Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

Report No. 02–01159–145 **August 5, 2002**

VA Office of Inspector General
Washington, DC 20420

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 purposes 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 VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training 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 March 11–15, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the William S. Middleton Memorial Veterans Hospital Madison, WI [referred to as VA Medical Center (VAMC) Madison in this report]. 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 125 VAMC employees.

Results of Review

VAMC Madison patient care and QM activities reviewed were generally operating satisfactorily. Management actively supported quality patient care and performance improvement. The QM program was comprehensive and 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, management needed to:

- Improve physician timekeeping, attendance, and productivity in Surgical Service.
- Strengthen information technology (IT) security.
- Establish controls for medical supply inventories.
- Improve security in research space.
- Ensure that informed consent for research involving human subjects is documented.
- Improve controlled substances inspections.
- Strengthen administration of the Homemaker/Home Health Aide (H/HHA) program.
- Ensure compliance with Preventive Medicine and Clinical Practice Guidelines.
- Strengthen controls on the use of Government purchase cards.

In addition, Veterans Integrated Service Network (VISN) 12 contracting staff, who award most VAMC Madison contracts, needed to ensure that clinical services contract prices were reasonable and properly supported.

VAMC Director and VISN 12 Director Comments

The VAMC Director and the VISN 12 Director agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

(original signed by Michael G. Sullivan for:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. VAMC Madison is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics located in Edgerton, Baraboo, and Beaver Dam, WI and Rockford, IL. The VAMC is part of VISN 12 and serves a veteran population of about 250,000 in a primary service area that includes 32 counties in Wisconsin and Illinois.

Programs. VAMC Madison provides medical, surgical, neurological, and psychiatric services. The VAMC has 87 inpatient beds and is a national referral center for heart and lung transplants and a regional referral center for cardiac surgery, neurosurgery, and epilepsy care. Other special programs include cardiac catheterization, magnetic resonance imaging, and axial tomography.

Affiliation and Research. VAMC Madison is affiliated with the University of Wisconsin Medical School and supports 83 medical resident positions. In Fiscal Year (FY) 2002, the VAMC research program had 229 projects and a budget of $2.6 million.

Resources. In FY 2002, VAMC Madison's medical care budget totaled $117 million. The FY 2001 medical care budget was $114 million. FY 2002 staffing through March 2002 was 759 full-time equivalent employees (FTEE), including 57 physician and 178 nursing FTEE.

Workload. In FY 2001, VAMC Madison treated 22,338 unique patients, an 11 percent increase from FY 2000. The FY 2001 average daily census was 66 inpatients, and outpatient workload totaled 202,302 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 health care system operations, focusing on patient care administration, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, and financial and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. 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 toured patient care and reception areas; inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, and financial and administrative records. The review covered the following activities:

Quality Management	Medical Supply Inventories
Decision Support System	Research Space Security
Environment of Care	Informed Consent for Research
Patient and Employee Satisfaction	Pharmacy Operations
Part-Time Physician Time and Attendance	Homemaker/Home Health Aide Program
Clinical Services Contracts	Clinical Performance Measures
Information Technology Security	Government Purchase Card Program

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

During the review, we presented two fraud and integrity awareness briefings for VAMC employees. About 125 employees attended these briefings, which 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 covered VAMC Madison operations for FYs 2000, 2001, and 2002 through February 28, 2002, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvements. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VAMC and VISN management until corrective actions are completed.

Results of Review

Organizational Strengths

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

The QM Program Was Comprehensive and Provided Effective Oversight. The VAMC had an effective QM program to monitor quality of care using national and local performance measures, patient safety management, and utilization reviews. Comprehensive QM monitors were in place to improve patient care. QM findings were properly analyzed to detect trends, and actions were taken to address individual issues. QM investigations and focused reviews were conducted properly, and corrective actions were implemented.

The Decision Support System (DSS) Was Fully Implemented and Utilized. VAMC staff had fully implemented DSS and routinely completed all required reports to Veterans Health Administration (VHA) DSS program officials on a timely basis. In addition, VAMC management utilized DSS reports in administering facility programs.

Management Maintained an Environment Conducive to Quality Care. Patient rooms, congregate bathrooms, hallways, nurses' stations, and public areas were clean and orderly. Chemical cleaning supplies were stored in appropriately locked storage areas located off the patient units. Environmental Management Service staff responded quickly to requests for cleaning assistance.

