accurate.
- In 12 responses, COTRs used contractor-furnished software to verify line counts without testing the software for reliability.
- In 22 responses, COTRs did not verify the contractors' line counts at all.

Our onsite reviews at six VHA facilities identified similar conditions. The reviews disclosed that some COTRs only compared contractor-provided transmission logs with contractor-provided invoices without verifying either, and some used contractor-provided software to verify contractor line counts without testing the reliability of the software. Additionally, some COTRs were not familiar with the terms of the contracts, some had not been properly trained in invoice verification procedures, and some had not been appointed by the contracting officer in writing, as required by VHA policy.

An OIG CAP review at a VHA facility disclosed that the COTR was not adequately verifying invoices.[4] The COTR did not verify the accuracy of the contractor's line counts before certifying invoices for payment. While the contract required the contractor to submit transmission logs containing report-tracking details, none were submitted or requested by facility staff. As a result, the facility paid about $3 million for transcription services without assurance that the related invoices were accurate.

While developing information to respond to our survey, one facility Director discovered that a facility employee, who was also providing transcription services to the facility after hours as a contractor, had overstated the line counts on invoices submitted to the facility for payment. The invoices were certified and paid without verification. A subsequent OIG investigation disclosed that, during the period September 2001 through November 2003, the contractor overbilled the facility by over $46,000. The former employee pleaded guilty to a felony count of overbilling VHA and was sentenced on September 22, 2005, to 5 years probation, 6 months of home confinement with electronic monitoring, $46,357 in restitution, and a $100 fine.

[4] *Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, Florida*, Report No. 02-03094-101, May 22, 2003.

Our discussions with VHA Central Office staff in July 2005 and February 2006 indicated VHA is planning to convene a working group to outline a SOW for a BPA to acquire transcription services. Part of the group's work will be to review VISN and medical facility contracts to identify well-defined requirements addressing quality, accuracy, timeliness, and invoice validation. Those types of requirements will then be added to the SOW. Invoice verification procedures can be further addressed by ensuring that facility COTRs are properly trained in how to verify contractor line counts.

Conclusion

VHA invoice verification practices did not ensure that the services paid for were received. VHA overpaid some contractors because contractors improperly billed VA and facility COTRs were not adequately trained and did not properly verify the contractors' invoiced line counts. Review of possible improprieties by contractors continues by the OIG in coordination with DOJ for appropriate action.

Recommended Improvement Action 3. We recommended the Under Secretary for Health require VHA to ensure that: (a) COTRs conduct independent line counts to ensure the accuracy of contractor invoices, (b) facility COTRs are properly trained to monitor contractor performance, and (c) contracting officers appoint COTRs in writing.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the finding and recommendation.

Implementation Plan

The Under Secretary indicated that the P&CLO will issue guidance through the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to the field contracting officers requiring that facility COTRs are adequately trained to verify that services and prices paid are proper and in accordance with the terms of the transcription contracts. In addition, COTRs will be assigned in writing.

(See Appendix E, page 35, for the full text of the Under Secretary's implementation plan.)

Office of Inspector General Comments

The Under Secretary's implementation plan is acceptable. We will follow up on planned actions until they are completed.

Issue 4: Management Controls Over Patient Privacy Needed Strengthening

Findings

VHA facilities did not have adequate controls to ensure that VHA patients' PHI was secure against unauthorized access once the information was in the possession of contractors. Some contractors were not required to perform VHA work in the U.S. or its territories or meet minimal data security requirements, and some VHA facilities had not established BAAs with their contractors, as required by HIPAA. OIG CAP reviews have consistently identified deficiencies in VHA's controls over automated information systems (AIS) security, including some deficiencies relating to transcription services contractors. Deficient controls over medical transcription left VHA patient PHI subject to misuse, as shown in the following paragraphs.

Operating Controls Did Not Safeguard Patients' PHI

In August and September 2004, two U.S. Senators contacted the VA Congressional Liaison Service and expressed concerns that transcription contractors were sending confidential VHA medical information overseas to be transcribed in India and Pakistan. One Senator was particularly concerned, based on contact from a constituent, that terrorists had access to medical data identifying U.S. service members and their families. While determining whether terrorists had access to data identifying U.S. citizens was beyond the scope of our audit, we did learn that VHA patient data had been sent overseas and that VHA's current operating controls were incapable of controlling or detecting where the information was transcribed, or who had access to it.

The following incident illustrates VHA's vulnerability when contractors are used to transcribe confidential patient information. Beginning on February 23, 2005, the OIG Hotline Division received several e-mails from a subcontractor in India claiming that a subcontractor working for a U.S. contractor with numerous VHA contracts had not paid them over $28,000 for transcribing VHA medical records. The offshore subcontractor claimed having access to medical data from 5 VHA facilities and threatened to expose about 30,000 VHA patient records over the Internet if the amount owed was not paid.

This incident occurred because VHA lost control over its patient information once the information traveled outside the VA system firewall. The U.S. contractor paid the amount in dispute, and the offshore subcontractor certified in writing that all VHA records were destroyed. However, VHA has no way of validating whether the subcontractor actually destroyed the information or whether other VHA patient records are in the possession of offshore subcontractors, or individuals and groups hostile to U.S. interests.

