Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the John D. Dingell Veterans Affairs Medical Center Detroit, Michigan

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VA Office of Inspector General
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Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purpose of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness briefings for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, members of Congress, or others.

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Executive Summary

Introduction

During the week of May 14 – 18, 2001, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the John D. Dingell Veterans Affairs Medical Center (VAMC) Detroit, MI. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to about 350 VAMC employees.

Results of Review

VAMC management actively supported quality patient care and performance improvement. The QM program provided effective oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, VAMC management needed to:

- Monitor overtime and compensatory time use in Pharmacy Service.
- Improve clinical oversight of contract nursing home (CNH) care.
- Strengthen timekeeping for part-time physicians in Medical Service.
- Improve timeliness of access to primary care.
- Ensure privacy of medical information.
- Assign appropriate sensitivity levels to staff with Veterans Information Systems Technology Architecture (VISTA) access.
- Improve physical security on an acute inpatient psychiatry ward.
- Implement effective inventory management practices in the warehouse and Supply Processing and Distribution (SPD).
- Ensure that all controlled substances are inventoried during monthly narcotics inspections and that outdated and unusable substances are disposed of quarterly.
- Improve documentation of consent for surgical procedures.
- Implement procedures to expedite collection of Federal accounts receivable.
- Require Fiscal Service staff to deobligate delinquent unliquidated obligations when appropriate.
- Follow up on clinician background investigations sent to the Office of Personnel Management (OPM).

VAMC Director Comments

The VAMC Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 15 - 23, for the full text of the Director's comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Based in Detroit, MI, the VAMC is one of seven medical facilities in Veterans Integrated Service Network 11. The facility's primary service area includes 4 southeastern Michigan counties with a veteran population of about 464,000.

Programs. The VAMC provides a broad range of services using 108 acute care, 25 intermediate care, and 84 nursing home care beds. The VAMC supports veterans outreach centers in Lincoln Park and Detroit, MI and a health care program for homeless veterans located at the VAMC. Primary, specialty, and follow-up care are provided on an outpatient basis at the main Detroit facility and at two community-based outpatient clinics located in Yale and Pontiac, MI.

Affiliations and Research. The VAMC is affiliated with the Wayne State University School of Medicine. In Fiscal Year (FY) 2001, the VAMC research program had 141 projects and a budget of $2.9 million.

Resources. In FY 2000, medical care expenditures totaled $138 million. The FY 2001 medical care budget was $143 million. FY 2001 staffing was 1,383 full-time equivalent employees (FTEE), including 95.5 physician FTEE and 234.3 nursing FTEE.

Workload. In FY 2000, VAMC staff treated 28,264 unique patients. The inpatient workload was 4,743 discharges, and the average daily census, including nursing home patients, was 175. The outpatient workload totaled 261,535 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information

systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts Receivable	Government Purchase Cards
Agent Cashier	Information Technology Security
Background Investigations of Clinicians	Inventory Management
Clinical Quality Management	Medical Care Collection Fund
Communication of Test Results to Patients	Medical Record Privacy
Consent for Research	Pharmacy Service Overtime
Consent for Surgery	Primary Care for Psychiatry Patients
Contract Nursing Home Oversight	Procurement of Printing Services
Controlled Substances Accountability	Service Contracts
Decision Support System	Timekeeping for Part-Time Physicians
Enhanced Use Sharing Agreements	Unliquidated Obligations

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with timeliness of service and quality of care. The full survey results were provided to VAMC management.

During the review, we also presented four fraud and integrity awareness briefings for about 350 VAMC employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review generally covered VAMC operations for FYs 1999, 2000, and 2001 (through May) and was completed in accordance with OIG standard operating procedures for CAP reviews.

In this report we make 12 recommendations and 1 suggestion for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The suggestion pertains to an issue that needs corrective action and should be monitored by VAMC managers until this action is completed.

Results of Review

Organizational Strengths

VAMC management had created an environment that supported quality patient care and performance improvement. The patient care management, QM, financial, and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

The Clinical QM Program Was Effective. Patient care data was collected, analyzed, and appropriately trended. The QM program was used to monitor and improve the quality of patient care and to identify, evaluate, and correct situations and occurrences that adversely affected patient safety and treatment.

Critical Test Results Were Effectively Communicated to Patients. Critical test results are those that are outside normal or therapeutic ranges and require immediate attention. When a clinician received notice of a critical test value, the clinician contacted the patient immediately, usually by telephone. If the patient was not available by phone, the clinician sent a letter reporting the test results, informing the patient of necessary follow-up action and providing phone numbers to call with questions. Clinicians created letter templates in the Computerized Patient Record System to facilitate this process.

Management Supported Efforts to Utilize the Decision Support System (DSS). DSS was fully implemented at the VAMC in 1998. DSS operations were staffed in accordance with Veterans Health Administration (VHA) guidelines, and information and reports were made available to VAMC end-users. The VAMC management team had also ensured that staff who could benefit from the information provided by DSS received adequate training.

Enhanced Use Sharing Agreements Were Being Pursued To Optimize Space Utilization. Management was attempting to address underutilized space at the VAMC by encouraging other VA organizations, Federal agencies, and the affiliated medical school to consider relocating functions to the VAMC. At the time of the review, the VA Regional Counsel had agreed to relocate to the VAMC, and this move was expected to be completed within a year. Exploratory discussions had been initiated to relocate the Detroit Veterans Benefits Administration Veterans Service Center from General Services Administration leased space to underutilized space at the VAMC. Finally, discussions were underway with Wayne State University for an enhanced use lease to provide an entire floor at the VAMC for the school's geriatric research program.