Patients and Employees Expressed Satisfaction with the Quality of Care. We interviewed 15 inpatients and 15 outpatients to obtain their opinions about timeliness of services and quality of care. Thirteen of the outpatients (87 percent) reported that they were seen within 30 minutes of scheduled appointments. Fourteen of the inpatients (93 percent) and 13 of the outpatients (87 percent) responded that they would recommend the VAMC's medical care to eligible family members or friends. Twenty-nine of the 30 patients interviewed (97 percent) rated the overall quality of care provided to them as good, very good, or excellent.

We distributed 247 employee satisfaction surveys to clinical employees, and 220 responded. All 220 respondents agreed with the statement "Quality patient care is the first priority at this medical center." Eighty-three percent stated that they would recommend the VAMC's medical care to eligible family members or friends. Ninety-seven percent rated the overall quality of care provided to patients as good, very good, or excellent.

Opportunities for Improvement

Part-Time Physician Time and Attendance – Surgical Service Timekeeping and Productivity Needed Improvement

Conditions Needing Improvement. Some part-time surgeons were not present at the VAMC during their scheduled tours of duty, timekeeping practices in Surgical Service did not comply with VA policy, and surgeon appointment levels were not in line with surgery workloads. We reviewed timekeeping practices for Medical Service, Radiology Service, and Surgical Service. Timekeeping practices in Medical Service and Radiology Service complied with policy. We checked for and located five physicians from those two services at the VAMC treating patients during their established tours of duty. However, physician attendance, timekeeping, and productivity in Surgical Service needed attention.

Surgeon Attendance and Timekeeping. We checked for five surgeons and found that only one was present at the VAMC during his scheduled tour of duty. We located the other four surgeons at the affiliated hospital. One reason these physician absences occurred was that Surgical Service policy allowed surgeons to be available by phone as a substitute for actual presence during their scheduled tours of duty.

Surgical Service timekeepers certified timecards by using physician schedules instead of by independently verifying attendance. As a result, if surgeons were scheduled to be on duty, they were paid even if they were not present at the VAMC. A significant contributing factor for these problems was a lack of training for timekeepers. The VAMC had not conducted annual training for timekeepers in more than 2 years.

Surgeon Workload. We reviewed surgeon workload for the month of February 2002. During this month, Surgical Service had staffing of 29 surgeons totaling 11.5 FTEE in 12 specialties such as neurosurgery and urology. (Annual surgeon salaries totaled $1.1 million.) The 11.5 FTEE surgeons had 1,472 hours available during February after adjusting for a holiday and for annual and sick leave. Operating room (OR) workload was 281 hours, or 19 percent of the total time available. Some surgeons spent less than 19 percent of their available time in surgery. For example, a .625 FTEE surgeon spent only 6 (8 percent) of 80 available hours in surgery, and another .625 FTEE surgeon spent only 12 (15 percent) of 80 available hours in surgery.

We also reviewed outpatient workload. Although we could not reliably determine if surgeons were always present for clinics, we counted all scheduled clinic time as productive time because surgeons are responsible for supervising care provided in these clinics. For all surgeons, scheduled clinic time was 376 hours, or 26 percent of the total time available.

A total of 657 hours, or 45 percent of the total time available, was used for OR and clinic activities. We allowed 20 percent of surgeons' time for additional VA duties such as rounds and administrative tasks, thus accounting for 65 percent of the total and leaving 35 percent of surgeon time unaccounted for. (Twenty percent x 1,472 hours available = 294.4 hours + 657 hours for OR and clinical activities = 951.4 hours divided by 1,472 total hours = 65 percent.)

Given the documented level of attendance and the number of potentially unproductive hours available, VAMC management should carefully assess the need for current surgeon staffing levels and adjust surgeon appointment levels to reflect workloads.

Recommended Improvement Action 1. We recommended that the VAMC Director ensure that: (a) physicians are present at the VAMC during their tours of duty, (b) Surgical Service timekeepers verify physician attendance, (c) all VAMC timekeepers receive required training, and (d) part-time surgeon appointment levels are adjusted as necessary to be consistent with workloads. The Director agreed and reported that the VAMC would ensure compliance with timekeeping requirements, timekeepers would be instructed to validate surgeon attendance and would receive refresher training on timekeeping procedures, and surgeon staff levels would be evaluated. The Director indicated that our review did not account for research and education activities. However, we allowed 20 percent of the available work hours for non-clinical activities, which would include research and education. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Clinical Services Contracts – Contract Prices Needed To Be Properly Supported

Conditions Needing Improvement. VISN 12 contracting staff needed to improve the contract award process by obtaining cost or pricing (C/P) data to ensure that proposed prices are reasonable and by preparing price negotiation memorandums (PNMs) that adequately document contract negotiations.

