Department of Veterans Affairs

Office of Inspector General

COMBINED ASSESSMENT PROGRAM REVIEW
William Jennings Bryan Dorn Veterans' Hospital
Columbia, South Carolina

Report No.: 00-01202-107

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Office of Inspector General
Washington DC 20420

VA Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's effort to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the Office of Inspector General's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected administrative and financial activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness Briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the Office of Inspector General by facility employees, patients, members of Congress, or others.

Executive Summary

Combined Assessment Program Review

William Jennings Bryan Dorn Veterans' Hospital
Columbia, South Carolina

1. The Office of Inspector General conducted a Combined Assessment Program (CAP) review of the William Jennings Bryan Dorn Veterans' Hospital (DVH) in Columbia, South Carolina. The purpose of the review was to evaluate selected operations, focusing on the quality of care delivered and the effectiveness of management internal controls.

2. DVH provides primary, secondary, and some tertiary care, including medical, surgical, psychiatric, and rehabilitative services. The facility operates a nursing home care unit (NHCU), a satellite outpatient clinic, and two community-based outpatient clinics (CBOC). In Fiscal Year 1999, the medical center's budget was about $115 million.

3. The CAP team visited DVH from March 13 to 17, 2000. Part I of this report provides more detail on the organizational structure of the medical center, and the purpose, scope, and methodology of the CAP review. Part II contains the results of the CAP review and includes recommendations to enhance patient care and strengthen management controls. The following are highlights of our observations:

- Patient Care and Quality Management - We found that appropriate health care monitors were in place and effectively working. We identified opportunities to improve: access to outpatient care; access to care in the primary and specialty clinics; inpatient medical record documentation; design and allocation of space in the Physical Medicine and Rehabilitation Clinic; nursing proficiency evaluations; security issues in the mental health building; and restorative nursing therapy and patient participation in structured therapies in the NHCU. For more details, see Part II.

- Management Controls - We concluded that overall, the medical center generally maintained an effective system of internal controls in the areas we reviewed and tested. We recommended that management develop a measurable statement of work for the surgical service contract. We identified minor deficiencies and made suggestions for improvements in six areas: contracted otolaryngology services; government purchase card program; means test certifications; unannounced audits of the agent cashier; Pharmacy Service security; and third-party reimbursable insurance accounts receivable. For more details, see Part II.

- Fraud and Integrity Awareness Briefings - These briefings discussed issues concerning the recognition of fraudulent situations, referral of issues to the Office of Investigations, and the type of information needed to make a complaint referral. For more details, see Appendix I.

4. You concurred with the findings and recommendations in the report and provided acceptable implementation plans. Therefore, we consider the issues resolved. However, the Office of Inspector General may follow up later to evaluate corrective actions taken. Comments and planned corrective actions are in Appendix II.

(*Original signed by:)*

RICHARD J. GRIFFIN
Inspector General

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PART I

INTRODUCTION

A. Purpose

The purposes of a Combined Assessment Program (CAP) review are to help management identify opportunities for improvement, and to help prevent fraud, waste, and abuse. See the inside cover for a full description of the CAP.

B. Scope and Methodology

We reviewed quality assurance documents and more than 60 patients' medical records. We also inspected the physical environment of all inpatient and outpatient treatment areas at the medical center. Using structured survey instruments, we interviewed more than 50 clinical managers/clinicians and 97 patients, and analyzed their responses. Additionally, we sent questionnaires to 237 randomly selected full-time employees. The questionnaire return rate was 42 percent (100/237). As part of the CAP process, we met with 14 employees and 1 patient [who had called the hotline number and specifically requested a visit with the Office of Inspector General (OIG) team]. In addition, we reviewed the following 19 patient care and quality management areas:

Acute Care Medicine and Surgery	Geriatrics and Extended Care
Community-Based Outpatient Clinics	Physical Medicine & Rehabilitation
Homeless Veterans Program	Substance Abuse Treatment Program
Ambulatory Care Services	Quality Management Program
Clinician Staffing	Hemodialysis
Informed Consent	Autopsy Rates
Contract Nursing Homes	Home-Based Primary Care
Laboratory and Pathology Service	Radiology
Mental Health	Pharmacy
Post Traumatic Stress Disorder Program	

Our review of management internal control issues involved analysis of operational reports, discussions with facility staff, and visits to selected program areas. We reviewed and tested controls in 12 areas:

Agent Cashier	Government Purchase Card
Third-Party Receivables	Contracted Otolaryngology Services
Pharmacy Security	Community Nursing Home Contracts
Means Test	Information Technology Acquisitions
Printing Practices	Time and Attendance
Contracted Surgery Services	Personal Identification Number
	Telephone System

In an effort to enhance medical center employees' awareness of fraud and their understanding of the OIG's role in investigating indications of fraud, we conducted 6 fraud and integrity awareness briefings for 183 employees.

C. Background

The William Jennings Bryan Dorn Veterans' Hospital (DVH) had 297 authorized inpatient beds. DVH provides primary, secondary, and some tertiary care; including medical, surgical, psychiatric, and rehabilitative services. The hospital operated a 150-bed Nursing Home Care Unit (NHCU). The facility also supported a satellite outpatient clinic (OPC) in Greenville, South Carolina, and two community-based outpatient clinics (CBOC) in Florence and Rock Hill, South Carolina.

In Fiscal Year 1999, the medical center's budget was about $115 million. DVH employed about 1,255 full-time equivalent employees and treated about 4,400 medical care inpatients and 270 nursing home patients. DVH provided about 271,000 outpatient visits, including 45,400 visits at the Greenville OPC and 1,100 visits at the Florence CBOC. The Rock Hill CBOC was not operational in FY 1999.

PART II

RESULTS OF CAP REVIEW

A. Patient Care and Quality Management Were Generally Effective

Medical center managers had established a positive work environment. Overall, staff morale appeared to be good. Patients and employees alike feel that the facility provides good care. As discussed below, we reviewed 19 patient care and quality management areas. We found the substance abuse treatment and hemodialysis programs were commendable in all areas reviewed. We did not find any significant deficiencies in several areas, including laboratory, pathology, radiology, and home-based primary care.

During our review of medical center operations, we identified several issues that required management attention in order to ensure high quality patient care and quality management. These issues included: restorative nursing therapy and patient participation in structured therapies in the Nursing Home Care Unit (NHCU); waiting times for clinic appointments; inpatient medical record documentation; design and allocation of space in the Physical Medicine and Rehabilitation (PM&R) Clinic; waiting times for Audiology Clinic appointments; nursing proficiency evaluations; and Mental Health Building security.

We also found several minor issues in which we made suggestions for improvement. These issues included: designation of Ward 3-West as a subacute unit; NHCU attending physicians' medical record notes; NHCU cleanliness, privacy, and safety; training and responsibility for Boards of Investigation (BOI); autopsy rates; inpatient psychiatry therapeutic activities and goal achievements; Health Care for Homeless Veterans (HCHV) program; policies and guidelines for the HCHV and Post Traumatic Stress Disorder (PTSD) programs to assure consistent quality of care; training and policy for conducting community nursing home (CNH) inspections; annual physical examinations and assessment for the need for continued CNH care; Surgical Service space constraints; and medical records security.

1. Extended Care

At the time of our survey, DVH had 121 occupied NHCU beds on 3 units (NHCU-1, Ward 3-East, and Ward 3-West). NHCU issues needing medical center management attention were: the re-designation of Ward 3-West as a subacute medical ward, documentation of attending physician notes in patient medical records, and the NHCU environment. We made recommendations in two areas to improve patient and family satisfaction with NHCU operations, and to improve availability of and increased participation in restorative nursing and structured therapies.

Areas Needing Management Attention

Re-designation of Ward 3-West - The level of care delivered to nursing home patients on Ward 3-West was more in line with subacute medical care [as described in the Interqual Subacute Care Criteria (ISCC)] than with nursing home care. ISCC is based upon intensity of services and severity of illness, and an intermediate rehabilitation offering, as defined by the Rehabilitation Accreditation Commission. We suggest that medical center managers change the designation of Ward 3-West to subacute, which will allow the medical center to better define the level of care delivered on the unit, assist in the establishment of clear admission criteria, and support utilization review based upon nationally recognized criteria.

Physicians' Documentation - Record reviews reflected overall adequate physician documentation in medical records, including descriptions of interdisciplinary treatment and continuity of care. However, documentation of attending physician notes needed improvement. The medical staff by-laws require attending physicians to document their assessments of each NHCU patient in the medical record every 30 days, with the provision that attending physician notes could alternate with Nurse Practitioner notes. We reviewed 14 patients' medical records on NHCU-1. None of these records had a physician note within the past 60 days. We suggest the Director require attending physicians write required notes in the NHCU patient medical records.