Medical Care Collection Fund (MCCF) Activities Complied With Requirements. Staff assigned to the MCCF coding function accurately identified and coded treatments to be billed under MCCF. A review of 20 MCCF cases showed that in all 20 instances there was evidence that care billed for was actually provided, medical records were properly coded, bills were accurate, and accounts receivable were properly established.

Printing Services Were Properly Procured. All printing services with costs exceeding statutory limitations were procured through the Government Printing Office, as required. No inappropriate or excluded printing services had been obtained from any other source.

Government Purchase Card Program Controls Were Effective. Transactions completed using Government Purchase Cards were approved and reconciled as required. Purchase cards were issued only to appropriate individuals, and there were no apparent inappropriate purchases among the transactions examined.

Informed Consents for Research Were Aggressively Monitored and Documented. Informed consents from veterans to be included in research projects were documented in all 12 cases reviewed. The original signed and witnessed consent forms were included in patients' medical records in all 12 instances. In addition, copies of these consent forms were included in research files maintained by Research Service staff. We reviewed protocols for four research projects and reviewed Human Subject Investigation Committee meeting minutes. This documentation showed that Research Service staff were aware of the need to obtain and document informed consents from all veteran patients participating in research projects.

Clinical Services Contracts Were Properly Established. Reviews of six contracts to procure clinical services showed that adequate competition for bids was solicited, market surveys were used to determine reasonable rates, and appropriate Medicare-based rates were paid where applicable. In addition, contracting staff were aware that exceptions to approved rates required approval by the Director.

Agent Cashier Activities Were Properly Conducted. Audits of the Agent Cashier were conducted on a timely basis, and management acted on recommendations resulting from those audits. The size of the Agent Cashier's advance was appropriate, and primary responsibility for Agent Cashier functions was transferred to an alternate cashier for 2 weeks annually as required. Physical security was adequate.

Opportunities for Improvement

Pharmacy Service – Overtime and Compensatory Time Should Be More Effectively Controlled

Conditions Needing Improvement. Management did not monitor the use of overtime and compensatory time in Pharmacy Service. During the CAP review, we received a complaint alleging that certain individuals in Pharmacy Service were routinely asked to work the majority of overtime and compensatory time because they were favored by the person who scheduled this work. The complainant also alleged that the amount of overtime and compensatory time worked was excessive and unjustified.

A review of payroll records supported the allegation that certain employees worked the majority of overtime. As of May 2001, Pharmacy Service had 62 employees with annual salaries of $3.2 million. Timekeeping records for Pharmacy Service for the 1-year period May 2000 through April 2001 showed that Pharmacy Service staff worked 12,782 overtime hours, costing $467,399. Pharmacy Service staff also worked an additional 521 hours of compensatory time costing $17,340. Of the 62 employees assigned to Pharmacy Service, 19 (31 percent of the staff) worked 10,739 overtime hours (84 percent of the total). Similarly, with regard to compensatory time, one individual was granted 345 hours of compensatory time (66 percent of the total).

We could not confirm that the individual responsible for work assignments directed opportunities for overtime and compensatory time only to her friends within the service. However, we did find that the individual in question worked 1,044 hours of overtime (8 percent of the total). In contrast, the complainant worked just 26 hours of overtime (0.2 percent of the total), despite having requested overtime work on many occasions.

Pharmacy management stated that their service had a system for allotting overtime and compensatory time based on seniority. We evaluated the system and found that it failed to adequately address such basic issues as right-of-first-refusal and order-of-selection after first refusal. Management should review the process used for assigning overtime in Pharmacy Service and ensure that, within the needs of medical care, overtime is equitably available to all service employees.

The amount of overtime and compensatory time worked was also questionable. The cost of overtime and compensatory time worked by all employees during the period reviewed was 15 percent of the total annual salary costs for Pharmacy Service. Overtime and compensatory time should be used only to accommodate unpredictable fluctuations in workload or staffing; overtime and compensatory time should not be used on a regular basis. If overtime or compensatory time is required on a regular basis, management should determine if adjustments to staffing levels are necessary to correct the situation. For example, the $484,739 spent on overtime and compensatory time would have allowed the medical center to hire an additional 6.9 FTEE staff pharmacists.

Recommended Improvement Action 1. The VAMC Director should ensure that:

a. Pharmacy Service's policy on overtime be revised to include all necessary issues.

b. Within the needs of medical care, Pharmacy Service allots overtime and compensatory time equitably among its employees.

c. The excessive overtime and compensatory time used in Pharmacy Service is analyzed and necessary staffing adjustments are made.

The VAMC Director concurred with all three parts of this recommendation. In his response, the Director noted that overtime use in Pharmacy service was due to an inability to hire pharmacists and technicians in southeastern Michigan. However, since the CAP review, two pharmacists and three technicians have been hired. This and other measures have reduced overtime use in the service. The Director also reported that actions have been taken to distribute overtime equitably and to review the service's overtime policies, all within the requirements of the local union agreement. The implementation actions are acceptable, and we consider the issues resolved. (The monetary benefit associated with this recommendation is shown in Appendix B, page 24.)

Contract Nursing Home (CNH) Care – Greater Clinical Oversight Is Needed

Condition Needing Improvement. VAMC clinicians did not properly monitor CNH care. VHA policy states that after a patient is transferred to a CNH a VA nurse will visit the patient every 60 days, and more often if necessary, to ensure that adequate care is being provided. At the time of our review, the VAMC had 31 CNH patients at 6 different facilities. Only 2 of the 31 patients had been visited by a VA nurse during the previous 5-month period. The nurse responsible for performing the visits to CNHs stated that she was aware of the visitation requirement, but that other demands of her position prevented this. She also stated that she planned to reinstitute a 60-day visitation cycle as soon as her workload allowed. Management should ensure that the care of veteran patients in CNHs is monitored as required.