VISN 12 has regionalized contracting activities in the Great Lakes Acquisition Center (GLAC) located in Milwaukee, WI, about 80 miles from the VAMC. The GLAC is responsible for negotiating all contracts for the VAMC, including contracts for clinical services.

To determine if clinical services contracts were properly awarded, we reviewed five noncompetitive contracts with the affiliated university (total annual contract costs = $1.1 million). Four of the contracts were procedure-based (pulmonary services, cardiology consultations, surgical pathology services, and specialty radiology services), and one was FTEE-based (anesthesiology services). VAMC Contracting Officer Technical Representatives had adequately monitored all five contracts to ensure that the VAMC received the services paid for. However, GLAC management needed to address the following contracting deficiencies:

Support for Prices Not Properly Documented. None of the prices for the five contracts were supported by C/P data. The contract files for procedure-based contracts should normally contain data showing that procedure prices are at or below Medicare rates. If the affiliated university proposes prices higher than Medicare rates, then VA contracting staff should obtain from the university C/P data supporting the proposed prices and should make an informed decision on the reasonableness of prices. For FTEE-based contracts, VA contracting staff should obtain information, such as salary and benefits data, showing the costs the university would incur to provide the services. According to GLAC staff, they did not obtain C/P data because they wanted to expedite the contracting process. During the CAP review, we obtained enough C/P

data to conclude that prices on four of the five contracts appeared to be reasonable. However, to comply with VA policy the GLAC should obtain complete cost data for these four contracts.

Specialty Radiology Services Contract Prices Too High. The prices for specialty radiology procedures were 210 percent of Medicare rates (annual cost = $733,000). GLAC contracting staff had accepted these prices without requesting cost data from the affiliated university. University officials told us that they did not have C/P data to support the contract prices, and they also acknowledged that the university hospital provided specialty radiology services at Medicare rates for some non-VA patients. Given this, the GLAC should immediately renegotiate the contract at prices that are in line with Medicare rates. This could reduce contract costs by about $348,000 a year.

Price Negotiation Memorandums Not Complete. The purpose of the PNM is to provide documentation for critical elements of the contract negotiation process. GLAC staff prepared PNMs for the five contracts reviewed, but these PNMs only stated acceptance of the proposed contract prices and did not provide any documentation of a contract negotiation process.

Recommended Improvement Action 2. We recommended that the VISN 12 Director ensure that GLAC staff: (a) use C/P data or other pertinent information to support prices on all existing and future noncompetitive contracts, (b) adjust prices on existing contracts as necessary based on C/P data, (c) pursue recovery of any overcharges that have occurred as a result of not basing prices on C/P data, (d) renegotiate the specialty radiology services contract at prices that are in line with Medicare rates, and (e) prepare PNMs that adequately document contract negotiations.

The VISN 12 Director agreed and reported that cost data would be obtained to support contract prices and that contracting staff would receive training on procedures such as determining price reasonableness and preparing PNMs. On the issue of the specialty radiology services contract, the VISN 12 Director reported that the contract would not be renewed when it expires in June 2002 and that VAMC Madison would hire an interventional radiologist. This should significantly reduce specialty radiology costs. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Information Technology Security – Emergency Equipment Needed To Be Upgraded and Internal Controls Strengthened

Conditions Needing Improvement. The IT security program did not fully comply with VHA policy. The VAMC needed to correct the following deficiencies:

- Emergency power provisions for IT were not adequate. VHA policy requires that main IT data storage areas be equipped with an emergency electrical power supply in case of a power failure. The emergency power supply should be an uninterrupted power supply (UPS) that would be effective both immediately and indefinitely. The VAMC's three mainframe computers were only protected with an auxiliary storage battery power supply that was designed to last 10 to 15 minutes. After that time had passed, Information Resource

Management Service (IRMS) staff would need to take action to avoid irretrievable data loss. VAMC management stated that they hoped to install a UPS within a year.

- Contingency plans and back-up storage disks were not stored off-site.

- Access to the main VAMC data storage facility was not logged. As a result, IT staff did not have the ability to retrospectively determine who had access to data at a given time.

- IT staff did not perform a risk assessment in 2001. According to the facility IT contingency plan, a risk assessment should be performed annually.