NHCU Environment - Cleanliness, safety of non-patient areas, and patient privacy on NHCU-1 needs management attention. We found NHCU-1 dirty and it had a detectable pungent odor on the day of our survey. Several non-patient areas were unsecured, including an unlocked cleaning supply room and a storage room that contained oxygen canisters. The congregate bath was on the main hall. It afforded little privacy, as the door was propped open with only a curtain in place.

Recommendations for Improving NHCU Operations

Customer Satisfaction - Customer satisfaction (patient and family) with NHCU-1 services was less than optimal. Many families of patients on NHCU-1 were dissatisfied with the care. The most frequently heard complaints pertained to infrequent diaper changes, lack of assistance in feeding patients, and NHCU employee unresponsiveness to requests. Several family members told us they felt that nursing employees spent too much time congregated at the nursing station or in meetings. We observed breakfast trays getting cold while all employees attended a shift change meeting. We also observed as many as 10 patients' wives feeding their husbands lunch. Some families hired private duty sitters to assist their relative in feeding and other daily activities when the family members could not be at the medical center.

The NHCU has a family council that meets monthly to discuss patient and family concerns and issues. We attended a family council meeting and observed that family members were not given the minutes of the previous meeting to approve. Written feedback on actions to be taken to resolve families' concerns could enhance the

effectiveness of the family council, and would strengthen family members' confidence in NHCU care. A more structured system to receive and resolve family and patient complaints could improve customer satisfaction.

A number of administrative changes in NHCU operations could enhance patient care and improve customer satisfaction. The following suggestions were discussed with NHCU-1 employees:

- Discontinue the use of an employee to sit with three patients in the "dementia activity room" while they eat. These patients could eat in the dining room and free this employee to feed other patients.
- Consider assigning "primary care teams" to patients instead of rotating employees daily. This may promote better rapport between patients, families, and employees and allow employees to better understand the patients' conditions.
- Reschedule the morning staff meeting from the breakfast time, or allow only representatives (not all employees) to attend. Changing time of tray delivery or staggering tray delivery is another possibility.
- Allow employees a period of "administrative time" to complete reports at a designated time each day. Stagger these times to avoid having too many employees in the nurse's station at any one time.
- Disseminate family council meeting minutes to family members.

Restorative Nursing Therapy Programs - Participation in restorative nursing therapy programs was limited. While restorative nursing therapy programs for continence, mobility, and eating were available, they were not aggressively pursued for patients. For example, 46 of 53 patients were wearing diapers; however, only 5 patients were on a bowel and bladder training program. We also noted that 17 of 53 patients were on tube feedings and 13 required total feeding. Less than 12 patients were eating in the dining room. None of the patients were participating in the restorative nursing feeding program. Employees told us that their goal was to have 50 percent of the patients out of bed daily by the end of March. We saw less than 25 percent of the patients out of their beds, and only 3 of 53 patients were participating in a restorative mobility program at the time of our visit.

Structured Activities - At the time of our review, we saw very little structured activity (group or individual). Patients were generally observed in their rooms or in day rooms watching television.

Recommendation 1

The Medical Center Director should require the Chief of Staff to ensure that restorative nursing therapy and patient participation in structured therapies are increased.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

Lead head nurse and Extended Care Management Committee will increase oversight of ward restorative nursing program by monthly reporting of participation and outcomes. Also, Extended Health Care Service (EHCS) has identified a specific room for dementia activities to take place. Recreation therapist, nursing assistant, and volunteers, will do these activities. EHCS has obtained a full-time adult volunteer who assists Monday through Friday from 8:00 a.m.-12:00 p.m. We currently have 17 patients on the treatment list for the dementia room.

Office of Inspector General's Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

2. Quality Management

DVH had a comprehensive Quality Management (QM) Program that included national and local performance measures, risk management, utilization management, peer review, and occurrence screening. Areas we reviewed in assessing the QM Program included: delivery of ambulatory care services, resident supervision, medical records documentation, Boards of Investigation (BOI), autopsies, root cause analyses (RCAs), and informed consent. Areas reviewed were generally operating effectively. We concluded the facility's informed consent, RCAs, and resident supervision processes were generally well organized and effective. However, BOIs and autopsy rates needed management attention. We also identified the need to reduce waiting times for clinic appointments and to improve medical records documentation.

Informed Consent - The facility's informed consent process was generally well organized and effective at documenting informed consent discussions. Informed consent is a process of promoting "informed" decision making by the patient. It defines the obligations and duties of healthcare employees to assure that the patient is given sufficient information to make an informed decision concerning available treatment options. In 21 of 23 (91.3 percent) medical records reviewed that related to invasive procedures, we found the informed consent documentation completed appropriately with:

- Patient and/or guardian signature,
- Procedure explanation in layman terms,
- Physician/surgeon signature,
- Witness signature, and
- Appropriately dated consent forms.

We also reviewed clinical research procedures to assess the presence of properly informed consent. DVH had 36 active research projects that involved 343 VA subjects and 123 non-VA subjects requiring their consent. We reviewed the records of 11 VA and 10 non-VA research subjects to determine if informed consent forms were on file. Signed informed consent forms were appropriately documented in the records for each research subject.

Root Cause Analyses - The medical center had an effective process in place for conducting root cause analyses and followed the Veterans Health Care Patient Safety Handbook. We reviewed 12 months of RCAs, peer reviews, and tracking and trending of patient incidents. Medical center employees documented the findings of the RCAs and identified opportunities for improvement.

The medical center forwarded all peer reviews that were classified as level 1 or level 2 to the Professional Standards Board for further review and action. The information gathered from the peer review process was forwarded to the respective service chief for inclusion in the physicians' proficiency and re-privileging process.

Residency Supervision - The Surgical Service had an active residency program. Based on our discussions with the Chief of Surgery, the Operating Room Nurse Manager, and the Associate Chief of Staff for Education, we concluded that the medical center had developed an effective program for providing and monitoring the supervision of residents who perform surgical procedures. The residents were categorized as I, II, or III, depending upon the level of their training and experience. The categories define the level of supervision required from the attending surgeon. The information was kept on the medical center's computer system and was readily available to all employees. Senior nursing supervisors did not allow residents to proceed with surgical procedures unless the required supervision was in place. The overall policy and process for resident supervision developed in collaboration between the medical center's education department, the medical school, and Surgical Service could serve as an example of a commendable practice throughout the system.

Areas Needing Management Attention

Boards of Investigation - Overall actions identified for improvement by the BOIs appeared to be appropriate based on the documented findings. We reviewed the 11 BOIs regarding patient incidents that medical center employees completed in the last 12 months and found that all but 2 had been conducted in compliance with medical center policy. In one case, the designated investigators stated that they had not received enough training to effectively conduct the BOI. The other case involved a review of the practice and documentation of a physician and would have been more effectively handled as a peer review rather than a BOI.

In order to improve the BOI process we suggested that:

- Human Resource Management Service (HRMS) work with Education Service in the development of a comprehensive training program to provide leaders and members of BOIs with the knowledge and skills required to conduct an investigation in accordance with medical center policy.

Autopsy Rates - DVH had a 9-percent autopsy rate. The Chief, Pathology and Laboratory Medicine Service, was aware of the low autopsy rate and had established a goal to achieve a 15 percent autopsy rate within the next 12 months. He noted, however, that medical and surgical staff obtained consents for autopsies, and that he was reliant on these departments to forward cases. We reviewed 14 medical records of veterans who died in February 2000 and found that only 2 of the records contained documentation that the physician had discussed an autopsy with the family. Medical center managers should provide physicians with additional education and training concerning the need to obtain consent for autopsies.

Recommendations for Improving QM Operations

Waiting Times for Appointments - The patient waiting time for the next available clinic appointment was excessive and the Computerized Patient Record System was not used to schedule and track clinic consultations. Waiting times were a major concern among patients, employees, and top managers. Only 25 of the 62 (40 percent) patients whom we surveyed felt that they could schedule an appointment with their primary care providers within 7 days. Waiting times for an appointment in the primary care clinics ranged up to 300 days. Clinic availability reports indicated waiting times of more than 30 days in many clinics. Surgical clinics with patient waiting times greater than 30 days included the Orthopedics, Pain, Neurosurgery, Urology, and Genitourinary Clinics. The Urology Clinic's next available appointment was December 5, 2000.