Recommended Improvement Action 2. The VAMC Director should ensure that all CNH patients are visited by a VA nurse at least once every 60 days.

The VAMC Director concurred and reported that a performance monitor has been established to ensure that VA patients in community nursing homes are visited at least every 60 days. The implementation action is acceptable, and we consider the issue resolved.

Timekeeping for Part-Time Physicians – Medical Service Staff Needed To Comply With VHA Policy

Conditions Needing Improvement. Medical Service timekeepers did not verify attendance of part-time physicians before completing timecards. In addition, supervisors certified timecards

with no information or with inaccurate information about physician attendance. VHA policy requires that timekeepers have personal knowledge of physician attendance before completing timecards. Certifying officials are accountable for the schedules and attendance of employees whose timecards they certify. As of May 2001, Medical Service had 28 part-time physicians. To determine their whereabouts, we attempted to contact 18 of these physicians during their scheduled tours of duty. In the process, we interviewed 3 timekeepers, 2 certifying officials, and Medical Service administrative staff. We found that:

- There was significant difficulty in contacting all 18 physicians because timekeepers and supervisors were confused about physicians' required core hours and about the locations where they were scheduled to be working.

- Although we were ultimately able to contact 17 of the 18 physicians by phone, the process required more than 1 workday, and we were not able to verify that the physicians were physically present at their VAMC duty locations during their scheduled tours. The remaining physician called his timekeeper from his automobile during his scheduled tour.

- One certifying official, a section chief with two part-time physicians assigned to his section, incorrectly believed that the assigned physicians were full-time.

- Timecards were completed and certified without personal or documented knowledge of physician attendance because timekeepers and certifying officials incorrectly believed that physicians always worked their scheduled tours.

- Medical Service administrative staff were aware of the problems with timekeeping practices. However, they also voiced reservations about whether timekeepers, who were clerical staff, could successfully question physicians about their attendance based on the traditional relationship of professional to clerical staff within the service.

In contrast to Medical Service, timekeeping practices in Surgical Service complied with VHA policy. Surgical Service timekeepers had personal knowledge of physician attendance, and certifying officials demonstrated knowledge of activities of physicians for whom they were accountable for timekeeping purposes. Staff responsible for timekeeping in Medical Service should confer with Surgical Service staff for a model of better timekeeping practices.

Recommended Improvement Action 3. The VAMC Director should ensure that Medical Service timekeeping practices comply with VHA policy.

The VAMC Director concurred and reported that policies for establishing adjustable work schedules and procedures for monitoring attendance by part-time physicians have been revised. With only minor deviations common to most new procedures, these actions have resulted in full compliance. The implementation action is acceptable, and we consider the issue resolved.

Access to Primary Care – Timeliness Needs To Be Improved

Condition Needing Improvement. We interviewed 10 patients who were receiving ambulatory care. Eight informed us that they could not schedule an appointment with their primary care provider within 7 days as required by VHA policy.

Recommended Improvement Action 4. The VAMC Director should ensure that access to primary care is available within 7 days as required.

The VAMC Director concurred and reported that patients who need to be seen by their primary care provider are scheduled based on clinical need and that patients who need or want to be seen sooner have other options including telephone triage, the use of "shadow" clinics[1] for patients with urgent needs, and through intentional overbooking of clinics when necessary. The implementation action is acceptable, and we consider the issue resolved.

Medical Records – Privacy Was Not Protected

Condition Needing Improvement. Federal law and VHA policy require VAMC staff to protect medical information against deliberate or inadvertent misuse or disclosure. We found that paper medical records were sometimes transported via unlocked messenger envelopes by patients, employees, and volunteers working in Escort Service. Also, a cart containing three medical records was found in a busy hallway on the main floor of the facility. The employee transporting the records had stopped to purchase items in the Veterans Canteen Service store, leaving the cart unattended. In another instance, we found an unattended computer terminal with sensitive patient information displayed on the screen. The user who had logged on to the terminal had walked away without signing off and was no longer in the area.

Recommended Improvement Action 5. The VAMC Director should ensure that medical record privacy is maintained by:

a. Transporting medical records in locked containers.

b. Allowing medical records to be transported only by persons who are trained to maintain privacy and security of the records.

c. Training staff to protect sensitive information that may be displayed on computer screens.

The VAMC Director concurred and reported that a full review will be conducted of the methods of transporting medical records, including the kinds of equipment and staff used to transport records. The Director also reported that a newly developed information security program will include the need to protect computer-based information. The implementation actions are acceptable, and we consider the issues resolved.

[1] The VAMC's term for special, limited access clinics for patients with a more urgent need for care.

Information Technology Security – Proper Security Clearances Were Needed

Condition Needing Improvement. Security clearances had not been obtained for individuals with high-level access to VISTA. This occurred because Human Resources Management (HRM) Service staff did not ascertain from Information Resources Management (IRM) Service the level of access granted to each user before determining whether that user required a background investigation and security clearance. Therefore, no background investigations were performed and, as a result, appropriate security clearances were not obtained for some users with high-level access to VISTA. Fourteen staff with high-level access to VISTA did not have the necessary security clearances, including the Associate Director, the Chief of Police, and the Information Security Officer.

Recommended Improvement Action 6. The VAMC Director should ensure that security clearances are obtained for all employees with high-level VISTA access.

The VAMC Director concurred and reported that clearance levels are determined jointly among the Information Security Officer, the Chief of IRM Service, and the Chief of HRM Service. He also reported that HRM staff will review personnel records and VA policies to determine which staff require clearances or reinvestigation for clearances. The implementation action is acceptable, and we consider the issue resolved.