- The contingency plan did not comply with VHA policy. For example, the plan did not detail actions to be taken by individual VAMC services in an emergency and did not list the steps for recovering from a disaster. The Information Security Officer (ISO) had drafted acceptable contingency plans, but these had not been approved or implemented.

In addition to the deficiencies described above, the Assistant Information Security Officer (AISO) was not sufficiently trained to assume the duties of the ISO. The ISO was absent during our review. The AISO should have been able to perform the duties of the ISO. However, we concluded that the AISO did not have sufficient training or information to be able to act in the ISO's place. For instance, the AISO was not able to provide us the VAMC contingency plan and did not have access to VAMC IT security reports and monitors.

Recommended Improvement Action 3. We recommended that the VAMC Director ensure that: (a) a UPS emergency system is installed, (b) contingency plans and backup storage disks are stored off-site, (c) a system to monitor and record access to the VAMC data storage facility is implemented, (d) IT staff perform a risk assessment to identify current vulnerabilities, (e) draft contingency plans are implemented, and (f) the AISO is trained and technically able to perform the duties of the ISO. The Director agreed and reported that all the IT security deficiencies would be corrected by September 30, 2002. The improvement plans are acceptable, and we will follow up on the implementation of planned actions.

Medical Supply Inventories – Stronger Controls Would Reduce Inventory Costs and Improve Supply Management

Conditions Needing Improvement. Inventories of medical supplies in Supply Processing and Distribution (SPD) and Radiology Service were not adequately managed. This occurred because medical supply inventory reports were inaccurate. As a result, SPD had excess stock, and Radiology Service staff could not account for costly pharmaceuticals.

VHA policy requires that VHA managers maintain only enough supplies to meet current needs so that resources are not tied up in excess inventory. For most types of supplies, including medical supplies, the standard is a 30-day supply. Of 716 medical supply items in SPD, 654 (91 percent) exceeded a 30-day supply. In addition, there had been no documented use of 280 (39

percent) of these 716 items during the 12 months preceding our review. After adjustments for reporting errors, the value of excess SPD inventory was $106,137.

VHA policy also requires that stock on hand be accounted for. The "Days of Stock on Hand" report for Radiology Service listed seven line items for pharmaceutical contrast media used in radiographic imaging. The report showed that 5,196 units with a value of $161,090 should have been on hand. Our physical count found only 216 units with a value of $5,371. Therefore, 4,980 units with a value of $155,894 were not accounted for in inventory records. Based on discussions with Radiology Service staff, we concluded that the inventory discrepancies occurred because staff did not adjust inventories when stock was issued for patient care.

The excess inventory in SPD and the loss of inventory control in Radiology Service occurred because inventory reports were not accurate. To illustrate, we reviewed 10 selected line items included on the "Days of Stock on Hand" report for SPD. The report showed that 2,669 units with a value of $15,414 should have been on hand for these 10 line items. However, our physical count showed that only 433 units with a value of $6,515 were actually on hand.

VAMC procurement staff stated that they did not use the reports for inventory management. Instead, they estimated stock levels and attempted to anticipate demand when ordering supplies. They also stated that they intentionally over-ordered SPD stock to avoid running out of critical items. They were aware of inventory control problems in SPD and Radiology Service and, in fact, had successfully implemented effective inventory management practices in the general warehouse. The practices used in the warehouse should be applied to inventory management in SPD and Radiology Service.

Recommended Improvement Action 4. We recommended that the VAMC Director ensure that: (a) excess SPD stock is reduced and (b) Radiology Service establishes inventory controls and accurate inventory records. The Director agreed and reported that the VAMC had begun reducing SPD inventory and implementing GIP in Radiology Service, with September 30, 2002, as the target date for completing these actions. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Research Space Security – Access Controls Needed To Be Strengthened

Conditions Needing Improvement. VA research laboratories may contain biological, chemical, and radioactive agents that the Centers for Disease Control and Prevention have identified as "critical agents" that could be used as or developed into weapons of mass casualty. Because of this, security enhancements to prohibit unauthorized individuals from accessing research facilities, clinical laboratories, and other high-risk areas have become a national security concern for VHA.

We inspected the VAMC's research space and noted the following security deficiencies:

- An unlocked door opening from a parking lot allowed unrestricted access to research space.

- A Bio-Safety Level (BSL) 2 laboratory was unlocked and unoccupied, allowing access to potentially hazardous materials. (BSL 2 laboratories may contain critical agents.)