Top managers were aware of the excessive waiting times in ambulatory care and have made attempts to reduce the waiting times by adding physician extender clinics and a "Triage Doctor" who sees only patients who present with minor illnesses or injuries (those who don't appear to need laboratory or radiology services). At the time of our review, managers were in the process of evaluating the feasibility of implementing Institute of Healthcare Improvement (IHI) initiatives. Additionally, hospital managers have established a "Waits and Delays Team" to address patient waiting time issues. The "Waits and Delays Team" suggested ways to reduce patient waiting times, which included the use of fee-basis to reduce pending consultations, as well as screening of magnetic resonance imaging consultations for appropriateness.

Recommendation 2

Medical center managers should consult with other VA medical centers that have successfully reduced ambulatory waiting time and consider implementing documented best practices.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

We implemented the IHI plan for spread in Primary Care and Specialty Clinics exploring ways to increase capacity and reduce demand. Special emphasis has been placed on using 1.2 million dollars in VISN Waiting Time Initiative (WTI) monies on reducing the backlog of specialty clinic consults. The new mid-levels have been in Primary Care since early this year. There are a total of 14 Primary Care clinics. A physician covers two of these clinics only. In one of these clinics, an intern under supervision of a physician sees patients. The other clinics are covered by 11 mid-levels with support and supervision by four physicians. Five of these clinics have a next available appointment of greater than 30 days. The average wait for next available appointment for all of these clinics is 26 days as of July 10, 2000 (in January, the average availability was 128 days). Since we understand VA regulations to require primary care availability within 30 days, it would appear that all but five of the primary care clinics are now in compliance. Steps are being taken to make availability more uniform throughout the clinics and also to further improve the waiting time for next available appointment.

Specialty Clinics increased clinic capacity by reconfiguring clinics, calling patients with long-standing consult requests to determine if the appointment was still needed, and implementing consult screening for new consults. We plan to contract for GU services with private physicians in the community while we are aggressively attempting to recruit a second urologist and are in process of hiring two audiologists to reduce the Audiology Clinic backlog. The Orthopedic Clinic now has seven-day appointment availability. The Neurosurgery Clinic is run and staffed by the Charleston VA Medical Center. We will make that facility aware of your team's concerns. We are recruiting a pain anesthesiologist who will help in anesthesia, as well as staff an additional Pain Clinic. Recruitment is ongoing with target date for locating physician of November 2000. It should be noted, however, that with pain anesthesiologist and other specialty physician categories, the VA salary table is not comparable with private sector.

Office of Inspector General's Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

Medical Record Documentation - Medical records that we reviewed indicated that a significant number did not contain any documented evidence of medical history and physical (H&P) examination work-ups, treatment plans, pain assessments, patient/families education, and/or evidence that the patients were advised about advance directives. Medical center executive managers need to ensure that these services are provided and properly recorded in the medical record.

We reviewed 47 medical records during our visit. The purpose of these reviews was to assess the quality of documentation of patient H&Ps, treatment plans, pain assessments, patient education and discharge planning, and counseling on advance directives. Our review showed that:

- 34.8 percent of the records did not have a documented H&P.
- 33.3 percent of the records did not have a treatment plan.
- 29.8 percent of the records did not have pain assessments.
- 37.3 percent of the records did not contain evidence of interdisciplinary patient/family education. In this review, three records were excluded because patient/family education was inappropriate or not possible, and the fourth record was incomplete.
- 34.8 percent of the records did not contain any evidence that knowledgeable employees had discussed advance directives with the patient. One record was excluded, because it was deemed not appropriate to discuss advance directives with this patient.

While most records documented some level of discharge planning, the documentation was at times incomplete and inconsistent.

We concluded that inpatient medical record documentation needed to be improved in the areas discussed above. Medical center managers need to ensure compliance with the quality and documentation in the above-identified areas.

Recommendation 3

The Medical Center Director should require that senior clinicians perform periodic reviews of inpatient medical records in order to identify and correct medical record deficiencies.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

Approximately 25% of discharges from acute care wards are monitored for completion of history and physical examinations. This is accomplished by medical record technicians (MRT) assigned to Incomplete Record Room, as well as the multidisciplinary medical record review teams in conjunction with their monthly medical record reviews. The completion of treatment plans, pain assessments, patient/family education and advance directives is included in the Closed Medical Record Review Criteria that are reviewed monthly by the Multidisciplinary Medical Record Review Teams. Results of reviews are reported quarterly to the Computerized Patient Record System (CPRS) Steering Committee, Information Management Steering Board and Professional Standards Board. Results are also reported to the appropriate service line

director or service chief, with a request that plans for corrective action be implemented and reported back to the CPRS Steering Committee.

At the time of your visit, Medical Center Bylaws required that medical records be completed within 15 days and provided mechanism for privilege suspension for delinquent medical records after due process. The Medical Center's Professional Standards Board for Physicians, Dentists and Optometrists, with concurrence of the Chief Executive Officer, amended the bylaws in July to allow 30 days for medical record completion. When initial corrective action fails to result in compliance in correcting medical record deficiencies, letters are sent to practitioners by the Chief Medical Officer. If still noncompliant, steps are taken for privilege suspension.

Office of Inspector General's Comments

The Director's actions are responsive to the intent of the report recommendation and we consider the issue resolved.

3. Physical Medicine and Rehabilitation (PM&R)

PM&R Service is part of the Diagnostic and Ancillary Services Line and includes Audiology and Speech Pathology, Physical Therapy (PT), Kinesiotherapy (KT), and Occupational Therapy (OT). PT, OT, and KT together managed 18,105 inpatient and outpatient visits in calendar year 1999. In 1999, the PM&R Clinic surpassed its regional and national counterparts as measured by improvement of patient Functional Independence Measures scores. Areas needing improvement, which impact patient care delivery, are the apparent lack of space in the PM&R Clinics and the backlog in obtaining audiology appointments.

Therapy Clinic Space - The OT, PT, and KT Clinics were extremely small, and space was inefficiently designed or poorly used. Hallways and storage areas were cluttered with equipment. Treatment space was reduced by patients who were waiting in wheelchairs, as there was no designated waiting area. A therapist had difficulty walking a patient or training a family member without colliding with other therapists and/or patients. Managers are aware of the space issue; however, they had not taken any apparent definitive action to address the problem.

Audiology Backlog - An area of concern to the Chief, PM&R Service, and to patients was the audiology scheduling backlog. There was a backlog of more than 340 patients who needed appointments (next available appointment was February 26, 2001). Also, 40 hearing aids had not been dispensed to patients. One hearing aid had been in the department since July 1999. The Audiology Clinic was receiving 40 consultation requests a month. The Chief, PM&R Service had undertaken a number of initiatives to reduce the waiting time, including requesting an additional employee, and sending patients to the Ear, Nose and Throat (ENT) Clinic for cerumen (ear wax) removal prior to testing. However, sending patients to the ENT Clinic sometimes delayed the hearing aid evaluation process. The DVH clinic had only one audiology technician for cerumen

removal, ear mold fabrication, and hearing aid distribution. Medical center top managers had authorized one additional audiologist for the service. Medical center managers should continue to monitor audiology waiting times to ensure the desired result is achieved.

Recommendation 4

The Director should require the Chief of Staff to review the design and allocation of space in the PM&R Clinic and monitor waiting times in the Audiology Clinic to assure planned corrective actions achieve the desired results.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

PMR has been located in the basement of Building 100 since the hospital opened, with remote clinics in Buildings 103 and 106. A request has been submitted to have the majority of PMR operations consolidated on the fifth floor of Building 100. This plan is contingent upon the move of medical outpatient clinics on Ward 5 west to the planned ground floor location following the clinic renovation. This would appear to be 18-24 months away from completion.

Audiology appointment availability is being followed very closely as a part of the VHA WTI. To provide immediate assistance with the backlog, we have arranged fee basis audiology assessments with community audiologists. The existing backlog of hearing aid fittings is completed. Audiology is on a 30-day cycle for assessment, impression and fitting for all routine cases after the first visit.

Office of Inspector General's Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

4. Annual Nursing Proficiency Evaluations

Several Nursing employees told us that their proficiency evaluations were not completed at the prescribed times. They believed this could adversely affect their chances for promotion. We reviewed seven registered nurses' personnel files to determine the timeliness of their annual proficiency evaluations and the communication of their functional statements. We found that nursing managers had not completed six of the seven nurses' proficiency reviews, and the communication of present functional statements in a timely manner. Four reviews were delinquent from 20 to 30 months.

Managers should conduct a focused review of all Title 38 Registered Nurses' (RNs) personnel files to identify those that do not have up-to-date proficiency reviews. Proficiency reviews that are more than 60 days delinquent should be completed and

communicated to involved staff immediately. Medical center managers should establish a quality improvement initiative to track all employee proficiency and performance reviews to assure that all employees receive timely feedback on their performance. Managers agreed that the severity of this deficiency warranted immediate corrective action.