Acute Inpatient Psychiatry Treatment Area – Security of a Nurses' Station Should Be Improved

Conditions Needing Improvement. Physical security needed improvement on one inpatient psychiatry ward. The nurses' station counter on this ward was not high enough to prevent a patient from leaping over it, and posing concerns about employee safety and security of pharmaceuticals. Additionally, there were two half doors to this nurses' station, which also allowed easy access by patients, because the doors were low and could not be locked. Nursing employees told us that they had requested door locks, but they had not been installed. The security of the nurses' station needs to be improved in order to enhance employee safety and control over pharmaceuticals.

Recommended Improvement Action 7. The VAMC Director should ensure adequate security of the nurses' station by installing a higher counter, replacing the half doors with full doors, and placing locks on the doors.

The VAMC Director concurred and reported that appropriate staff will undertake a risk analysis of the area to determine what changes are needed, and those changes will be made. The implementation action is acceptable, and we consider the issue resolved.

Inventory Management in the Warehouse and in Supply Processing and Distribution – Improvements Were Needed in Accuracy of Inventories and Completeness of Surgical Case Carts

Conditions Needing Improvement. Inventory management improvements were needed in the general warehouse and Supply Processing and Distribution (SPD) section. VA policy requires that every VA facility implement the Generic Inventory Package (GIP) and that reported inventory levels be accurate. We found that:

- GIP data was inaccurate for the general warehouse and SPD inventories. In the warehouse, 51 percent of all items posted to GIP were erroneously shown on GIP documents to have been on hand more than 9,999 days[2] as of May 2001. In SPD, 94 percent of all items posted to GIP also were erroneously shown to have been in stock more than 9,999 days.

- Judgment samples of 10 items from the warehouse and SPD showed inaccuracies in inventory levels. In SPD, actual inventory levels agreed with those shown on GIP documents for only 2 of 10 items. SPD staff attributed this disparity, in part, to difficulty in obtaining properly working bar code scanners. They stated that older, deficient scanners had been replaced but that the replacements performed no better than the old units. In contrast, the inventory levels for all 10 items in the warehouse were correct.

- SPD staff could not account for the nonexpendable items in the Sterile Processing Unit (SPU). These items were for use in surgery and on ward areas and were maintained and distributed by SPU staff. SPU staff did not know what items, or how many of each item, were in stock. They stated that there was an automated system in place that notified SPU staff of items needed. However, that system did not provide control over a number of nonexpendable items.

- Operating room nurses told us that surgical case carts were often incomplete or did not contain needed items. As a result, the nurses had started preparing their own case carts.

Recommended Improvement Action 8. The VAMC Director should ensure that:

a. GIP is used to accurately track usage of stock.

b. Actual inventory levels in SPD are reflected in GIP inventory documents.

c. SPU staff maintain accurate inventories of nonexpendable items.

d. Surgical case carts contain all items needed for surgery.

The VAMC Director concurred and reported that the use of GIP will be expanded, and that improvements were being made in correcting problems with the GIP bar code system that contributed to inaccurate inventory levels. He also reported that staff were exploring the

[2] In the GIP system, an on-hand stock level of 9,999 days indicates that staff were not tracking usage rates for the items.

acquisition of an automated system to track equipment issued by SPU staff. The Director reported that correct case carts were not always delivered to operating rooms because of problems with an automated case cart request system. These problems were being corrected and should eliminate that situation. The implementation actions are acceptable, and we consider the issues resolved.

Controlled Substances – Outdated Drugs Were Not Destroyed Quarterly and Were Not Counted During Monthly Narcotics Inspections

Conditions Needing Improvement. VAMC staff did not adequately monitor controlled substances awaiting disposal or dispose of those substances timely. VHA policy requires that outdated (and unusable) controlled substances be disposed of every quarter and that while awaiting disposal these controlled substances should be counted during monthly narcotics inspections. In contrast, we found that:

- Before May 2001, outdated controlled substances had not been disposed of for 14 months. Before that disposal, 18 months had passed between disposals, from September 1998 to March 2000. Staff stated that outdated controlled substances were not disposed of as required because the VAMC's incinerator was not functioning and the VAMC did not have a contract with a private firm to dispose of outdated controlled substances.

- Narcotics inspectors were not aware that outdated controlled substances needed to be counted during inspections. During a narcotics inspection that we requested and observed, there were 10 items in the Outpatient Pharmacy and 5 items in the Inpatient Pharmacy that were awaiting disposal and should have been counted, but were not. None of the 15 items were readily identifiable through Pharmacy Service accountability documents.

Pharmacy Service management agreed with these assessments and initiated corrective action while we were onsite.

Recommended Improvement Action 9. The VAMC Director should ensure that outdated and unusable controlled substances are disposed of quarterly and are included in monthly inspections while awaiting disposal.

The VAMC Director concurred and reported that modifications were made to the automated controlled substance inventory system that will ensure that outdated and unusable drugs awaiting disposal are included in monthly inspections. In addition, he reported that destruction procedures have been modified to ensure quarterly destructions. The implementation actions are acceptable, and we consider the issues resolved.

Informed Consents for Surgical Procedures – VAMC Staff Needed To Fully Document Consents

Condition Needing Improvement. VHA and VAMC policy is specific about the conditions that must be met to document informed consents by patients (or their representatives) for surgical procedures. Informed consent consists of 11 elements. Our review of 21 surgical patient records found that 6 elements were missing from one or more of these 21 records:

- 1 case - there was no consent form.
- 4 cases - there were no legible patient signatures on the consent forms.
- 1 case - there was no witness signature (the witness' name was printed).
- 1 case - there was no evidence that a witness was present.
- 16 cases - there were no legible signatures of practitioners.
- 1 case - the consent form was not dated.