Transcription Contracts Did Not Contain Basic Security Requirements

Our survey showed that some VHA transcription contracts did not contain basic security requirements necessary to protect PHI or provide recourse against contractors in the event of unauthorized disclosure or misuse of the information. Survey responses from the 129 facilities with 147 transcription contracts showed that:

- One hundred thirteen facilities with 127 contracts did not remove patients' personal identifiers before contractors were allowed to access the information. While 13 facilities with 14 contracts reported that they required the removal of patients' personal identifiers, our contact with these facilities disclosed that the facilities had not de-identified the data, but relied on the contractor to do so.[5] Therefore, none of the responding facilities removed patient identifiers before the contractor accessed the information. De-identification of patient information would eliminate the risk of unauthorized disclosure of VHA data and meet HIPAA requirements. However, VHA Heath Information and Management staff told us that de-identification of patient information would be extremely difficult and impractical because the process to file reports in CPRS is based on patients' social security numbers.

- Limitations on access to VHA data at contractors' facilities were not specified in 82 (56 percent) contracts.
- Security requirements were not specified for transcriptionists working at home in 73 (50 percent) contracts.
- Background investigations and signed "Rules of Behavior" for contract staff working at VHA facilities were not specified in 53 (36 percent) contracts. "Rules of Behavior" define acceptable practices for the use of an information system.
- Requirements concerning when and how to purge VHA data from contractor computer systems were not specified in 45 (31 percent) contracts.
- VHA did not require contractors to transcribe VHA patient data in the U.S. or its territories in 70 (48 percent) contracts.

We reviewed 78 transcription contracts in detail to determine whether they prohibited the use of subcontractors, required VHA approval to use subcontractors, or required all work to be performed in the U.S. or its territories. Our review disclosed that 58 (74 percent) of the 78 contracts permitted the use of subcontractors, while in many cases the contracts did not contain precise or consistent specifications concerning the use of subcontractors or where the work was to be performed, as shown below:

- Sixteen (21 percent) contracts required the VHA contracting officers to approve the use of subcontractors, while the remaining 62 contracts did not.

[5] Three facilities with three contracts did not respond.

- Twenty-five (32 percent) contracts required that all work be performed in the U.S. or its territories or prohibited the use of offshore transcriptionists.
- Forty-four (56 percent) contracts neither required approval by the contracting officers to use subcontractors nor specified that all work be performed in the U.S. or its territories.
- Ten (13 percent) contracts required that the contractor employees or subcontractors be U.S. citizens; however, the contracts did not address the use of offshore subcontractors or the location of transcriptionists.

While some contracts did appear to contain adequate requirements to hold contractors liable for unauthorized disclosure or misuse of VHA patient data, there was no practical way for facilities to know whether contractors were complying with the requirements after the data was in their possession. Because patients' personal identifiers, such as names, addresses, dates of birth, and social security numbers are not removed before contractors access VHA data, unauthorized disclosure could result in misuse of the data and could be detrimental to patients.

Some VHA Facilities Did Not Have BAAs With Their Contractors

Our audit showed that 13 VHA facilities did not have BAAs with their transcription contractors, as required by HIPAA. HIPAA requires "covered entities" to establish agreements with their business associates concerning the protection of all individually identifiable health information (personal identifiers) held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The HIPAA Privacy Rule refers to this information as "protected health information." HIPAA requires covered entities using contractors or other non-workforce members to perform "business associate" services or activities to include certain protections for the information in BAAs. The BAAs must impose specific written safeguards on the PHI used or disclosed by its business associates.

CAP Reviews Identified Vulnerabilities in VHA Automated Information Systems

During the period October 1, 2001, through March 24, 2005, OIG CAP reviews identified AIS security issues at 60 VHA facilities, including 40 occasions where background investigations were not completed for VA and contract employees and 2 occasions where media storage hard drives were not degaussed before disposal of the equipment. VHA has similar vulnerabilities concerning transcription contractors. As indicated above, transcription contracts frequently did not specify that contractor staff have background investigations or that computer systems be properly purged of VHA data. This increases the vulnerability of VHA AIS and patient data to misuse.

VHA Central Office staff stated that the BPA for transcription services, which was still in the planning phase as of February 8, 2006, would include language prohibiting the use of offshore subcontractors and address privacy and security controls.

Conclusion

VHA did not have effective processes or procedures to ensure that contractors protect patients' PHI from unauthorized access and misuse.

Recommended Improvement Actions 4. We recommended the Under Secretary for Health require VHA to ensure that: (a) all contracts specify limitations on the access to VHA data at contractor facilities, contain security requirements for transcriptionists working at home, require contract staff working at VHA facilities to undergo background investigations and sign "Rules of Behavior" defining acceptable practices concerning the use of VHA information systems, specify when and how contractors are to purge VHA data from contractors' computer systems, and require contractors to transcribe VHA data in the U.S or its territories, and (b) all facilities complete required BAAs with their transcription contractors.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the finding and recommendation.

Implementation Plan

The Under Secretary indicated that the P&CLO will issue guidance through the DUSHOM to the field contracting officers requiring that all contracts meet the security specifications defined in this recommendation. In addition, VHA will gather information on the extent to which VISNs and facilities are meeting security requirements and develop an action plan to monitor and correct identified deficiencies.

(See Appendix E, page 36, for the full text of the Under Secretary's implementation plan.)

Office of Inspector General Comments

The Under Secretary's implementation plan is an acceptable interim solution until VHA develops a national strategy for acquiring medical transcription services, including the implementation of technologies to protect veterans' identities and PHI while the data is in the possession of transcription contractors. We will follow up on planned actions until they are completed.