Recommendation 5

Medical center management should ensure that delinquent nursing proficiency evaluations are completed immediately and that a system is designed and implemented to assure future compliance within required timeframes.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

Proficiencies of those six nurses assigned to the Surgical Outpatient area cited in the CAP Review as being deficient have been completed. The Nurse Executive plans to implement a process so that the proficiencies (work copies) and notices to be done come out of her office. She can track when they were sent out. In turn, the completed proficiencies would come back through her office for review, as well as a completion of the tracking process for that rating period. The proficiencies would then be sent to human resources for inclusion in the OPF to be available for boarding. Human Resources Management has begun supplying the Nurse Executive with a list of delinquent proficiencies for her service line and extended health care. She has not received those for Primary Care, etc. The Nurse Executive will put pressure on those service lines to complete the delinquent ones.

Office of Inspector General's Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

5. Mental Health

Mental Health employees implemented an innovative approach to promoting a 'seamless' system of health care by chartering pilot teams to work with both inpatients and outpatients. In addition to ensuring compliance with Veterans Integrated Service Network (VISN) performance standards for mental health, they also addressed utilization review concerns and clinical guidelines. We reviewed operations of the acute psychiatry unit, the Mental Health Clinic, the Substance Abuse Treatment Program (SATP), the Post Traumatic Stress Disorder (PTSD) Program, and HCHV program. We found that the SATP utilized individual and group treatment methods and a multidisciplinary team approach. Areas that needed management attention included documentation of patients' achievement of treatment goals in the acute psychiatry unit,

implementation of formal quality review and performance improvement activities specific to HCHV and PTSD patients, and security of the Mental Health Building.

Substance Abuse Treatment Program - The SATP served approximately 45 outpatients weekly, utilizing individual and group treatment methods. The SATP's treatment approach and phasing of services were both logical and insightful, and program performance improvement activities included measuring generic monitors such as urinalysis testing, and a sophisticated review of the efficacy of cognitive behavioral group therapy. SATP medical record documentation used input from all treatment disciplines. The medical records that we reviewed reflected goal planning and the establishment of treatment time frames. SATP was a model program in all areas.

Areas Needing Management Attention

Acute Psychiatry Unit - The Acute Psychiatry Section operated 10 beds, with a capacity to increase to 12 beds as needed. The 10 beds included both locked and open units, and the facility accepted committed patients. Documentation of patient assessment and treatment planning was good; however, there was no discussion in the medical records of the patients' actual compliance with the treatment plans (i.e., therapeutic activities attended and levels of participation were not recorded in the chart).

HCHV and PTSD - The HCHV and the PTSD Programs were relatively new and were still evolving. In discussions with program clinicians, we concluded that both programs had proper treatment curriculums and knowledgeable employees, but lacked policies and guidelines which established basic program structure, admission and discharge criteria, and employee responsibilities and accountability. Both program areas would benefit from implementation of formal quality review and performance improvement activities specific to their program and population.

Notwithstanding a strong mental health service line, medical center managers should improve the documentation of patient treatment activities and goal achievement in the inpatient psychiatric unit and develop and implement program policies and guidelines to assure consistent, quality care for all HCHV and PTSD patients.

Recommendation for Improving Building Security

Mental Health Care Building Security - Security of the Mental Health Building needs improvement. This large 2-story structure had only one panic button located in the entire building and the main entrance was not secure after 4:30 or 5:00 PM. We entered the building through the main entrance at 8:30 PM, and found the first floor to be unsupervised. The registration area was enclosed by a chest-high counter, but was otherwise unsecured. We observed computer equipment and unsecured patient medical records behind the registration desk. Mental Health employees advised us that the doors remained open in the evenings to allow acute psychiatry patients to smoke (which they typically do without supervision).

The Chief, Police and Security Service, reported that the Mental Health Building had strategically located surveillance cameras in all patient care areas. The cameras were monitored from the police station and the telephone operator's station, both of which are located in an adjacent building. The Police Chief stated that the police station was often empty as officers were expected to be on patrol. The entire facility had two police officers per shift, and the Mental Health Building was scheduled for patrol twice per shift. The lack of safety measures, combined with a high-risk treatment population, leaves staff, visitors, and patients at increased risk for theft or violence.

According to medical center managers, a plan for telephone panic buttons is under review, and they were currently recruiting additional police officers with a goal to have three officers per shift. These measures will improve security in the Mental Health Building, but do not address the issues of the doors being open and the first floor being unsecured and unsupervised after hours.

Recommendation 6

Medical center management should continue their efforts to improve security in the Mental Health Building and consider ways to secure the building after hours.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

There is a panic button available at Building 106. It is located in Psychiatry east. Once activated, the alarm sounds in the Police Operations Office, the Engineering Control Center and the Telephone Operators panel. In addition, a station-wide telephone panic button system has been planned and developed. Funding for this system has already been secured, and equipment will be ordered in the near future. It is anticipated that this will be complete in October 2000. Based on medical center policy, the front doors to Building 106 are scheduled to be locked at 8:30 p.m. daily. This decision allows visitor access, as well as providing patient access to established smoking areas. We have also moved the encounter form printers and patient medical records to a locked room and secured all equipment through the use of security cable tie downs.

This medical center is currently recruiting additional police officers. It is anticipated that this process will be complete by the end of August 2000. A room on the first floor of Building 106, in close proximity to the registration area, has been designated for and assigned to the VA Police. As staffing permits, police officers will receive watch assignments immediately in and around Building 106. This should greatly increase law enforcement presence in this area.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

6. Medical Services

Patient satisfaction in the 9-bed Hemodialysis Unit was high and the unit was well managed. The Medical Intensive Care Unit (MICU) and Cardiac Care Unit (CCU) both had areas that needed to be improved. The open designs of the MICU and the CCU represent potential infection control problems and do not afford patients adequate privacy. Medical center managers revised procedures used to clean and refill crash carts during our review, to ensure the carts did not have outdated drugs and to prevent drug diversions.

Hemodialysis Unit - The Hemodialysis Unit is a 9-bed unit that provides approximately 90 outpatient dialysis treatments per week, as well as providing acute treatments in the intensive care units. Hemodialysis Unit employees were appropriately certified and patient satisfaction was high. The performance improvement measures taken in this area resulted in a reported 14.3 percent reduction (from $36.77 to $32.17) in the cost of each dialysis treatment in the last year. The unit was clean and bright, and equipment was up-to-date. Educational materials for patients and families were attractive, inviting, and understandable.

MICU and CCU - The MICU has an open bay. There are glass dividers between beds, but the ends of the bed cubicles are completely open. The MICU's openness provides the potential to be an infection control problem. The national average for nosocomial infections is 23 infections per 1,000 bed days of care. In March 2000, the MICU rate was 25/1,000 and the CCU rate was 24/1,000. This facility has an active and progressive infection control program. Infection Control Program clinicians monitor infection rates closely, and attempt to stop any trends that may occur. Several persons whom we interviewed commented on the MICU's openness in relation to the high infection rate. One method used to attempt a reduction in infections was a highly visible hand-washing program. Sinks were added to each MICU bed cubicle for hand washing and clinical managers approved the use of a new alcohol-based hand gel. These measures should increase hand washing compliance and decrease infections. Another problem expressed by a patient complaint was the lack of privacy afforded to MICU patients. A family complained that another family heard all about an illness that they did not want revealed because of this lack of privacy, which compromised patient confidentiality. MICU managers have attempted to reduce the chances of visitors overhearing confidential information by restricting visiting hours at those times when doctors are making rounds.

Crash Carts - During the inspection, we found two separate expired medications (more than 6 months old). We also identified problems with the way in which clinical employees cleaned and refilled crash carts. The process utilized by Supply Processing and Distribution (SPD) and Pharmacy Service allowed drugs to be unsecured at two different times during restocking. This raised the potential for drug diversion that could go unnoticed until such time as the medications were needed.

Inspectors addressed the crash cart issue with pharmacy managers during our review and the managers changed the process to ensure appropriate pharmacy control over crash cart medications. The facility has also ordered numbered locks the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommended during its last visit.

7. Contract Nursing Home Program

The DVH's Contract Community Nursing Home (CNH) Program had 22 locally negotiated contract facilities and one multi-state nursing home contract (negotiated by VA Central Office). At the time of our review, DVH had 51 patients in CNHs. We found that CNH contract rates were appropriate and annual CNH inspections were made in accordance with VHA policy. However, we found that medical center clinicians were not visiting some CNH patients each month as required, and that some patients' physical examinations were not documented in the patient's VA medical record.

CNH Contract Rates - CNH contract rates were negotiated in accordance with VA policy. Annual contract costs were about $1.3 million and ranged from $128 to $185 a day. Contracting officers negotiated CNH rates within the specified percentages of the nursing home's state approved Medicaid rates.