Recommended Improvement Action 10. The VAMC Director should ensure that:

a. Informed consents for surgical procedures are documented in medical records.

b. All 11 required elements of informed consent are present and correct on all consent forms.

c. All required signatures are either legible or annotated by witnesses.

The VAMC Director concurred and reported that monitors currently in place have contributed to improvements in compliance with informed consent procedures. Compliance increased from 79 percent in FY 2000 to 88 percent in FY 2001. In addition, consideration was being given to acquiring equipment that would allow for electronic scanning of consent forms into automated patient records, which would eliminate missing or lost consent forms. The Director also reported that consent forms are reviewed by pre-operative nursing staff to ensure that essential elements are present. In addition, the need for legible signatures will be stressed in meetings with clinicians. The implementation actions are acceptable, and we consider these issues resolved.

Federal Accounts Receivable – Accounts Needed To Be Collected

Condition Needing Improvement. VAMC staff did not take advantage of an automated funds transfer system to expedite collection of Federal accounts receivable. The On-Line Payment and Collection (OPAC) system enables Federal agencies to easily transfer amounts owed to each other. A review of accounts receivable pending as of May 2001 showed that the VAMC had 96 Federal accounts receivable totaling $88,139. Fiscal Service staff stated that they were aware of OPAC, that some of the accounts had been categorized as non-Federal when in fact they were Federal, and that as a result of our review they intended to initiate collection procedures for those accounts utilizing OPAC.

Recommended Improvement Action 11. The VAMC Director should ensure that Fiscal Service staff collect Federal accounts receivable through OPAC.

The VAMC Director concurred and reported that fiscal staff were reviewing open receivables and that the OPAC process will be used to collect receivables where appropriate. The implementation plan is acceptable, and we consider the issue resolved. (The monetary benefit associated with this recommendation is shown in Appendix B, page 24.)

Unliquidated Obligations – Obligations Were Not Followed Up Timely

Condition Needing Improvement. Unliquidated obligations were not processed in a timely manner. Accepted financial practices dictate that unliquidated obligations, such as undelivered orders or accrued services payable, be deobligated to provide for better use of funds earmarked for items or services that may have already been paid for or that may no longer be needed. VHA policy states that unliquidated obligations become delinquent after 90 days. As of March 30, 2001, the VAMC had 339 undelivered orders, totaling about $14.7 million, of which 88 (26 percent, valued at about $835 thousand) were delinquent.

The VAMC also had 1,288 accrued services payable, totaling about $7.2 million, of which 552 (43 percent, valued at $2.9 million) were delinquent. Fiscal Service staff informed us that they routinely followed up on unliquidated obligations by telephone. However, they also stated that these follow-ups had not been documented. A judgment sample of 67 high dollar delinquent accrued services payable accounts showed that, on average, these accounts were 273 days delinquent. Thus, based on our experience at other medical centers, it is likely that the $2.9 million in delinquent accrued services payable represent items that were either unneeded as originally obligated or were paid for with other obligations.

Therefore, a total of over $3.7 million ($835 thousand in undelivered orders and $2.9 million in accrued services payable) are subject to being deobligated.

Recommended Improvement Action 12. The VAMC Director should ensure that delinquent unliquidated obligations are deobligated when appropriate.

The VAMC Director concurred and reported that since our visit Fiscal Service staff review open obligations monthly. After reviews by fiscal staff, only 11 orders from March 30, 2001 remained open for a variety of legitimate reasons. The implementation action is acceptable, and we consider the issue resolved. (The monetary benefit associated with this recommendation is shown in Appendix B, page 24.)

Background Investigations of Clinicians – Results of Background Investigations Should Be Monitored for Timeliness

Condition Needing Improvement. HRM Service staff needed to develop a procedure to follow up with OPM when clinicians' background investigation results were not returned within 2

months of their submission to OPM. Newly appointed clinicians are subject to background investigations conducted by OPM. In order for the investigations to be completed, employees are fingerprinted by HRM staff and the fingerprints are forwarded to OPM. HRM staff are required to request the investigation within 14 workdays of each employee's appointment and to follow up if results are not received within 2 months.

We reviewed a judgment sample of 20 official personnel files of clinicians hired during the previous 3 years. Our sample included 12 registered nurses, 3 nurse practitioners, and 5 physicians. Five of the 20 employees' background investigation results had not been received from OPM within 2 months, and HRM Service staff had not followed up with OPM as required. The HRM Officer acknowledged that HRM staff did not routinely monitor the return of background investigation results from OPM.

We are not making a formal recommendation because, while we were onsite, HRM staff contacted OPM and received electronic confirmation that none of the five delinquent background investigations revealed information that would bar the subjects from VA employment.

Suggested Improvement Action. We suggested that the VAMC Director ensure that HRM Service staff routinely follow up with OPM when results of clinicians' background checks are not received within 2 months of submission to OPM. The VAMC Director responded positively to the suggestion.

Appendix A

Medical Center Director Comments

Following is the complete text of the VAMC Director's verbatim comments to the 12 recommended improvement actions and 1 suggestion contained in this report. These comments were received in three separate e-mails from the Director and were assembled into the following document that contains the Director's latest comments to each recommendation.

Recommended Improvement Action 1. The VAMC Director should ensure that:

a. Pharmacy Service's policy on overtime be revised to include all necessary issues.

VAMC Director Comment: Concur. The Pharmacy section is adhering to the provisions of overtime allocation that [are] consistent with the Master Agreement between the VA and AFGE. The medical center will continue to monitor overtime usage and will institute the use of an overtime roster to assure fair and equitable allocation of overtime in the service.

b. Within the needs of medical care, Pharmacy Service allots overtime and compensatory time equitably among its employees.