Appendix A

Survey of Veterans Health Administration Facilities

VHA Facility		Responses[6]	Facilities
Station 358	Manila, PI	1	1
Station 402	Togus, ME	1	1
Station 405	White River Junction, VT	1	1
Station 436	Fort Harrison, MT	1	1
Station 437	Fargo, ND	1	1
Station 438	Sioux Falls, SD	1	1
Station 442	Cheyenne, WY	1	1
Station 452	Wichita, KS	2	1
Station 459	Honolulu, HI	1	1
Station 460	Wilmington, DE	1	1
Station 463	Anchorage, AK	1	1
Station 501	Albuquerque, NM	1	1
Station 502	Alexandria, LA	2	1
Station 503	Altoona, PA	1	1
Station 504	Amarillo, TX	2	1
Station 506	Ann Arbor, MI	1	1
Station 508	Atlanta (Decatur), GA	2	1
Station 509	Augusta, GA	1	1
Station 512	Baltimore, MD	1	1
Station 515	Battle Creek, MI	1	1
Station 516	Bay Pines, FL	1	1
Station 517	Beckley, WV	1	1
Station 518	Bedford, MA	1	1
Station 519	Big Spring, TX	1	1
Station 520	Biloxi, MS	1	1
Station 521	Birmingham, AL	1	1
Station 525	Brockton, MA	1	1
Station 528A8	Albany, NY	1	1
Station 528A6	Bath, NY	1	1
Station 526	Bronx, NY	1	1
Station 528	Buffalo, NY	1	1
Station 529	Butler, PA	1	1
Station 531	Boise, ID	1	1
Station 532	Canandaigua, NY	1	1
Station 534	Charleston, SC	2	1
Station 537	Chicago, IL	1	1
Station 538	Chillicothe, OH	1	1
Station 539	Cincinnati, OH	1	1
Station 540	Clarksburg, WV	1	1
Station 541	Cleveland, OH	1	1
Station 542	Coatesville, PA	1	1
Station 543	Columbia, MO	2	1
Station 544	Columbia, SC	1	1
Station 546	Miami, FL	1	1
Station 548	West Palm Beach, FL	1	1

[6] Some facilities had more than one contract and provided a response for each contract.

Appendix A

VHA Facility		Responses	Facilities
Station 549	Dallas, TX	1	1
Station 550	Danville, IL	1	1
Station 552	Dayton, OH	1	1
Station 553	Detroit, MI	1	1
Station 554	Denver, CO	1	1
Station 556	North Chicago, IL	1	1
Station 557	Dublin GA	1	1
Station 558	Durham, NC	2	1
Station 561A4	Lyons, NJ	1	1
Station 562	Erie, PA	1	1
Station 564	Fayetteville, AR	1	1
Station 565	Fayetteville, NC	1	1
Station 568	Fort Meade, SD (Fort Meade Campus)	2	1
Station 568	Fort Meade, SD (Hot Springs Campus)	1	1
Station 570	Fresno, CA	2	1
Station 573	Gainesville, FL	1	1
Station 575	Grand Junction, CO	1	1
Station 578	Hines, IL	1	1
Station 580	Houston, TX	1	1
Station 581	Huntington, WV	1	1
Station 583	Indianapolis, IN	1	1
Station 584	Iowa City, IA	1	1
Station 585	Iron Mountain, MI	1	1
Station 586	Jackson, MS	1	1
Station 589	Kansas City, MO	2	1
Station 590	Hampton, VA	1	1
Station 593	Las Vegas, NV	1	1
Station 595	Lebanon, PA	1	1
Station 596	Lexington, KY	1	1
Station 598	Little Rock, AR (Little Rock Campus)	1	1
Station 598	Little Rock, AR (North Little Rock Campus)	1	1
Station 600	Long Beach, CA	1	1
Station 603	Louisville, KY	2	1
Station 605	Loma Linda, CA	1	1
Station 607	Madison, WI	1	1
Station 608	Manchester, NH	1	1
Station 609	Marion, IL	1	1
Station 610	Marion, IN	1	1
Station 612	Martinez, CA	1	1
Station 613	Martinsburg, WV	1	1
Station 614	Memphis, TN	2	1
Station 618	Minneapolis, MN	1	1
Station 619	Montgomery, AL	1	1
Station 620	Montrose, NY	1	1
Station 621	Mountain Home, TN	1	1
Station 623	Muskogee, OK	2	1
Station 626	Nashville, TN	1	1
Station 629	New Orleans, LA	1	1
Station 630	New York, NY	1	1
Station 631	Northampton (Leeds), MA	1	1
Station 632	Northport, NY	1	1
Station 635	Oklahoma City, OK	1	1