- Interior doors in research areas adjacent to public elevators in shared corridors were unlocked or propped open, which allowed unrestricted access to research space.

- Stairwell doors leading to research space were unlocked.

Recommended Improvement Action 5. We recommended that the VAMC Director ensure that: (a) all exterior, interior, and stairwell doors leading to research space are kept locked and (b) an individualized key card system to restrict and monitor access to research areas is installed. The Director agreed and reported that procedures to keep doors locked had been implemented and that the VAMC had received funding to install electronic card-access locks for all main research areas, with the installation to be completed by December 31, 2002. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Informed Consent for Research – Patient Consent Needed To Be Better Documented

Condition Needing Improvement. VAMC staff did not adequately document informed consent for all patients involved in research projects. VHA policy requires that informed consent be documented by a written consent form signed by the subject or the subject's legally authorized representative. The original signed form should be filed in the patient's medical record, and copies should be maintained in the research investigator's files under conditions of confidentiality. Controls needed to be strengthened in the following areas:

- Research staff did not maintain a roster of VA patients enrolled in research projects. Therefore, they could not perform systematic reviews to determine if consents were obtained and documented.

- VAMC policy did not require that consent forms be maintained in medical records. Our review of the medical records of 10 patients involved in research projects found that only 5 records included consent forms. The other five forms were filed in investigator records at the affiliated university.

Suggested Improvement Actions. We suggested that the VAMC Director ensure that: (a) procedures to identify all VA patients involved in research projects are implemented, (b) all original consent forms are filed in patient medical records, and (c) a systematic review process is implemented to ensure that consent forms are maintained as required by VHA policy. The Director agreed to implement the suggested improvement actions.

Pharmacy Operations – Controlled Substances Inspections, Inspector Training, and Narcotics Destructions Needed Improvement

Conditions Needing Improvement. VAMC management needed to ensure that controlled substances inspections were conducted on time; narcotics inspector training was formally conducted and documented; and excess, expired, or unusable controlled substances were destroyed quarterly.

- Monthly unannounced controlled substances inspections were not completed in 1 day, but instead took from 2 to 21 days. All controlled substances storage locations should be inspected on the same day to prevent concealment of shortages by shifting of stock from previously inspected locations to locations not yet inspected.

- The VAMC had no training program for controlled substances inspectors. VAMC staff stated that training was conducted on an informal "on-the-job" basis and was not documented.

- Expired, excess, and unusable controlled substances were destroyed during the first 3 quarters of FY 2001 as required, but were not destroyed during the 4th quarter.

Suggested Improvement Actions. We suggested that the VAMC Director ensure that: (a) monthly unannounced controlled substances inspections are completed in 1 day, (b) training of narcotics inspectors is documented, and (c) expired, excess, and unusable controlled substances are destroyed every quarter. The Director agreed to implement the suggested improvement actions.

Homemaker/Home Health Aide Program – Stronger Clinical and Administrative Oversight Was Needed

Conditions Needing Improvement. There was inadequate clinical and administrative oversight of the H/HHA program. VHA has made long-term care an important element of its effort to provide comprehensive care for VA patients. VHA's policy is to develop an innovative, flexible approach to provide home and community-based care that is fully integrated into the VA healthcare system and that uses resources efficiently and effectively to meet the needs of an aging and chronically ill patient population. As part of this policy, VHA medical facilities are required to implement the H/HHA and several other non-institutionally based programs to provide long-term care.

The H/HHA program allows VA medical facilities to contract with private providers for home health care and other in-home assistance for eligible beneficiaries. VHA facilities are required to coordinate and review the appropriateness of home care referrals, determine the most appropriate in-home services for individual patients, and monitor the appropriateness of costs. In FY 2001, VAMC Madison authorized $169,139 for H/HHA services. At the time of our review, the VAMC used 14 Community Health Agencies (CHAs) to provide H/HHA services for 16 patients. The following areas needed improvement:

- Management Oversight. VAMC management had not established an oversight or steering committee to monitor H/HHA operations.

- Patient Assessments. Only 1 of the 10 H/HHA patient medical records reviewed contained evidence of interdisciplinary assessments.

- Reassessments of Need for Services. Clinicians did not evaluate the need for continuation of H/HHA services every 3 months.

- Verification of Services. The H/HHA program coordinator did not verify that billed visits had actually occurred.

- VAMC Assessments of CHA Clinical Performance. H/HHA staff did not use CHA quality assurance data and quarterly patient assessments to evaluate the quality of care.