VAMC Director Comment: Concur. The Pharmacy Section uses a process for allocation of overtime that was mutually agreed to by both Pharmacy management and the AFGE Local representatives. The process adheres to Section 4, general overtime provisions of the 1997 Master Agreement between the Department of Veterans Affairs and the AFGE. In order to assure that the provision of overtime is equitable among the Pharmacy section employees, a roster system will be instituted which will track the dates of last overtime worked and will assure that all employees have a fair and equal opportunity to work overtime when the need arises.

c. The excessive overtime and compensatory time used in Pharmacy Service is analyzed and necessary staffing adjustments are made.

VAMC Director Comment: Concur. Workload data and schedule patterns are being examined to determine what [actions] or staffing adjustments may be available. This is being done with staff involvement and union cooperation.

From May 2000 until the last week of December 2000 pharmacy was unable to hire staff for eight vacant positions. These eight positions total approximately $518,000 which is more than the $485,000 identified as the amount of overtime/comp time monies in the report. In late December, two pharmacists were hired and from February to May 2001 three technicians were added. In May 2001 a pharmacist was hired to replace a retiring outpatient pharmacist. Outpatient prescription volume is 6.2 percent over budget YTD

FY 01 and 9.5 percent above the number filled last fiscal year. Through recent monitoring efforts overtime expense for the last four pay periods was reduced 33 percent vs. the overtime expense for the first nine pay periods of this fiscal year. Starting July 1, 2001 the outpatient department hours of operation were reduced 2 hours per day to reduce overtime demand and improve supervision capability.

Southeastern Michigan continues to experience a shortage of hospital pharmacist and qualified technicians. Nationally hospitals have 20 percent of their pharmacist positions vacant. Even with special rates approximately 8 percent above the locality pay scale for Federal positions in the Detroit area and the use of recruitment bonuses, the Detroit VAMC salary structure still lags [behind] competitive salaries in area hospitals [and] chain pharmacies.

Recommended Improvement Action 2. The VAMC Director should ensure that a VA nurse visits all CNH patients at least once every 60 days.

VAMC Director Comment: Concur. The conditions as reported are accurate and the medical center has instituted a performance monitor to assure that all VA patients in community nursing homes are visited at least once every 60 days. The results of the monitor will be reported to the Chief, Nursing Section, Chief, Social Work Section, Associate Director Patient Care Services, and the Chairperson, HLC [Healthcare Leadership Committee] for Performance Improvement.

Recommended Improvement Action 3. The VAMC Director should ensure that Medical Service timekeeping practices comply with VHA policy.

VAMC Director Comment: Concur. Shortly after completion of the IG Review, the Chief, Human Resources Management Section, met with the Chief, Surgical Service, the Chief, Medical Service, and the Administrative Officer for Medical Service. The procedures used by Surgical Service to monitor the attendance of part-time physicians were reviewed and the timekeeping procedures required for proper documentation of timecards were also reviewed. The Chief, Medical Service had already developed an interim sign-in procedure for part-time staff that was due to be implemented the next day. This procedure has been in place since that time and with only minor deviations common to most new procedures, all part-time physicians have been in full compliance. Additionally, Medical Center Numbered Memorandum #001R-624, dated June 26, 2001 (copy attached) was developed to set criteria for establishing adjustable work hours for part-time physicians medical center-wide. Paragraph 4e requires that: "A written attendance record of the arrival and departure times will be kept for each part-time physician utilizing adjustable work hours. These physicians must sign in at the time of arrival and sign out at the time of departure." Supervisors are then required by

paragraph 4f to "review all entries for the prior workday not later than the beginning of business on the following workday and, if correct, certify the entries for that particular day."

Recommended Improvement Action 4. The VAMC Director should ensure that access to primary care is available within 7 days as required.

VAMC Director Comment: Concur. Patients that need to be seen by their primary care provider are scheduled based on their clinical need. Patients that need (and want) to be seen sooner than available have several options:

- Calling telephone triage – In many instances, this may address concerns patients have without seeing the provider. Access is available 24 hours a day, 7 days a week. Clinical issues can be addressed by a registered nurse following approved protocols, appointments and medications can be clarified, and connections to a pharmacist can be arranged. If a patient still needs (and wants) to see their primary care provider, this can be arranged.
- Shadow clinics – These clinics were established many years ago to allow all providers to see patients with more urgent needs. Appointments in these clinics may only be made with the approval of the nurse coordinator of the firm [the term for a team of providers] or the provider. There is at least one shadow clinic for each provider each week.
- Overbooks – Many providers approve overbooks for patients that need to be seen before an appointment is available. Nurse coordinators have the ability to overbook into a clinic if necessary.

We have educated our patients about these options, and will continue to do so. Our providers are committed to providing timely and quality care to our patients. In all cases, if it is determined that a patient has a clinical need, they will be seen by a provider in as short a time as possible.

Recommended Improvement Action 5. The VAMC Director should ensure that medical record privacy is maintained by:

a. Transporting medical records in locked containers.

VAMC Director Comment: Concur. Business Practice Service will undertake a full review of the methods used to transport medical records to determine how best to insure privacy of medical record information. This review will include all regulations pertaining to medical record protection and privacy and a determination of availability of locking containers for transport of the records.

b. Allowing medical records to be transported only by persons who are trained to maintain privacy and security of the records.