Appendix A

VHA Facility		Responses	Facilities
Station 636	Omaha, NE	1	1
Station 636A6	Des Moines, IA	1	1
Station 637	Asheville, NC	1	1
Station 640	Palo Alto, CA	1	1
Station 642	Philadelphia, PA	1	1
Station 644	Phoenix, AZ	1	1
Station 646	Pittsburgh, PA	1	1
Station 647	Poplar Bluff, MO	2	1
Station 648	Portland, OR	1	1
Station 649	Prescott, AZ	1	1
Station 650	Providence, RI	1	1
Station 652	Richmond, VA	1	1
Station 653	Roseburg, OR	1	1
Station 654	Reno, NV	2	1
Station 655	Saginaw, MI	1	1
Station 656	St. Cloud, MN	1	1
Station 657	St. Louis, MO	2	1
Station 658	Salem, VA	1	1
Station 659	Salisbury, NC	1	1
Station 660	Salt Lake City, UT	1	1
Station 662	San Francisco, CA	1	1
Station 663	Seattle, WA	1	1
Station 664	San Diego, CA	1	1
Station 666	Sheridan, WY	1	1
Station 667	Shreveport, LA	1	1
Station 668	Spokane, WA	1	1
Station 670	Syracuse, NY	1	1
Station 671	San Antonio, TX	1	1
Station 672	San Juan, PR	1	1
Station 673	Tampa, FL	1	1
Station 674	Temple, TX	1	1
Station 676	Tomah, WI	1	1
Station 677	Topeka, KS	2	1
Station 678	Tucson, AZ	1	1
Station 679	Tuscaloosa, AL	1	1
Station 687	Walla Walla, WA	1	1
Station 688	Washington, DC	1	1
Station 689	West Haven, CT	2	1
Station 691	Los Angeles, CA	1	1
Station 692	White City, OR	1	1
Station 693	Wilkes-Barre, PA	1	1
Station 695	Milwaukee, WI	1	1
Station 756	El Paso, TX	1	1
Station 757	Columbus, OH	1	1
	Totals	**159**	**141**

Appendix A

	Count	Percent
Medical transcription service is performed by:		
VA staff only	8	5.03 %
VA staff and by contract	78	49.06 %
By contract only	71	44.65 %
Other (i.e., DoD Sharing Agreement), Specify	2	1.26 %
Total Responses	**159**	**100 %**
Did the facility conduct an A-76 Cost Comparison for in-house versus contract performance of the transcription function?		
Yes	21	13.21 %
No	138	86.79 %
Total Responses	**159**	**100 %**
The primary solicitor of the facility's transcription contract is:		
Veterans Integrated Service Network	68	46.26 %
Health Care System	9	6.12 %
Medical Center	70	47.62 %
Total Responses	**147**	**100 %**
Was the current contract competitive?		
Yes	127	86.99 %
No	19	13.01 %
Total Responses	**146**	**100 %**
Was the current contract an 8A small business set aside?		
Yes	30	20.55 %
No	116	79.45 %
Total Responses	**146**	**100 %**
Does the method used by VA to transmit dictation to the contractor provide for security of the confidential information being transmitted?		
Yes	117	82.39 %
No	25	17.61 %
Total Responses	**142**	**100 %**
Do contract specifications address the security of internal transmissions of VA information at non-VA facilities?		
Yes	57	41.01 %
No	82	58.99 %
Total Responses	**139**	**100 %**
Does the contract specify the security requirements for contractor employees working in VA facilities, i.e., background investigations and signed rules of behavior?		
Yes	78	59.54 %
No	53	40.46 %
Total Responses	**131**	**100 %**

Appendix A

	Count	Percent
Are personal identifiers, such as patient names and social security numbers, excluded before the facility transmits the data to the contractor for transcription?		
Yes	13	9.29 %
No	127	90.71 %
Total Responses	**140**	**100 %**
Do contract specifications address the security of internal transmission of VA information between the contractor's offices and/or homes of transcriptionists?		
Yes	69	48.59 %
No	73	51.41 %
Total Responses	**142**	**100 %**
Does the facility have a procedure in place to detect the contractor's use of offshore subcontractors?		
Yes	25	17.24 %
No	120	82.76 %
Total Responses	**145**	**100 %**
Does the contract specify that all work will be performed in the U.S. or its territories?		
Yes	75	51.72 %
No	70	48.28 %
Total Responses	**145**	**100 %**
Have there been any complaints by veterans over the past 3 years concerning possible breaches of confidentiality by contractor personnel?		
Yes	0	0.00 %
No	146	100.00 %
Total Responses	**146**	**100 %**
Does the contract disclose the HIPAA and Privacy Act requirements for privacy and confidentiality of VA patient data, including the penalties for breaching these laws?		
Yes	118	81.38 %
No	27	18.62 %
Total Responses	**145**	**100 %**
Does the contract specify when VA data are to be purged from the contractor's computer systems?		
Yes	97	68.31 %
No	45	31.69 %
Total Responses	**142**	**100 %**
Does the contract specify the invoice verification procedures to be used by the facility to certify or adjust contractor bills?		
Yes	99	67.81 %
No	47	32.19 %
Total Responses	**146**	**100 %**
Does the facility verify the number of units billed by the contractor before payments are made?		
Yes	112	76.71 %
No	34	23.29 %
Total Responses	**146**	**100 %**

Appendix A

	Count	Percent
During the past 3 years, what percentage of invoices from the current or prior contractor was paid in full?		
100 percent	96	67.13 %
76-99 percent	43	30.07 %
51-75 percent	4	2.80 %
Total Responses	**143**	**100 %**
Does the facility have a BAA with the transcription contractor outlining the contractor's responsibilities for the privacy and security of PHI?		
Yes	109	83.85 %
No	21	16.15 %
Total Responses	**130**	**100 %**
Does the facility use speech recognition software that transcribes voice dictation into written reports?		
Yes	52	39.69 %
No, and there are no plans to use voice recognition software	48	36.64 %
No, but the facility plans to replace conventional transcription methods with voice recognition software	31	23.66 %
Total Responses	**131**	**100 %**

Appendix B

The State of Speech Recognition Technology in the Industry and Within the Veterans Health Administration

Description of SRT

Definition. Speech recognition is a computer process that converts digital audio from a sound card into recognized speech.