Areas Needing Management Attention

Annual CNH Inspections - The DVH has a comprehensive CNH inspection program. The inspection team consists of a nurse, social worker, dietitian, and a safety officer. Inspection teams effectively utilized data from outside agencies to identify already cited deficiencies and the teams were comprised of appropriate disciplines. Of the 22 nursing homes that we reviewed, 19 had annual inspections. The remaining three nursing homes did not have inspections in 1999, but were all scheduled to have them in 2000. Five nursing homes did not require site inspections because team members determined that no site inspection was required, based on a review of Health Care Financing Administration (HCFA) and On-Line Survey, Certification and Reporting System (OSCAR) reports. The remaining facilities were all inspected by at least a nurse and a social worker, and proper inspection reports were filed in a timely manner.

Three CNHs were cited for deficiencies (2-safety, 1-dietary) in 1999. We found that in all cases, medical center clinicians completed the reports and forwarded them to the CNH administrator within 7 days of the inspection. Typically, the nursing home was given 30 days to respond with a plan of correction. Follow-up actions by the VA nurse and the safety officer were prompt and adequately documented. However, in the future, we suggest that the Chief, Extended Care Service Line (ECSL), review and concur with inspections when deficiencies are found.

While DVH's inspection process was effective, it was due in large part to the extensive experience and tenure of the individual inspection team members. DVH does not have any written policies regarding inspections, and does not have a training program for new inspectors. To ensure the continuity of the CNH inspection program, DVH managers should develop a written policy that defines inspection requirements, responsibilities, and follow-up activities, and establish a training program for new inspection team members.

Annual Physical Examinations - CNH patients were not always visited monthly by VA clinical employees as required by M-1, Part 1, Chapter 12. While the seven short-term contract patients we reviewed received monthly visits, the renewable contract cases (veterans with long-term eligibility) that we reviewed (seven charts) only had visits documented every 2–3 months. Also, none of the VA medical records for renewable contract patients that we reviewed showed any evidence that clinicians completed annual physical examinations. According to the CNH coordinator, for logistical reasons, the CNH physicians complete the annual physical examinations and document them in the patients' medical records at the nursing home. Without the annual physical examination documented in the VA medical record, a determination of a patient's appropriateness for continued nursing home care is more difficult. We suggest that the Chief, ECSL, review the annual physical examinations along with recommendations from the VA nurse and social worker either supporting or rejecting the patients' continued need for nursing home care. The Chief, ECSL, should either concur or non-concur with the recommendations, with all documentation then becoming part of the VA medical record.

8. Surgical Services

Space and Patient Records - The Surgical Intensive Care Unit (SICU) and the Surgical Outpatient Clinic area had equipment stored in a hallway that obscured the line of sight of a patient care room. The feedback from SICU employees validated the lack of available storage space on the unit. A clean utility room had a potential for cross-contamination that represented a potential infection control issue. We found patient medical records and radiological films unattended and easily accessible in the hallway outside rooms 2C-147 and 2C-161 in the Surgical Outpatient Clinic. We suggest that medical center managers: (i) review the space constraints and use of the Surgical Service clean utility room; (ii) provide for storage space as appropriate; and, (iii) ensure that patient medical records are adequately secured.

9. Urgent Care

We received several complaints from patients and employees regarding the recent closing of DVH's Emergency Room (ER). These complaints prompted our review of this issue. In January 2000 the facility closed its ER and was instead operating an Urgent Care Center from 8:00 AM to 7:30 PM. Managers advised us that this decision was based on several factors, including a low caseload of truly emergent cases from 8:00 PM to 8:00 AM, as well as the cost associated with maintaining an ER given the low workload. Patients have been advised of the change, and although some patients have expressed concern about this issue, facility managers reported that they have seen a steady decline in the number of patients presenting after-hours for emergent and non-emergent care.

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B. Management Controls Were Generally Effective

Administrative activities reviewed were generally operating satisfactorily and management controls were generally effective. As discussed below, we reviewed and tested controls in 12 management and administrative areas. We found no significant deficiencies in several areas reviewed, including time and attendance for part-time physicians, personal identification number (PIN) telephone system, acquisition of Information Technology (IT) equipment, and printing practices. We made one recommendation that managers develop a measurable statement of work for the surgical services contract.

During our review, we noted several administrative issues that did not warrant individual recommendations, but needed some management attention. We made suggestions for improvements in seven areas: contracted general, plastic, thoracic, and vascular surgery services; contracted otolaryngology services; government purchase card program; third-party reimbursable insurance accounts receivable; means test; unannounced audits of the agent cashier; and Pharmacy Service security.

1. Contracted General, Plastic, Thoracic, and Vascular Surgery Services

The contract for provision of a variety of general, plastic, thoracic, and vascular surgery services did not contain a definitive and measurable statement of work. Without proper definition, responsible medical center staff cannot effectively monitor and administer the contract. Review of the contract file showed that on November 17, 1999, the Sharing and Purchasing Office (175) provided DVH with a technical and legal review of the proposed contract for Surgery Services. The technical and legal review, dated October 19, 1999, from Acquisition Resources Services (95A), which was concurred in by the Assistant General Counsel (25), stated the following:

> *"The actual statement of work outlining the services to be performed by the contractor is minimal. The Contracting Officer should ensure that the statement of work is sufficiently detailed to ensure that the contractor is able to adequately perform and the Contracting Officer is able to adequately administer this contract."*

The contract was awarded on December 21, 1999, without revising the statement of work. Discussions with Purchasing and Contracting (P&C) Section staff disclosed that they did not change the statement of work prior to awarding the contract because the memorandum stated that it was minimal. P&C staff also stated that since the statement of work was not considered unsatisfactory, they awarded the contract without making any changes. Additionally, in a memorandum dated January 5, 2000, the Acting Director of Surgical Service, stated the following concerning the contract:

> "*This is a comprehensive contract for surgical care in the four surgical specialties specified. However, the contract methodology was not described or defined beyond the request for 12 of each of the 7 submitted*

items. The surgeons requested to perform the requested services were not identified as to number or FTEE. Therefore, this does not represent a completed contract which can be evaluated for legal or technical approval."

Although Surgical Service's comments were provided after the contract was awarded, they further support the need for DVH to provide a statement of work that will ensure that medical center staff have a better measurement of work to evaluate the contractor's performance. Management should ensure that the P&C Section, in conjunction with Surgical Service staff, develop a measurable statement of work that will provide sufficient details so as to allow the contract to be administered and ensure that DVH is receiving the surgical services required by the contract. The statement of work should be FTEE-based, or based on some other measurable unit.

Recommendation 7

Medical center management should ensure that a measurable statement of work is developed for the surgical services contract.

Medical Center Director's Comments

The Director concurred with the findings and recommendations.

Our next contract will have a revised statement of work to reflect the appropriate monitoring mechanisms.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

2. Contracted Otolaryngology Services

Medical center management needs to increase competition for otolaryngology services. The cost for the provision of contracted otolaryngology services significantly increased from $184,000 in 1998 to $240,000 in 1999 (30 percent increase). The facility awarded the contract to the same healthcare provider in both years. The price negotiation memorandum noted that the provider knew he was the only provider interested in the contract in 1999, and that, *"VA could either agree to his terms or do without the service."* Five other providers that requested bid invitation packages did not submit offers, so the facility awarded the higher contract rate to the only provider making an offer. We found that Acquisition and Material Management Service (A&MMS) did not follow up with these other providers to determine why they did not submit bids. We suggest that management contact the other providers to determine why they did not submit bids, and use the information to determine what changes should be made to the Invitation for Bid package to attract more competition for these services.

3. Government Purchase Card Program

Controls over the purchase card program were generally effective; however, management attention is needed to ensure that purchasing agents (PA) do not exceed their procurement warrant and that purchase cards are appropriately distributed.

VA medical centers (VAMCs) are required to use government purchase cards for small purchases of goods and services (usually $2,500 or less). VHA policy requires VAMCs to establish adequate internal controls to ensure that items purchased are actually received, charges are for official purposes, and that the facility's right to dispute errors and overcharges are protected. From January 1 through December 31, 1999, purchase cardholders processed 14,055 transactions totaling about $8.8 million. As of December 31, the facility had 76 cardholders using 497 cards. Cardholders often held more than one card to accommodate separating purchases among various program areas or fund control point activities. There were 26 approving officials.

While internal controls were effective for monitoring the program, two areas need attention:

- One purchasing agent regularly made purchases in excess of that agent's procurement warrant of $1,000.