VAMC Director Comment: Concur. Business Practice Service, as part of the review of methods to insure medical record privacy, will determine who is now transporting records to determine if these personnel are appropriate transporters of medical records and to determine that appropriate persons are properly trained. The medical center has hired a full-time Information Security Officer (ISO) who reports directly to the Chief, Business Practice Service. The ISO will be developing a new information security-training program that will be mandatory for all employees.

c. Training staff to protect sensitive information that may be displayed on computer screens.

VAMC Director Comment: Concur. The need to protect computer-based information will be included in the newly developed information security program provided by the medical center ISO.

Recommended Improvement Action 6. The VAMC Director should ensure that security clearances are obtained for all employees with high-level VISTA access.

VAMC Director Comment: Concur. The Human Resources Management (HRM) section is in the process of reviewing VA Handbook 0710, Personnel and National Information Security, dated October 30, 2000 to determine which positions within the medical center are in need of security clearances, the level of clearance needed, and the level of background investigation required. In addition, HRM will also review the Official Personnel Folder (OPF) of all personnel in positions determined to need security clearances to determine if they are in need of reinvestigation. Reinvestigations are required every five years as outlined in paragraph 3.c of VA Handbook 0710.

The medical center has recently hired a full-time Information Security Officer (ISO) who will consult with HRM to implement the steps outlined above. To assure that newly hired personnel who require a security clearance and personnel on duty who require reinvestigation have these completed in a timely manner, HRM and the ISO will collaborate on the development of medical center policy to assure that clearances are obtained.

Recommended Improvement Action 7. The VAMC Director should ensure adequate security of the nurses' station by installing a higher counter, replacing the half doors with full doors, and placing locks on the doors.

VAMC Director Comment: Concur. Facility Management Service, in conjunction with the VAMC Police, the VAMC Safety Office, and the B2 North Clinical Nurse Manager and the interdisciplinary treatment team will undertake a complete risk analysis of this area to determine what changes are appropriate and needed. At the completion of the risk analysis, all approved engineering changes will be accomplished. Since the completion of the IG CAP in May 2001, the planned installation of additional video monitoring equipment has been completed.

Recommended Improvement Action 8. The VAMC Director should ensure that:

a. GIP is used to accurately track usage of stock.

VAMC Director Comment: Concur. We are actively expanding the use of GIP to manage department level inventories in this medical center. VHA Handbook 1761.2, "Inventory Management" requires that GIP be implemented within 12 months of its publication date of October 26, 2000. As of this date, GIP has been implemented in most clinical areas including SPD, wards [and] clinics, surgery, dialysis, respiratory and dental. This accounts for a significant portion of our expenditures for medical/surgical supplies. Other areas, including administrative departments such as Environmental Management, will be brought up on GIP in the near future.

b. Actual inventory levels in SPD are reflected in GIP inventory documents.

VAMC Director Comment: Concur. Since the implementation of GIP in SPD, we have experienced problems with our bar code scanning system. This problem was essentially the inability of the bar code system to communicate through the VISTA hardware. Because of this, issues of stock were not accurately recorded in GIP and therefore, it appeared that stock was not being used. This resulted in inaccurate inventory levels and artificially high days-on-hand reports. With the assistance of IRMS [Information Resources Management Service], this problem has been resolved, and the stock records are being corrected. Inventory levels and days-on-hand reports will reflect accurate data as of the September 2001 reports.

c. SPU staff maintains accurate inventories of nonexpendable items.

VAMC Director Comment: Concur. Although nonexpendable items issued by SPU are inventoried annually using the CMR [Consolidated Memorandum of Receipt], there is no day-to-day tracking of these items in SPU by the staff in that department. The VAMC is exploring the use of an automated system that will track location and quantities of equipment issued by SPU.

d. Surgical case carts contain all items needed for surgery.

VAMC Director Comment: Concur. The surgical case carts are assembled using a pick-list that is generated through the GIP system. The GIP system is prompted to generate this pick-list based on a prompt from the Surgical OR [operating room] computer package. This prompt is initiated when a surgical case is scheduled. We have encountered some problems with the linkage between these two systems, and the correct case cart is not always called for by the system due to incorrect CPT [current procedural terminology] codes. Although the staff has developed some manual methods to work around this problem, there are situations when the wrong case cart is delivered. We are enlisting the help of IRMS to resolve this problem.

In addition, a new SPD supervisor has been hired and is now on duty. The individual selected for the SPD supervisor position was formerly the OR clinical nurse manager and assumed her duties subsequent to the May CAP review. She is very aware of the problem described above and has made solving this problem one of her top priorities.

Recommended Improvement Action 9. The VAMC Director should ensure that outdated and unusable controlled substances are disposed of quarterly and are included in monthly inspections while awaiting disposal.

VAMC Director Comment: Concur. The Pharmacy Section has modified the computer based controlled substance inventory to include all controlled substances being held pending destruction. The controlled substances are physically held in the inpatient controlled substance vault and when the controlled substance inspection is conducted, these drugs being held in effect become another "location" within the medical center to be reviewed. The destruction of controlled substances has been modified to insure that quarterly destruction occurs. Upon recommendation of VACO [VA Central Office], the medical center is using a pharmaceutical returns management program, Guaranteed Returns, Setauket, New York. All pharmaceuticals to be destroyed are returned to Guaranteed Returns, which receives the inventory and prepares proper notification to the DEA [Drug Enforcement Administration]. This system is also indorsed by the DEA as the preferred method for disposal of outdated and unusable drugs.

Recommended Improvement Action 10. The VAMC Director should ensure that:

a. Informed consents for surgical procedures are documented in medical records.