Implementation. There are two approaches to implementing SRT:

- Using Transcriptionists To Edit Recognized Text. Clinicians dictate into a digital recorder for transcriptionists to download onto a personal computer. Instead of transcribing from scratch, the transcriptionist downloads the audio file, listens to the recorded dictation while reading the text on screen, and makes corrections or edits as necessary.
- Physician Self-Edit. Clinicians dictate directly into CPRS and view the text as it appears in order to correct any errors. Maximum efficiency is achieved through the physician self-edit approach. By dictating directly to the computer and correcting their own errors, clinicians can retain control over the documentation of patient medical records and eliminate the concerns associated with using contractors.

State of the Transcription Industry

The transcription industry has been affected by the following conditions:

Shortage of Medical Transcriptionists. Occupational assessments by the Department of Labor (DOL) indicate that the number of retiring medical transcriptionists is exceeding new hires and has resulted in a nationwide shortage of medical transcriptionists. In 2002, DOL statistics showed there were 101,000 medical transcriptionists in the U.S. In May 2003, the number had declined to about 98,000, and in May 2004 had further declined to about 93,000. The shortage is affecting contractors, as well as health care organizations. Legislation introduced in the U.S. Congress would address the shortage of medical transcriptionists. The bills, House Bill H.R. 215, the Allied Health Professions Reinvestment Act, and Senate Bill S. 473, the Allied Health Reinvestment Act, have been referred to committees.

Offshore Subcontracting. The use of offshore subcontractors by transcription contractors has resulted in concerns by Members of Congress about privacy rights. The SAFE-ID Act, introduced into the U.S. House of Representatives and the U.S. Senate on April 14, 2005, as bills H.R. 1653 and S. 810, respectively, would regulate the transmission of personally identifiable information, including health information for

medical transcription, to foreign affiliates and subcontractors. The bills have been referred to committees.

State of the SRT Industry

SRT can be used for any size medical office, clinic, or department within a health care organization or an entire hospital. Case studies from health care organizations using SRT indicate that the technology can be used in a variety of settings. Testimonials from customers using two of the most popular speech recognition programs in the U.S. consistently identified increases in productivity, significantly lower costs, and reductions in turnaround times as the most tangible benefits derived from using SRT. For example:

- A staff of 10 physicians and 6 physician mid-level providers in the Emergency Department (ED) at a private hospital bypassed third-party transcriptionists by implementing SRT using the physician self-edit approach. The ED reported cost savings of 60–80 percent, while eliminating security risks and reducing report turnaround time by providing physicians with the ability to dictate, review, and sign medical reports in one session.
- The Health Information Management Department at a university medical facility with 397 physicians implemented SRT using transcriptionists to edit speech-recognized documents generated by physicians. In 3 months, the university trained a transcription staff of 74 full-time employees to use SRT. Within 6 months, the university discontinued outsourcing, reported an increase in productivity of 57 percent for in-house staff and a reduction in report turnaround time from an average of 52 hours to less than 24 hours, and projected annual savings of almost $500,000. The university is exploring the option of upgrading to physician self-editing to allow physicians greater control over the documentation process and achieve additional savings.
- A DoD installation, housing the largest American hospital outside the U.S., increased operating efficiency, improved patient care, and reduced costs by implementing SRT using the physician self-edit approach.

According to literature from an SRT company, whose speech recognition products are in use at 17 VHA facilities, SRT is extending horizontally across health care organizations of all sizes, from large teaching hospitals to small physicians groups. The literature indicated that the company's speech recognition programs are in use at 3,500 hospitals and clinics throughout North America. During a demonstration of the company's speech recognition products conducted at our request on March 16, 2005, a company representative told us that contractors are also using SRT to meet client demands, including some contractors who transcribe medical reports for VHA.

Appendix B

State of SRT Usage in VHA

Implementation of SRT within VHA has been left to the discretion of each VHA facility. A systematic approach to evaluating available SRT technologies has not been developed by VHA, resulting in an uncoordinated, piecemeal implementation of SRT. In July 2005, VHA officials told us they were committed to the future implementation of SRT in VHA and established a working group in August 2005 to develop an approach for evaluating various technologies. As of February 2006, the group had held discussions with some SRT equipment vendors and had consulted with some VHA facilities currently using SRT to study the methods in use at those facilities. According to VHA officials, about 120 VHA entities have licenses to use SRT programs. However, our survey showed that only 52 of 131 facilities responding had implemented SRT to some degree, and none had implemented it facility-wide. The remaining 79 facilities responded that they were not using SRT. Concerning plans to implement SRT, 31 facilities reported that they planned to convert to SRT within the next 5 years, while 48 (37 percent) facilities reported that they had no plans of converting to SRT.