- Decentralization of the use of purchase cards to an appropriate number of end users had not taken place, as evidenced by 74 percent of all purchase cards assigned to staff in A&MMS.

Warrants - Our review found that A&MMS management allowed one PA to make purchases ranging from $2,667 to $14,050 when the PA was warranted for $1,000. The PA was warranted in October 1994, but had not been given a higher warrant even though the PA continuously made purchases that exceeded $1,000. A&MMS management indicated that the PA warrant was going to be increased once the individual was promoted. It is not clear why the PA's warrant was not increased prior to our review. Medical center management should ensure that the PA's warrant is reviewed and appropriate action is taken to warrant the PA commensurate with experience and education, and ensure that the PA does not exceed the warranted amount.

Purchase Card Distribution - Our review showed that DVH had 76 cardholders with 497 purchase cards and 26 approving officials as of December 31, 1999. We determined that 19 of the 76 cardholders (25 percent) were assigned to A&MMS. These 19 cardholders had 367 (74 percent) of the purchase cards at DVH and one approving official was responsible for authorizing purchases made with these 367 purchase cards. It appeared unreasonable to expect that one approving official could properly review and approve transactions for 367 cards timely. We suggest that medical center management require A&MMS to evaluate the need for the purchase cards assigned to A&MMS and determine if individuals in other services can be issued purchase cards. We also suggest that the 19 cardholders assigned to the one

approving official be reviewed to determine if review responsibility can be more equitably distributed among other supervisors.

4. Third-Party Reimbursable Insurance Accounts Receivable

Recovery of third-party receivables could be improved by reducing the time needed to establish debts and increasing the use and frequency of telephone follow up. VA Manual MP-4, Part VIII, Chapter 19, requires VHA facility staff to follow up with insurance carriers on delinquent accounts receivable. The initial claim document is to be sent as soon as the debt is identified. A follow-up notice should be sent after 45 days and a third notice should be sent after another 30 days if the claim remains unsettled. Telephone follow up should be made with the third-party payer at the time the third notice is sent to ensure the insurance carrier received the bill and to identify and resolve any impediments to collection. DVH had about $3.6 million outstanding for third-party receivables as of March 16, 2000.

Debt Establishment - We reviewed 12 third-party receivables valued at $412,880 for VA services provided between December 16, 1998, and October 19, 1999. Follow up was generally appropriate; however, debts should be established more timely. In our sample, the time to establish a debt ranged from 7 to 223 days and averaged 43 days (excluding the 233-day case). A recent DVH study showed an average processing time of 40 days. Staff at DVH used 30 to 45 days as a goal, noting that there was no local, VISN, or national VA standard. In 5 of the 12 receivables sampled, the processing time exceeded 45 days as follows: 56, 81, 82, 83, and 223 days. The private sector uses a processing time as short as 9 days.

Telephone Follow up - DVH made appropriate telephone follow up on 10 of the 12 cases in our sample. Facilities are to telephonically follow up at the time the third notice is sent to the insurance carrier. In two cases, telephonic follow up was not made. In one case, 3 months had passed without telephone follow up and 4 months in the other. DVH staff attributed the lack of follow up to a shortage of accounts receivable clerks in the first quarter of FY 2000. They were addressing the backlog with new staff in an effort to resolve the problem.

Telephone Follow up Frequency - Frequent telephone follow up with insurance carriers results in more timely payments. While there is no agency standard for the frequency of telephone follow up after the third notice is sent to the insurance carrier, a fee service provider used by DVH for a brief period performed follow up on a 2-week interval, which DVH staff said resulted in more timely payments by insurance carriers. Follow up by DVH staff typically took place on a 30- to 45-day interval. In order to maximize the medical center's collection efforts, we suggest that DVH staff identify the largest receivables and ensure telephonic follow up every 2 weeks. This should maximize collections in a cost-effective manner.

5. Means Test

Medical center staff obtained reports of income (means tests) from veterans obtaining services from VA. However, there were some means tests that were not signed by the veteran. Veterans whose income exceeds a certain level, or who have insurance, must pay part of the cost of medical care provided for treatment of non-service connected conditions. If VA provides treatment for the veteran, the medical facility should have a signed means test form in the veteran's administrative records. By signing the form, the veteran attests to the reported income and, having been informed of rights under the Privacy Act, is aware that the information is subject to verification with Internal Revenue Service and Social Security Administration records.

We reviewed a sample of 40 means test records of 376 persons that the facility reported had filed a means test from January 1 through February 16, 2000. Six of the 40 files did not contain a signed means test. We suggest that medical center management periodically check patient files to ensure that the signed means tests are documented in the patients' files.

6. Agent Cashier Unannounced Audits

Unannounced audits of agent cashier functions were completed quarterly and shortages were not identified. VA medical centers are required to perform an unannounced audit of the agent cashier's cash advance at least every 90 days. The dates and times of unannounced audits should be varied to ensure the element of surprise. A facility should also ensure that the agent cashier advance is turned over at least every 3 weeks.

We reviewed unannounced audits for calendar years 1998 and 1999. Audits were held on different days of the week. However, they generally all started between 8 to 9 AM, and were always held at least 60 days after the last audit. We suggest that the starting times and the periods between audits be varied to more effectively ensure the element of surprise.

7. Pharmacy Service Security

DVH conducted unannounced inspections of controlled substances as required with no significant discrepancies identified. The medical center has not been able to destroy unusable controlled substances quarterly because its incinerator is not functioning.

We reviewed internal controls over controlled substances to determine compliance with: the conduct of monthly inspections of Schedule II, III, IV, and V drugs; physical security of the pharmacy; and management of unusable controlled substances. Monthly inspections under specific guidelines are required to ensure that all controlled substances are accounted for properly. Specific standards for the physical security of drug locations and staff access to them are also mandated. Unusable controlled substances such as expired and contaminated drugs should be properly disposed of and accounted for by Pharmacy Service.

We found that the facility generally held unannounced inspections over controlled substances as required for calendar year 1999 at the 13 locations holding such drugs. Inspectors were appropriately assigned and trained in their duties, and they reported discrepancies to the Director as required. No significant discrepancies were identified in 1999. In addition, a tour of Pharmacy Service did not reveal any physical security deficiencies.

However, it had been almost a year since the last quarterly destruction of unusable controlled substances. Staff attributed this problem to a broken incinerator. At the time of our visit, Pharmacy management had made arrangements to destroy on hand expired drugs at a nearby VA medical center. There were 3 boxes of drugs about 12 x 12 x 18 inches in size pending destruction. We suggest that a means of scheduling quarterly off-site destruction be established until the facility's incinerator is repaired or replaced.

Fraud and Integrity Awareness Briefings

We conducted six fraud and integrity awareness briefings. Approximately 183 individuals from all services in the medical center attended the briefings, which included a lecture, a short film presentation, and question and answer opportunities. Each session lasted approximately 1 hour and 15 minutes. The material covered in the briefings appears below.

Reporting Requirements

VA employees are encouraged, and in some circumstances required, to report allegations of fraud, waste or abuse to the OIG. VA Manual MP-1, Part 1, Chapter 16, outlines the responsibility of VA employees in reporting such allegations. Subordinate employees are encouraged to report such activities to their management. However, reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an available auditor, investigator, or healthcare inspector. Management is required to pass along these allegations to the OIG once they have been made aware of them. The OIG is heavily dependent upon VA employees to report suspected instances of fraud, waste, and abuse and, for this reason all contacts with the VAOIG to report such instances are handled as confidential contacts.

Referrals to the Office of Investigations - Administrative Investigations Division

The Administrative Investigations Division investigates allegations of serious misconduct on the part of VA officials that are not criminal in nature. Such an example would be misuse of a government owned vehicle by a senior VA official.

Referrals to the Office of Investigations - Criminal Investigations Division

Upon receiving an allegation of criminal activity, the Office of Investigations will assess the allegation and make a determination as to whether or not an official investigation will be opened and conducted. Not all referrals are accepted. If the Office of Investigations decides to open a case, the matter is assigned to a case agent, who then conducts an investigation. If the investigation substantiates criminal activity, the matter is then referred to the Department of Justice (DOJ), usually through the local U.S. Attorney's Office. DOJ then determines whether or not it will accept the matter for prosecution. Not all cases referred to DOJ by the OIG are accepted.

If DOJ accepts the case, either an indictment or a criminal "information" follows. These two vehicles are used to formally charge an individual with a crime. Following the issuance of an indictment or information, an individual either pleads guilty or goes to trial. If a guilty plea is entered or a person has been found guilty after trial, the final step

in the criminal referral process is sentencing. If the investigation only substantiates administrative wrongdoing, the matter is referred to management, usually the medical center or regional office director, for action. Management, with the assistance of Human Resources and Regional Counsel, will determine what administrative action, if any, to take.