VAMC Director Comment: Concur. The documentation of informed consent has been and continues to be a high priority monitor for all clinical services beginning in FY 1999. On a monthly basis there are eight monitors that are reported on to the HLC on

Organization Improvement. Although continuous monitoring does not yet show 100 percent compliance; surgical service has shown significant improvement since informed consent became a priority monitor. Compliance for surgical service was at 71.4 percent for FY 1999, in FY 2000 compliance improved to 79 percent, and during FY 2001 to date compliance is at 88 percent. Informed consent will continue to be monitored and will continue to be emphasized with surgical staff at their monthly staff meetings and with surgical residents as they rotate through this medical center for training. In addition, surgical service and IRM has discussed the possibility of locating document scanners in key areas of the medical center such as ER [emergency room], Pre-Admission Testing, Same Day Surgery, and the OR, so that consent forms, once determined complete, could be scanned into the electronic record. This would preclude missing or lost consent forms. A request for equipment has been submitted.

b. All required elements of informed consent are present and correct on consent forms.

VAMC Director Comment: Concur. Prior to patients proceeding to surgery, the consent form is reviewed in pre-operative holding by the nursing staff. Eight different elements are reviewed, including presence of the consent from, availability of the consent form ½ hour prior to surgery, is it dated, is the time noted, is the consent form witnessed, is it completed but outdated, are all elements of the consent form completed, and was substitute consent secured if appropriate. As indicated above, compliance has been improving so that to date for FY 2001, compliance is at 88 percent.

c. All required signatures are either legible or annotated by witnesses.

VAMC Director Comment: Concur. The signature of the physician is required on both page 1 and page 2 of the consent form. In addition, the patient's name is required on both pages as well. It is difficult to require a legible signature, as these are individual and idiosyncratic to the writer. However, we require by policy that the printed name is legible and this is usually sufficient to facilitate understanding of the signature. The need for legibility will be stressed in meetings with providers as we continue to monitor informed consent.

Recommended Improvement Action 11. The VAMC Director should ensure that Fiscal Service staff collect Federal accounts receivable through OPAC**.**

VAMC Director Comment: Concur. Fiscal (MCCR Unit) is reviewing open receivables to determine if they are valid. This process will be completed by September 30, 2001. Included in the monthly reconciliation process, all Federal receivables will be reviewed to ensure proper application and follow-up of payments in a timely manner. When appropriate the OPAC process will be utilized.

Recommended Improvement Action 12. The VAMC Director should ensure that delinquent unliquidated obligations are deobligated when appropriate.

VAMC Director Comment: Concur. Fiscal Section is aware that obligations over 90 days are considered delinquent; however, it is not always possible to close out obligations within the established time period. On a monthly basis, Fiscal Section reviews all open obligations to determine which need to remain open and which can be closed. If all items or billings have not been received from the vendor it would not be appropriate to close out the obligation and reuse these dollars. To do so could potentially cause the medical center to overspend and become deficient.

The majority of unliquidated obligations that were open as of March 31, 2001 have been decreased prior to August 7, 2001. Since August 7, 2001, 13 additional orders were decreased as of August 20, 2001. There are now 11 orders from the March report that need to remain open for the following reasons:

Three permanent change of station orders
Construction order on replacement hospital
Three NRM orders that are not yet completed
Two orders that have not been completely received
One order for convenience check charges that need to remain open through FY 01
One transit program order which needs to remain open through FY 01

In regard to accrued services, many are established as annual contracts and the fee contract hospital, medical and dental invoices are often not submitted to fiscal for payment after 90 days have elapsed from the time of the obligation. However, on a monthly basis Fiscal Section reviews all open obligations to determine the appropriate action to be taken.

Of the 552 delinquent accrued services payable obligations reviewed using the March 31, 2001 report, 331 have been closed out from April through August 2001. The remaining 221 obligations have been left open for the following reasons:

Construction contracts	General Post Funds
Millennium Bill	Cancelled checks by Austin
Austin Franchise Fund	Fee Basis
Coding contract	College Tuition
Equipment purchases	Annual maintenance contracts

In September 2001, any obligations open over 4 months are normally closed out and the funds reallocated. This determination is made by the CFO in conjunction with the accounting staff to maximize the use of the remaining resources. However, in some cases

when it is determined an invoice will be received the obligation will remain open until it is received.

Suggested Improvement Action. We suggest that the VAMC Director ensure that HRM Service staff routinely follow up with OPM when results of clinicians' background checks are not received within 2 months of submission to OPM.

VAMC Director Comment: Prior to completion of the IG Review in May 2001, a tracking system (copy attached) was developed to monitor the progress of security clearances. Fingerprinting and completion of the SF-85, Questionnaire for Non-Sensitive Positions, continues to be completed during the orientation process on the employee's first day of work. The Human Resources Management Section employee assigned responsibility for security clearances enters the data into the tracking system as actions occur and reviews all entries at least weekly. Since the date of the review, 54 employees have entered on duty requiring security clearances. All actions are in compliance with processing timelines with the exception of one clearance that has yet to be returned from OPM. Required follow-up is being completed timely; however, to date the results of this clearance request have not been received. Additionally, to ensure completion of clearances on all employees an audit of the Official Personnel Folders of each medical center employee is in progress.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the John D. Dingell Veterans Affairs Medical Center

Report Number: 01-01252 –37

Recommended Improvement Action	Explanation of Benefits	Better Use of Funds
1	Eliminate unnecessary overtime and compensatory time in Pharmacy Service.	$ 484,739
11	Collect Federal accounts receivable.	88,139
12	Deobligate delinquent unliquidated obligations when appropriate.	1,850,000[3]
	Total	$2,422,878

[3] We know that some unliquidated obligations may continue to be valid and that other obligations committed in prior fiscal years may not be recoverable. Therefore, we conservatively estimate that one-half of the total of $3.7 million in outstanding unliquidated obligations, or about $1.85 million, is recoverable.

Appendix C

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