Our discussions with staff at some VHA facilities disclosed several concerns about the use of SRT. Staff at some facilities stated they did not believe SRT worked very well, and some physicians were opposed to using SRT because they felt that editing speech-recognized reports would require time that could be spent on patient care. Our research on the use of speech recognition by other health care organizations, observations of the operations of speech recognition programs, use of speech recognition programs, and discussions with speech recognition users and developers indicated that, if used properly, SRT should result in improved administration and patient care. SRT can help VHA avoid the risks of unauthorized disclosure of confidential information, reduce transcription costs, decrease report turnaround time, and eliminate the performance problems VHA facilities reported experiencing with contractors. As shown below, 78 (60 percent) of 129 facilities acquiring contract transcription services in FY 2004 identified the following deficiencies in reports transcribed by contractors:

Types of Deficiencies	Number of Deficiencies Identified	Number of Facilities Identifying The Deficiency[7]
Untimely Reports	49	47
Inaccurate Reports	40	39
Incomplete Reports	22	20
Inaccurate Line Counts	15	15
Duplicate Reports	9	9

[7] Twenty-six facilities identified 2 types of deficiencies; 10 facilities identified 3 types of deficiencies; and 2 facilities identified 4 types of deficiencies.

Additionally, 32 (25 percent) of 129 facilities rated the quality and timeliness of reports transcribed by contractors as average, poor, or very poor.

Concerning the impact of SRT on the amount of time available for patient care, our review showed that with proper training and improved dictation practices, physicians could reduce the amount of time needed to edit reports, which would result in more time for patient care. A consultant study entitled *Expanding the Use of Speech Recognition Technology*, dated May 12, 2003, sponsored by Dictaphone Corporation concluded that transcription productivity could be improved, on average, by 22 percent with minor modifications to such dictation practices as restarting sentences, filling pause time with no-dictation words, and not dictating format changes or including basic punctuation. Instead of dictating a summary, waiting several days for the transcribed report to be returned, reviewing the entire report for accuracy, and then signing the report for entry in the patient's medical record, SRT would allow physicians to dictate, edit, and sign reports in a single session.

Appendix C

Results of Site Visits to VHA Facilities Using Speech Recognition

During the audit, we visited VHA facilities located in Decatur, GA; Memphis, TN; and Milwaukee, WI, to observe the use and performance of SRT applications in actual health care environments. We selected these facilities for site visits based on the type and number of reports transcribed and the brand name of the speech recognition software used. SRT was limited to specific applications at all three facilities, and user participation at VA Medical Centers Memphis and Milwaukee was exceptionally low because the use of SRT was optional.

VA Medical Center Atlanta (Decatur, GA) Was Using the Talk Tech System To Transcribe Radiology Reports

The purchase price for the Talk Tech system manufactured by AGFA was about $350,000, which included project management, software application, and a 1-year warranty. The system used 2 servers (1 for backup) and consisted of 26 talk stations located in isolation rooms. Previous contract costs for transcription services totaled about $320,000 annually, with the medical center estimating a return on investment of over 190 percent in 5 years. Use of the Talk Tech system was mandated by VISN 7 and is being installed at all VISN 7 facilities. Ultimately, SRT will replace contractors for purposes of transcribing radiology reports in VISN 7. HIMS and Radiology Service staffs were unaware of any resistance by clinicians to using SRT.

The use of SRT to transcribe radiology reports appeared to be efficient in all respects. The physician self-edit approach and CPRS interface allowing clinicians to dictate directly into patients' medical records provided the medical center with total control over the transcription process. In addition, the medical center had achieved buy-in from staff radiologists and appeared to have made a seamless transition to SRT from traditional transcription methods.

VA Medical Center Memphis, TN, Was Using Dragon Naturally Speaking Software To Transcribe General Medicine Reports

The medical center was testing the Dragon Naturally Speaking (DNS) software from Scan Soft Corporation. The contract with Scan Soft allowed the medical center to obtain 750 network licenses to use the software. The medical center did not incur any costs for the software, but pays about $94,000 per year for maintenance and software upgrades. Use of SRT by medical center staff was low. Even though 1,700 potential users had the option of using DNS, there were only 107 regular users, which represented less than 15 percent of the 750 available user licenses. The training coordinator stated that many

clinicians refused to use DNS because they were unable or unwilling to overcome bad experiences with earlier versions of the software. The medical center was still using contractors to process part of its transcription workload due to the lack of physician buy-in.

We interviewed physicians regarding their perspectives on using DNS. Some stated they were impressed with the ability to change the transcripts immediately instead of days later when what they might have intended to say was no longer fresh in their memories. Some physicians also stated that seeing their comments on the screen immediately sometimes prompted revisions, which resulted in more accurate descriptions of patients' conditions. Other physicians stated that the time needed to edit the reports took away from direct patient care.

The medical center was not capturing sufficient operating data to quantify the benefits of using SRT. For example, the medical center did not maintain any statistics on transcription time or number of reports transcribed by users. Without this information, it is not possible to quantify the benefits of using the technology or the savings that could be transferred to other medical center needs.

Clement J. Zablocki VA Medical Center, Milwaukee, WI, Was Using XSpeech Software To Transcribe General Medicine Reports

The medical center was using XSpeech manufactured by Dictaphone Corporation. The XSpeech module was acquired on two lease-to-own plans for a total cost of about $351,000. The lease costs included the software, 5 servers, 10 editing licenses, equipment insurance plan, maintenance agreement, and installation and training costs. The medical center acquired 50 user licenses; however, only 33 had been assigned. The medical center had 1,520 physicians and clinicians on staff.

XSpeech did not interface with CPRS. The program was designed for use by transcriptionists to transcribe reports from scratch or edit speech-recognized reports generated by physicians. Due to concern about opposition from physicians, HIMS staff did not inform physicians that they were using SRT, and the physicians received no training in using the software. The medical center could have increased productivity by reducing recognition errors had physicians been trained to use the software.