- Agreements with CHA. VAMC program managers and VISN 12 contracting staff had not negotiated contracts or executed other formal agreements to ensure that H/HHA rates were appropriate. Instead, each time a patient was referred to the program the coordinator contacted the prospective CHA and informally agreed upon a rate.

- Cost Data for Rates. H/HHA staff had not obtained cost data to support rates paid to CHAs.

These deficiencies occurred because the H/HHA managers were not aware of VHA policy governing the program.

Suggested Improvement Actions. We suggested that the VAMC Director ensure that: (a) an H/HHA oversight function is established, (b) VAMC staff document interdisciplinary assessments, (c) clinicians document the continued need for H/HHA services every 3 months, (d) the coordinator verify that billed services are actually provided, (e) VAMC staff use CHA quality assurance data to assess CHA performance, (f) VAMC and VISN 12 staff negotiate formal agreements to obtain CHA services, and (g) all CHA rates are supported by cost data. The Director agreed to implement the suggested improvement actions.

Quality Management – Better Compliance with Clinical Performance Measures Was Needed

Condition Needing Improvement. VAMC clinical managers needed to ensure compliance with the Preventive Medicine and Clinical Practice Guidelines. VAMC Madison's results for some measures were below FY 2001 VHA national results and lower than VHA goals. Areas in need of improvement are shown in the following table:

Measure	VAMC Madison FY 2001	VHA-Wide Results FY 2001	VHA Goals FY 2002
1. Percent of patients receiving timely colorectal cancer screening during primary care visit(s) by fecal occult blood test, sigmoidoscopy, or colonoscopy within designated time frames.	41	60	65
2. Percent of patients screened for high risk factors for Hepatitis C, such as blood transfusion before 1992, illicit drug use, and tattoos.			
a. Primary care	28	51	60
b. Mental health	29	N/A	60
3. Percent of patients with Diabetes Mellitus who receive a retinal exam from an eye care specialist within designated time frames.	49	66	70
4. Percent of patients using tobacco who have been counseled three times in 12 months to cease tobacco use.			
a. Primary care	48	62	68
b. Mental health	10	N/A	68
5. Average processing days for compensation and pension exams.	48	33	35

Suggested Improvement Action. We suggested that the VAMC Director ensure that clinical staff complies with all elements of the Preventive Medicine and Clinical Practice Guidelines. The Director agreed with the suggested improvement action.

Government Purchase Card Program – Controls Needed To Be Strengthened

Conditions Needing Improvement. VAMC management needed to ensure that the Government Purchase Card program was effectively administered. VHA policy requires the use of purchase cards whenever possible for buying goods and services. Purchase card transactions generally should not exceed $2,500. At the time of our review, VAMC Madison had 78 cardholders and 44 approving officials. From October 2001 through January 2002, VAMC staff authorized 21,790 transactions costing $7.8 million. Management needed to correct the following control deficiencies:

- The Purchase Card Coordinator was a cardholder and an approving official, which is prohibited by VHA policy.

- The Coordinator and Fiscal Service had not performed required quarterly audits.

- Reconciled transactions should be approved within 14 calendar days. VAMC policy allowed 15 workdays.

- VA policy requires that access to automated program data be limited to personnel with a demonstrated need. However, 13 individuals had access to the Purchase Card Coordinator Menu in the Integrated Funds Distribution, Control Point Activity, Accounting Procurement system. To ensure adequate internal control, access should be limited to the Purchase Card Coordinator, the Alternate Purchase Card Coordinator, and the Chief of IRMS.

- Training for cardholders and approving officials should be documented. VAMC staff did not document all aspects of the training of cardholders on 2 of 10 occasions. Training for approving officials was not documented at all on 3 of 10 occasions, and all aspects of their training were not documented on another 4 occasions.

- One cardholder exceeded the single purchase limit of $2,500 on two occasions (one purchase for $2,946 and another for $2,999).

- One cardholder made two purchases after his interim warrant had expired and before a new interim warrant became effective.