Important Information to Provide When Making a Referral

It is very important to provide as much detailed information as possible when making a referral. The more information we know before we formally begin the investigation, the faster we can complete it. There are five items one should always provide, if possible, when making a referral. They are:

1. Who — Names, position title, connection with VA, and other identifiers.
2. What — Specify the alleged illegal activity.
3. When — Dates and times are critical.
4. Where — Specify the locations where the alleged illegal activity has occurred or is occurring.
5. Witnesses and Documents that can substantiate the allegation.

Specifics are vital. Don't just say, "an employee is stealing from the medical center." Say, "I saw John Doe, engineering technician, take buckets of paint from the VA warehouse and place them in his personally-owned truck on January 2, 1998. John Doe is building an addition to his house. Jane Doe, procurement clerk, recently purchased 100 gallons of paint to finish the clinical addition. The paint was delivered to the VA warehouse on December 29, 1997."

Importance of Timeliness

It is important to report allegations promptly to the OIG. Do not wait years to call. Many investigations rely heavily on witness testimony. The greater the time interval between the occurrence and an interview, the greater the likelihood that people will not recall the event in significant detail. Over time, documentation can be misplaced or destroyed. Also, most Federal criminal statutes have a 5-year period of limitations. This means that if a person is not charged with committing a crime within 5 years after its commission, in most instances the person cannot be charged.

Areas of Interest for the Office of Investigations - Criminal Investigations Division

The Office of Investigations, Criminal Investigations Division, is responsible for conducting investigations of suspected criminal activity having some VA nexus. The range and types of investigations conducted by this office are very broad. VA is the second largest Federal department and it does a large volume of purchasing. Different types of procurement fraud include bid rigging, defective pricing, double or over billing, false claims, and violations of the Sherman Anti-Trust Act. Another area of interest to us is bribery of VA employees, which sometimes ties into procurement activities. Bribery of VA officials can also extend into the benefits area. Other benefits-related frauds include fiduciary fraud, Compensation and Pension fraud, loan origination fraud, and equity skimming. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, improper fee basis billings (medical and transportation), and conflicts of interest. Still more areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by both staff and beneficiaries.

The videotape presentation covered the same basic information but was replete with real life scenarios. Attendees were provided with points of contact for VAOIG and were encouraged to call and discuss any concerns regarding the applicability of bringing a particular matter to the attention of VAOIG.

To report suspected wrongdoing in
VA programs and operations,
call the OIG Hotline at
800-488-8244.

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COMMENTS OF THE MEDICAL CENTER DIRECTOR

Department of Veterans Affairs

Memorandum

Date: July 26, 2000

From: Chief Executive Officer (544/001), Columbia, SC

Subj: DRAFT REPORT: Combined Assessment Program Review - Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center, Columbia, South Carolina (Project No. 2000-01202-R3-0222)

To: Assistant Inspector General for Auditing (52)
VHA Headquarters

1. VAMC Columbia submits the following comments to subject report:

a. **Extended Care**: **CONCUR**

(1) Physicians' Documentation:

Additional physician coverage has been provided for documentation.

(2) NHCU Environment:

Weekly management inspections of the units are done in addition to the daily facility management inspections. Additional facility management personnel have been hired.

(3) Customer Satisfaction:

(a) Breakfast times have been staggered to allow additional personnel time for feeding assistance.

(b) Family council meeting minutes have been posted previously. Minutes will have clear delineation of issue resolution.

(4) Restorative Nursing Therapy Programs:

Oversight of ward restorative nursing program will be increased by lead head nurse and Extended Care Management Committee by monthly reporting of participation and outcomes.

COMMENTS OF THE MEDICAL CENTER DIRECTOR

2.

Assistant Inspector General for Auditing (52)
VHA Headquarters

(5) Structured Activities:

Extended Health Care Service (EHCS) has identified a specific room for dementia activities to take place. The first month that we had scheduled activities was in May 2000. Attached is a calendar of the activities. These activities are done by recreation therapist, nursing assistant and volunteers. The dementia room has been stocked with games, indoor sports equipment, exercise equipment, TV with VCR, and stereo. EHCS has obtained a full-time adult volunteer who assists Monday through Friday from 8:00 a.m.-12:00 p.m. We currently have 17 patients on the treatment list for the dementia room.

Patients from Nursing Home Care Unit that can attend activities (bingo, volunteer groups) offered in adjacent building are encouraged to do so. There are four patients who regularly attend.

Additional programs and activities include:

ACTIVITY	FREQUENCY	SUPERVISION
Pet Therapy (Delta International)	1 time/month to all three wards	Recreation Therapist
Movie Time (VCR)	2 times/month 2nd and 4th Wednesdays at 2:00 p.m.	Recreation Therapist
One New Volunteer Group	Visit 1 time/month	Recreation Therapist

New volunteer group to start in September

Attached are calendars from April, June and July 2000. The additional activities are in red.

[Calendars Omitted]

COMMENTS OF THE MEDICAL CENTER DIRECTOR

3.

Assistant Inspector General for Auditing (52)
VHA Headquarters

b. **Quality Management**: **CONCUR**

(1) Boards of Investigation:

Human Resources Management Service has researched and found training materials to develop into a course. Contact with the local IG office has resulted in their being available as a resource. A training class should be available by September 30, 2000. Identification of both experienced and new participants will take place in the interim.

(2) Waiting Times for Appointments:

(a) We implemented the IHI plan for spread in Primary Care and Specialty Clinics exploring ways to increase capacity and reduce demand. Special emphasis has been placed on using 1.2 million dollars in VISN Waiting Time Initiative (WTI) monies on reducing the backlog of specialty clinic consults.

(b) The new mid-levels have been in Primary Care since early this year. They were working during your visit. The two physicians who retired left at the end of 1999. There are a total of 14 Primary Care clinics. Two of these clinics are covered by a physician only. In one of these clinics, patients are seen by an intern under supervision of a physician. The other clinics are covered by 11 mid-levels with support and supervision by four physicians. Five of these clinics have a next available appointment of greater than 30 days. The average wait for next available appointment for all of these clinics is 26 days as of July 10, 2000 (in January, the average availability was 128 days). Since we understand VA regulations to require primary care availability within 30 days, it would appear that all but five of the primary care clinics are now in compliance. Steps are being taken to make availability more uniform throughout the clinics and also to further improve the waiting time for next available appointment.

(c) Specialty Clinics increased clinic capacity by reconfiguring clinics, calling patients with long-standing consult requests to determine if the appointment was still needed, and implementing consult screening for new

COMMENTS OF THE MEDICAL CENTER DIRECTOR

4.

Assistant Inspector General for Auditing (52)
VHA Headquarters

consults. We plan to contract for GU services with private physicians in the community while we are aggressively attempting to recruit a second urologist and are in process of hiring two audiologists to reduce the Audiology Clinic backlog. The Orthopedic Clinic now has seven-day appointment availability. The Neurosurgery Clinic is run and staffed by the Charleston VA Medical Center. We will make that facility aware of your team's concerns. We are recruiting a pain anesthesiologist who will help in anesthesia, as well as staff an additional Pain Clinic. Recruitment is ongoing with target date for locating physician of November 2000. It should be noted, however, that with pain anesthesiologist and other specialty physician categories, the VA salary table is not comparable with private sector.

The Network Primary Care Service Line has established a waiting time team, which has weekly conference calls to discuss best practice throughout the VISN. The results of these practices are also shared with other service line directors. This is an ongoing effort.

Employees have been instructed not to automatically re-book, but rather to call patients to determine best times and dates for appointments. The Office of Stakeholder Relations has also implemented a program wherein volunteers are calling patients to remind them of clinic appointments in Primary Care to ensure they will keep the appointment. This reduces the "no show" rate in an effort to eliminate open appointments.

We are in the process of fully implementing the computerized patient records system (CPRS), with a target date of December 2000 for full implementation; however, we do not anticipate that CPRS will be of great benefit in improving appointment times.

(3) Medical Record Documentation:

Approximately 25% of discharges from acute care wards are monitored for completion of history and physical examinations. This is accomplished by medical record technicians (MRT) assigned to Incomplete Record Room, as well as the multidisciplinary medical record review teams in conjunction with their monthly medical record reviews.

COMMENTS OF THE MEDICAL CENTER DIRECTOR

5.

Assistant Inspector General for Auditing (52)
VHA Headquarters

The completion of treatment plans, pain assessments, patient/family education and advance directives is included in the Closed Medical Record Review Criteria that are reviewed monthly by the Multidisciplinary Medical Record Review Teams.