While the medical center avoided the contract and security issues related to the use of contractors, the medical center's use of SRT was not cost-effective. For example, the Transcription Unit in HIMS consisted of 15 full-time equivalent employees to transcribe and edit reports. In addition to their base pay, transcriptionists were paid incentive pay for exceeding daily line production requirements. In FY 2004, the medical center's transcriptionists were paid almost $704,000 in base salary and an additional $52,000 in

incentive pay. These costs could have been used to meet other needs if the physician self-edit approach was used.

Conclusion

While we identified benefits to using SRT at all three sites visited, we were most impressed with the way the technology was being used at VA Medical Center Atlanta. We believe that much of the success the medical center achieved in converting to SRT resulted from the fact that use of the program was mandated by the VISN and was not left to the discretion of individual facilities.

Appendix D

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds (Millions)
2	VHA could have saved an estimated $6.2 million if all VHA facilities had negotiated line rates at the lowest line rate paid.	$6.2

Appendix E

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 23, 2006

From: Under Secretary for Health

Subject: Audit of the Veterans Health Administration's Acquisition of Medical Transcription Service

To: Assistant Inspector General for Auditing (52)

1. Thank you for the opportunity to review the draft report. I concur with the recommendations and findings. I share your concern about the need for developing standardized VHA processes and procedures for the management of contracted medical transcription services that are economic and ensure patients' health information is properly protected. VHA has already implemented a variety of steps to address the issues raised in your report.

2. The Prosthetics and Clinical Logistics Office (P&CLO) has developed and implemented a data call to request comprehensive data from field facilities on network and facility medical transcription contracts and the current use of speech recognition technologies (SRTs) in VHA with the goal of developing a standardized national technology for use throughout VHA. This data was submitted to the P&CLO on May 31, 2006. In addition, a Request for Information (RFI) is being prepared. The P&CLO will coordinate an interdisciplinary workgroup to review this data and prepare a report with recommendations on the feasibility of a national contract for transcription services, a national roll out of speech recognition technologies (SRTs), or a combination of the two in VHA, along with cost information. The report and recommendations are due to me by October 1, 2006, with implementation to follow.

3. If the decision is made to implement a national contract for transcription services, the interdisciplinary workgroup coordinated by the P&CLO will develop a statement of work (SOW) for the contract. Depending on the information received from the data call, it may be necessary to award two or three multiple awards rather than a single award based on requirements.

Appendix E

Under Secretary for Health Comments

4. I defer concurring with your estimate of monetary benefit of an estimate savings of $6.2 million until October 1, 2006, in order to have an adequate opportunity to best review the issues involved. While it is possible that the privacy of patients' health information can be partially resolved by additional training, the economic concerns identified in the report can best be addressed by nationwide implementation of SRTs, a national medical transcription contract, or a combination of the two.

5. Your report indicates that the utilization of SRTs to transcribe medical reports in-house would resolve contract and security issues. VHA intends to study the feasibility of using SRTs and other technologies nationwide. In the meantime, to address the security and privacy issues you identified, VHA has already inserted language into the VHA business associate agreement (BAA) template that forbids the transfer of veterans protected health information outside the jurisdiction of the United States. In addition, the P&CLO will issue a memorandum through the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to the field contracting officers to require that all contracts meet the security specifications recommended in the report and that Contracting Officers Technical Representatives (COTRs) meet the training requirements recommended in the report. This memorandum will be sent to the DUSHOM for signature by May 31, 2006, for implementation to occur within 30 days of signing. These steps will serve as current methods of addressing the security and privacy issues you identified, until the national implementation of a medical transcription plan. These requirements may continue to be in effect after the implementation of the plan, as is appropriate.

6. In addition, the data call described earlier will provide information on the extent to which security requirements, including signed rules of behavior and background investigations, are currently specified in VHA contracts in the networks and medical facilities. The P&CLO will review this information and provide monitoring on corrective actions to address identified deficiencies as needed.

7. An action plan to implement the recommendations is included as an attachment to this memorandum. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

(original signed by:)
Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

Appendix E

Under Secretary for Health Comments

Under Secretary for Health's Comments to Office of Inspector General's Report

The following Under Secretary for Health's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Action Plan in Response to: OIG Draft Report, Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services (EDMS 348562)

Project No.: 2004-00018-R3-0195

Date of Report: April 5, 2006

Recommendation/ Actions	Status	Completion Date

Recommended Improvement Action 1: We recommend the Under Secretary for Health require VHA to follow through on efforts to evaluate the various Speech Recognition Technologies (SRTs) available and mandate the implementation of the SRT most suitable for VHA.

Concur

The Prosthetics and Clinical Logistics Office (P&CLO) is developing a data call that will provide information on the extent that SRTs are used within VHA. P&CLO will convene an interdisciplinary work group to review available SRTs and explore the feasibility of developing a standard technology for use throughout VHA. The data from the field facilities will be submitted to the P&CLO by May 31, 2006. Data gathered from both OIG VHA—wide surveys and responses from contractors to a request for information (RFI) will also be reviewed. The data review and analyses will be completed August 31, 2006. Recommendations will be made to the Under Secretary for Health on the feasibility of a national roll out of SRTs in VHA, along with cost information by October 1, 2006. Implementation plans will be developed based on the decision of the Under Secretary for Health.