Suggested Improvement Actions. We suggested that the VAMC Director ensure that: (a) the Purchase Card Coordinator's cardholder and approving activities are terminated, (b) quarterly audits are performed, (c) VAMC policy on time limits for purchase approvals reflects VA policy, (d) access to the Purchase Card Coordinator Menu is properly restricted, (e) all training for cardholders and approving officials is documented, (f) cardholders comply with single purchase limitations, and (g) interim warrants are properly granted. The Director agreed to implement our suggested improvement actions.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

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Recommendation	Explanation of Benefit	Better Use of Funds
2	Better use of funds by renegotiating the specialty radiology services contract.	$348,000
4	Better use of funds by reducing excess inventory in SPD.	$106,137
	Total	$454,137

Appendix C

VISN 12 Director and VAMC Madison Director Comments

Department of Veterans Affairs

Memorandum

Date: May 24, 2002

From: Network Director, VISN 12 (10N12), Hines, IL

Subj: Response to Draft Report of the Combined Assessment Program Review

To: Assistant Inspector General for Auditing (52), Office of Inspector General, Chicago, IL 60666

1. Attached are our comments to the Combined Assessment Program Review of the William S. Middleton Memorial VA Hospital draft report. The comments indicate concurrence or non-concurrence, and detail corrective action plans and completion dates for each Recommended Improvement Action.

2. Please note the comments for Recommended Improvement Action 2 reflect those of the VISN and the Great Lakes Acquisition Center, as requested. In addition, we have provided our concurrence on each of the Suggested Improvement Actions.

3. We appreciate the professionalism of the OIG in performing this review. If we can provide any additional information, or if you would like to discuss this response, please contact Allen Ackers, Associate Hospital Director, at (608) 280-7092.

/S/
Nathan L. Geraths
Director

/S/
Joan E. Cummings, M.D.
Network Director

Attachment

Appendix C

Hospital and VISN Comments to the Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital

Recommended Improvement Action 1.

Part-Time Physician Time and Attendance – Surgical Service Timekeeping and Productivity Needed Improvement

(a) Concur; we agree there are problems with the methodology used at the Madison VA to track the time and attendance for surgical staff. We have been using fixed tours of duty, which do not have adequate flexibility to match the level of activity of our surgeons. We intend to explore the use of the core time approach as a means of ensuring compliance with time and attendance regulations. This review is expected to be complete, and appropriate corrective actions taken, by December 31, 2002.

We would point out, however, that the methodology used by the OIG to account for surgical staff time did not take into account research time for merit review grants and other non-VA grant activity performed at the VA. Neither did the methodology account for the teaching activities of the surgeon staff, nor their continuing education activities.

(b) Concur; the timekeepers for Surgery will be instructed to validate the attendance of the surgical staff under their timekeeping responsibilities.

(c) Concur; the timekeepers for Surgery will receive refresher training in timekeeping policy and procedures by July 1, 2002. Annual training will be scheduled thereafter.

(d) Concur; we will evaluate the FTE level that is appropriate for the Surgical Service based on the considerations raised in the OIG report and the total value of the services provided. This review will be complete by September 30, 2002, and part-time surgeon appointment levels may be adjusted as necessary to be consistent with workloads.

Recommended Improvement Action 2.

Clinical Service Contracts – Contract Prices Should Be Properly Supported

(a) Concur; prior to exercising option years on all existing contracts, information other than certified cost or pricing data will be obtained to determine price reasonableness. Factors to be considered for cost negotiations may include, but are not limited to: published interagency rates; VA fee-basis rates from nearby VA facilities; existing rates from other federal facilities (including DOD); local rates from third party carriers (Blue Cross/Blue Shield) and cost, or pricing data from the contractor. Negotiations will be conducted to determine the best value to the Government. Determination of price reasonableness will be documented in the PNM.

Contract Number	Services	Contract Start Date	Contract End Date	Last Option Expires
V69DP-2968	Surgical Path	January 22, 2002	January 21, 2003	January 21, 2006
V69DP-3628	Int Radiology	October 1, 2001	September 30, 2002	Sept. 30, 2004
V69DP-3037	Cardiology	May 1, 2002	April 30, 2003	October 31, 2005
V69DP-3033	Pulmonary	April 11, 2002	April 10, 2003	April 10, 2005
V69DP-2500	Anesthesiology	November 1, 2001	October 31, 2002	October 31, 2003

With respect to all future contracts, commercial item solicitations are exempt from certified cost and pricing data [FAR 15.403-1 (10 U.S.C. 2306 & 41 U.S.C. 254b], however, determining price reasonableness is required. Information other than certified cost and pricing data described above would be utilized in negotiations prior to award. Documentation of negotiations and determination of price reasonableness will be reflected in the PNM. The Great Lakes Acquisition Center proposes the following action plan to address the deficiencies:

1. Within the next 60 days, mandatory training for all Contracting Officers will be coordinated with OA&MM Technical Staff. Components of this training will focus on: submission of cost and pricing data, determining price reasonableness and development of adequate PNMs.
2. A checklist will be developed to assist Contracting Officers during the pre-award phase to obtain costing data and adequately determine price reasonableness.
3. Develop language to include in solicitations the requirement for bidders to provide costing data with their proposal.
4. Establish internal quality assurance reviews to monitor documentation of price reasonableness determinations and PNMs.
5. Request field pricing assistance (i.e., DCAA Audit) if the proposed cost meets or exceeds the dollar threshold and adequate costing data cannot be obtained from the bidder.
6. Monitor per procedure invoices quarterly to ensure the VA is paying agreed upon rates.

(b) Concur; existing contracts are firm-fixed priced agreements in which the contractor has the right to recoup the cost for services rendered at the agreed upon price. At the time of option renewal, market research will be conducted in addition to obtaining costing data from the contractor to determine price reasonableness. Negotiations will be conducted to realize the best value for the Government and documented in the PNM. Recovery of any overcharges will be pursued if review of invoices deems overpayments were made.

(c) Concur; as stated above, recovery of any overcharges will be pursued if contractor billed for more than prices that were agreed upon and overpayment was made.

(d) Concur; VA Madison will be hiring an interventional radiologist not later than July 1, 2002; therefore, the option year(s) for contract V69DP-3628 will not be exercised. The base year of this contract expires September 30, 2002. A new solicitation will be issued for On-Call Interventional Services in support of VA staff. All required procedures as stated above will be performed and documented.

(e) Concur; FAR 15.406-3 provides guidance for documentation of a proper price negotiation memorandum. Such a document will become part of all negotiated contract files. As required, the PNM shall include a statement of the extent the Contracting Officer relied on cost and pricing data in negotiating the price.

Recommended Improvement Action 3.

Information Technology Security – Emergency Equipment Should Be Upgraded and Internal Controls Strengthened

(a) Concur; funding has been allocated from the FY 2002 NRM account in the amount of $40,000, with award scheduled in June of 2002. Completion is expected by September 30, 2002.

(b) Concur; we are exploring cooperative agreements with other federal agencies in the Madison area for the storage of contingency plans and back-up storage disks. Completion is expected by September 30, 2002.

(c) Concur; a system of electronically controlling and documenting access to the computer room is currently in place, but is not being fully utilized. The system will be activated by July 1, 2002.

(d) Concur; a complete risk assessment, coordinated by the Information Security Officer, will be completed by July 1, 2002, and annual assessments implemented on that anniversary date.

(e) Concur; contingency plans are already in draft form and being circulated for final approval and implementation. Completion is scheduled for September 30, 2002.

(f) Concur; the Assistant Information Security Officer responsibilities have been reassigned to another individual with a higher level of technical skills. We consider this item complete.

Recommended Improvement Action 4.

Medical Supply Inventories – Improved Inventory Controls Would Result in Reduced Costs and More Effective Management

(a) Concur; we are working toward improved inventory management practices in the SPD area, and are reducing the current level of supplies on hand to below a 30-day supply where practical. Our target date for completing the inventory reductions and implementing improved management oversight is September 30, 2002.

(b) Concur; we are implementing the Generic Inventory Package program in Radiology Service to improve the inventory management procedures in that department. Since contrast media is classified as a pharmaceutical, we are exploring the potential for its management under the Pharmacy Service. Completion of these corrective actions is scheduled for September 30, 2002.

Appendix C

Recommended Improvement Action 5.

Research Space – Security Needed To Be Strengthened

(a) Concur; we have received funding through a grant from headquarters to install electronic card-access locking mechanisms on all main research areas. A contract will be awarded prior to the end of the fiscal year, with completion of the installation scheduled by December 31, 2002. Manual locking procedures for the Level 2 Bio-Safety Lab have been implemented.

(b) Concur; see above.

Suggested Improvement Actions

Informed Consent for Research – Patient Consents Should Be Better Documented: Concur

Pharmacy Operations – Controlled Substances Inspections, Inspector Training, and Narcotics Destructions Needed Improvement: Concur

Homemaker/Home Health Aide Program – Clinical and Administrative Oversight Needed Improvement: Concur

Quality Management – Better Compliance With Clinical Performance Measures Was Needed: Concur

Government Purchase Card Program – Controls Need To Be Strengthened: Concur

Appendix D

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Appendix D

Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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