Results of reviews are reported quarterly to the Computerized Patient Record System (CPRS) Steering Committee, Information Management Steering Board and Professional Standards Board. Results are also reported to the appropriate service line director or service chief, with a request that plans for corrective action be implemented and reported back to the CPRS Steering Committee.

At the time of your visit, Medical Center Bylaws required that medical records be completed within 15 days and provided mechanism for privilege suspension for delinquent medical records after due process. The Medical Center's Professional Standards Board for Physicians, Dentists and Optometrists, with concurrence of the Chief Executive Officer, amended the bylaws in July to allow 30 days for medical record completion. When initial corrective action fails to result in compliance in correcting medical record deficiencies, letters are sent to practitioners by the Chief Medical Officer. If still noncompliant, steps are taken for privilege suspension.

c. **Physical Medicine and Rehabilitation (PMR): - CONCUR**

(1) Therapy Clinic Space:

PMR has been located in the basement of Building 100 since the hospital opened, with remote clinics in Buildings 103 and 106. A request has been submitted to have the majority of PMR operations consolidated on the fifth floor of Building 100. This plan is contingent upon the move of medical outpatient clinics on Ward 5 west to the planned ground floor location following the clinic renovation. This would appear to be 18-24 months away from completion.

COMMENTS OF THE MEDICAL CENTER DIRECTOR

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VHA Headquarters

(2) Audiology Backlog:

Audiology appointment availability is being followed very closely as a part of the VHA WTI. To provide immediate assistance with the backlog, we have arranged fee basis audiology assessments with community audiologists. The existing backlog of hearing aid fittings is completed. Audiology is on a 30-day cycle for assessment, impression and fitting for all routine cases after the first visit.

d. **Annual Nursing Proficiency Evaluations**:

(1) **CONCUR** - Proficiencies of those six nurses assigned to the Surgical Outpatient area cited in the CAP Review as being deficient have been completed.

(2) **CONCUR** - The process for tracking of proficiencies involves putting all registered nurses (RN) in all service lines into an Excel or Access data base with name, date of grade, date of proficiency, etc., in it so that information can be obtained quickly on any given day.

The Nurse Executive plans to implement a process so that the proficiencies (work copies) and notices to be done come out of her office. She can track when they were sent out. In turn, the completed proficiencies would come back through her office for review, as well as a completion of the tracking process for that rating period. The proficiencies would then be sent to human resources for inclusion in the OPF to be available for boarding.

The Nurse Executive has not hired a secretary yet but would anticipate this process being in place by September 1, 2000. In the meantime, Human Resources Management has begun supplying the Nurse Executive with a list of delinquent proficiencies for her service line and extended health care. She has not received those for Primary Care, etc. The Nurse Executive will put pressure on those service lines to complete the delinquent ones. She has also had about ten sessions with RN's in the past three weeks to introduce the new nurse qualification standards and has stressed in each class the importance of timely proficiencies. Nurse managers have been attending those sessions, although they are not the only ones writing proficiencies in the medical center.

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VHA Headquarters

e. **Mental Health Care Building Security**: **CONCUR**

There is a panic button available at Building 106. It is located in Psychiatry east. Once activated, the alarm sounds in the Police Operations Office, the Engineering Control Center and the Telephone Operators panel. In addition, a station-wide telephone panic button system has been planned and developed. Funding for this system has already been secured, and equipment will be ordered in the near future. It is anticipated that this will be complete in October 2000. Based on medical center policy, the front doors to Building 106 are scheduled to be locked at 8:30 p.m. daily. This decision allows visitor access, as well as providing patient access to established smoking areas.

This is a public building and the families of the patients have the right to visit their loved ones while they are hospitalized. We have placed additional safeguards in place since your visit to ensure this area is safe, however, no matter what we do, we can never assure that any area in a public facility will be 100% safe. We have also moved the encounter form printers and patient medical records to a locked room and secured all equipment through the use of security cable tie downs. We feel we have done everything possible to make this area safe for the patients, staff, equipment and medical records. This medical center is currently recruiting additional police officers. It is anticipated that this process will be complete by the end of August 2000.

A room on the first floor of Building 106, in close proximity to the registration area, has been designated for and assigned to the VA Police. As staffing permits, police officers will receive watch assignments immediately in and around Building 106. This should greatly increase law enforcement presence in this area.

As the mission at this medical center changes, such as the proposed contract between the South Carolina Department of Mental Health and VA, police staffing will be expanded to accommodate the increased patient and visitor load. Cost estimates for additional staffing, based on patient bed days of care, have already been submitted.

COMMENTS OF THE MEDICAL CENTER DIRECTOR

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VHA Headquarters

f. **Crash Carts**: **CONCUR**

A new Standard Operating Procedure (SOP) No. 90B-17, dated May 4, 2000, "Crash Carts Exchange and Maintenance System," has been developed and put into place to eliminate outdated drugs on crash carts. The SOP has been implemented by the SPD and Pharmacy areas and addresses the OIG concerns. The cart is locked by the pharmacist after the medications are replaced. No one can have access to the drugs at this point without breaking the lock. Each lock has a number that is recorded in a logbook in Pharmacy as to date/RPH. Once this is accomplished, SPD returns the locked cart to the crash cart pool.

g. **Contracted General, Plastic, Thoracic, and Vascular Surgery Services: CONCUR**

Surgical Contract - Measurable Statement of Work:

Our next contract will have a revised statement of work to reflect the appropriate monitoring mechanisms.

h. **Government Purchase Card Program**: **CONCUR**

Acquisition and Facility Planning Service (AFPS) in Columbia controls and manages 80 to 85 percent of all unofficial inventories which consist of over 8,500 line items. The 19 AFPS cardholders manage service inventories, which include funding control, inventory and ordering. Services having unofficial inventories controlled by AFPS are: all wards and clinics, catheterization laboratory, radiology, dental, engineering, facility process stores and forms, anesthesia, pulmonary, medical media, nursing home care units, medical/surgical items for pharmacy, along with posted stock. Services currently not under AFPS inventory management are: pathology and laboratory medicine, nutrition and food (paper products only), facilities

COMMENTS OF THE MEDICAL CENTER DIRECTOR

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management service line (janitorial supplies), and operating room. Since AFPS controls over 80 percent of the unofficial inventories for this facility, it would be reasonable to assume that 25 percent of the cardholders would be required to adequately provide customer service. In addition, the 19 AFPS cardholders are assigned to two supervisory approving officials. This facility found it necessary to issue purchase cards to our purchasing staff in order to provide back-up support to our using services. This has enabled our station to continue to obtain VA's mandatory 95 percent credit card purchases for orders under $2,500.

Warrants: The one purchasing agent that had exceeded the purchase authority of her warrant has had a new purchasing warrant issued to her, as her current job warrants a higher authority.

i. **Third-Party Reimbursable Insurance Accounts Receivable**: **CONCUR**

(1) Debt Establishment:

There is no established VISN or national goal for release of billing statement from date of service. There is now in place an unbilled inpatient monitor, which identifies the backlog that has a target level of 45 for VAMC Columbia to allow us to ensure timely billing of inpatient cases that will result in higher revenue.

(2) Telephone Follow-up Frequency:

Although there is no established agency standard for the frequency of telephonic follow-up on third party receivables, there is a VISN 7 monitor for outstanding receivables. This report provides a summary of all outstanding third party receivables, including the number of receivables and total outstanding balance. Benchmark: 10-20% over 90 days and 5-10% over 180 Days. VAMC Columbia facility, for example, in May 2000 reflects 19.07% over 90 days and the VISN average is 32.83%, and 7.78% over 180 days and the VISN average is 15.5%.

COMMENTS OF THE MEDICAL CENTER DIRECTOR

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Assistant Inspector General for Auditing (52)
VHA Headquarters

j. **Agent Cashier Unannounced Audits**: **CONCUR**

To ensure appropriate spacing between audits, a random number generator program was installed on the Chief Operating Officer's personal computer. Date and time will be assigned to the audit, so that predictability will not be a factor. The agent cashier's advance was reduced as of February 2000.

k. **Pharmacy Service Security**: **CONCUR**

Controlled substances were incinerated at VAMC Charleston VAMC April 3, 2000. We are coordinating with Acquisition and Facility Planning Service for destruction this quarter by using a DEA-approved disposer locally. If this cannot be accomplished in time to meet our quarterly destruction cycle, we will again use the incinerator at VAMC Charleston. Our long-range plan must be to do this under contract since the VAMC Charleston incinerator will not be operable beyond one year.

2. Thank you for the opportunity to provide comments to your draft report. If additional information is desired, please contact Jerry Willison, Chief Operating Officer, at (803) 695-7981.

/s/
Brian Heckert

Attachments: 3 **[Omitted]**

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