	In process	October 1, 2006, and implementation to be determined

Appendix E

Under Secretary for Health Comments

Action Plan in Response to: OIG Draft Report, Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services (ED MS 348562)

Project No.: 2004-00018-R3-0195

Date of Report: April 5, 2006

Recommendation/ Actions	Status	Completion Date

Recommended Improvement Action 2: We recommend the Under Secretary for Health require VHA to coordinate the acquisition of medical transcription services VHA-wide to ensure that comparable rates are paid for the same services and at the most economical rates.

Concur

The data call mentioned in response to Recommended Improvement Action 1 will also include requests for information on rates paid across the country for similar services, and will result in a report with recommendations on whether developing a national contract for transcription services is the most economic and effective method for securing the patient health information and providing medical transcription services VHA-wide. This data from the field facilities will be submitted to the Prosthetics and Clinical Logistics Office (P&CLO) by May 31, 2006. Data gathered from both OIG VHA—wide surveys and responses from contractors to a request of information (RFI) will also be reviewed. The interdisciplinary VHA workgroup will review and analyze the data and make recommendations concerning the feasibility of a national contract for VHA transcription services. These recommendations with associated cost information will be included in the report and recommendations that will be sent to the Under Secretary for Health by the workgroup by October 1 2006. Based on information received, it may be necessary to award two or three multiple awards rather than a single award based on requirements. Implementation plans will be developed based on the decision of the Under Secretary for Health.

	In process	October 1, 2006, and implementation to be determined

Appendix E

Under Secretary for Health Comments

Action Plan in Response to: OIG Draft Report, Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services (EDMS 348562)

Project No.: 2004-00018-R3-0195

Date of Report: April 5, 2006

Recommendation/ Actions	Status	Completion Date

Recommended Improvement Action 3: We recommend the Under Secretary for Health ensure that: a) Contracting Officer's Technical Representatives (COTRs) conduct independent line counts to ensure the accuracy of contractor invoices; b) facility COTRs are properly trained to monitor contractor performance and c) contracting officers appoint COTRs in writing.

Concur

The Prosthetics and Clinical Logistics Office (P&CLO) will issue a memorandum through the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to the field contracting officers to require that facility Contracting Officer's Technical Representatives (COTRs) are adequately trained for the task of verifying that services and prices paid are proper and in accordance with the terms of the transcription contracts, and COTRs are appointed in writing. This memorandum is being drafted and will be sent to the DUSHOM for signature by May 31, 2006, for implementation within 30 days of issuing the document. In addition, a draft statement of work (SOW) for a national blanket purchase agreement (BPA) to acquire medical transcription services is being developed. The draft is pending final review based on findings of facility-specific information that will be acquired from the data call and from OIG's VHA facility survey data. The SOW will ensure the inclusion of requirements such as quality, accuracy, timeliness, invoice validation, and security issues by the networks and medical facilities in medical transcription contracts. The P&CLO will be responsible for developing an action plan to monitor and correct identified deficiencies, as appropriate. The SOW will be completed by October 1, 2006. Its announcement will be pending the decision of the Under Secretary for Health on the VHA interdisciplinary workgroup's report and recommendations.

	In process	October 1, 2006, and implementation to be determined

Appendix E

Under Secretary for Health Comments

Action Plan in Response to: OIG Draft Report, Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services (EDMS 348562)

Project No.: 2004-00018-R3-01 95

Date of Report: April 5, 2006

Recommendation/ Actions	Status	Completion Date

Improvement Action 4: We recommend the Under Secretary for Health ensure that a) all contracts specify limitations on the access to VHA data at contractor facilities, contain security requirements for transcriptionists working at home, require contract staff working at VHA facilities to undergo background investigations and sign "Rules of Behavior" defining acceptable practices concerning the use of VHA information systems, specify when and how contractors are to purge VHA data from contractors' computer systems, and require contractors to transcribe VHA data in the US or its territories; and b) all facilities complete required BAAs with their transcription contractors.

Concur

Included in the memorandum that the Prosthetics and Clinical Logistics Office (P&CLO) will issue through the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to the field contracting officers will be the requirement that all contracts meet the security specifications defined in this recommendation. This memorandum will be sent to the DUSHOM for signature by May 31, 2006, for implementation within 30 days of issuing the document. In addition, the data call described in response to the previous recommendations will gather information on the extent to which security requirements, including signed rules of behavior and background investigations, are currently specified in VHA contracts in the networks and medical facilities. The data call will provide information on current compliance with the Health Information Portability and Accountability Act (HIPAA) privacy requirements, including the compliance of the network and facility business associate agreements (BAAs). This data from the field facilities will be submitted to the P&CLO by May 31, 2006. The responses will be reviewed and assessed by the P&CLO by August 31, 2006. This review will be completed by October 1, 2006. P&CLO will develop an action plan to monitor and correct identified deficiencies, as appropriate.

	In process	October 1, 2006, and implementation to be determined

Appendix F

OIG Contact and Staff Acknowledgments

OIG Contact	James R. Hudson, Director, Atlanta Audit Operations Division (404) 929-5921
Acknowledgments	Willie J. Toomer, Audit Manager Alvin S. Wiggins, Team Leader Marcia Drawdy, Staff Auditor Harvey Hittner, Staff Auditor Cheri Preston, Staff Auditor

Appendix G

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.