Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Marion, Illinois

Report No. 03–00760–102 **May 27, 2003**

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 agency 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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Introduction

During the week of February 10–14, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Marion, IL, which is part of Veterans Integrated Service Network (VISN) 15. 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 50 VAMC employees.

Results of Review

VAMC Marion patient care, QM, financial, and administrative controls were generally operating satisfactorily. To improve operations, the VAMC needed to:

- Involve clinicians in reviewing violent patient incidents and developing recommendations for managing violent patients.
- Secure medications, sharp instruments, and hazardous chemicals in patient areas and correct environmental deficiencies in Veterans Canteen Service (VCS) and Dining Service.
- Request appropriate background investigations for staff in high-risk positions.
- At the Evansville Community Based Outpatient Clinic (CBOC), improve accountability for controlled substances and include collections in unannounced audits of agent cashier assets.
- Pursue Medical Care Collections Fund (MCCF) accounts receivable more aggressively and reduce the backlog of unprocessed insurance billings.
- Provide refresher training on Government purchase card reconciliation and certification procedures and perform required audits of purchase card accounts.
- Strengthen controlled substances mail-out procedures and include the Evansville CBOC in the controlled substances inventory required when there is a change in the Chief of Pharmacy position.
- Reduce the backlog of undispensed hearing aids.

VISN 15 Acting Director Comments

The VISN 15 Acting Director agreed with the CAP findings and provided acceptable implementation plans. (See Appendix B, pages 14-22, for the full text of the Acting Director's comments.) We will follow up on the implementation of recommended improvement actions.

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

Introduction

Medical Center Profile

Organization. VAMC Marion is an acute care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at CBOCs in Effingham and Mt. Vernon, IL, Evansville, IN, and Paducah, KY. The VAMC is part of VISN 15 and serves a veteran population of about 129,000 in a primary service area that includes 27 counties in Illinois, 17 counties in Kentucky, and 8 counties in Indiana.

Programs. The VAMC provides acute medical, surgical, and psychiatric inpatient services and has a total of 45 acute care beds. Programs include primary and specialty care, ambulatory surgery, mental health, and women's health. The VAMC also has 60 extended care beds.

Affiliations. The VAMC is affiliated with the Southern Illinois University School of Medicine and supports four residents in internal medicine. The VAMC has 20 other affiliations with various schools and universities in the surrounding area.

Resources. In Fiscal Year (FY) 2003, the VAMC's budget was $72.4 million, a 5 percent increase from the FY 2002 budget of $68.9 million. Staffing through January 2003 was 743 full-time equivalent employees (FTEE), including 40 physician and 254 nursing FTEE. FY 2002 staffing was 730 FTEE, including 39 physician and 248 nursing FTEE.

Workload. In FY 2002, the VAMC treated 36,123 unique patients, a 12 percent increase from FY 2001. The FY 2002 average daily census (ADC) was 36 inpatients and 59 nursing home patients. In FY 2003 through January, the ADC was 31 inpatients and 59 nursing home patients. Outpatient workload totaled 308,785 visits in FY 2002, and the projected FY 2003 outpatient workload was 339,663 visits, a 10 percent increase.

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, 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 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. The review covered VAMC operations for FYs 2001, 2002, and 2003 through January and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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 15 activities:

- Agent Cashier
- Clinical Laboratory Security
- Community Based Outpatient Clinics
- Contracting
- Controlled Substances Accountability
- Enrollment and Resource Utilization
- Environment of Care
- Government Purchase Cards
- Information Technology Security
- Management of Violent Patients
- Medical Care Collections Fund
- Medical Supply Inventory
- Medical Supply Preparation and Decontamination
- Quality Management Program
- Unliquidated Obligations

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–12). For these activities, we make recommendations or suggestions. 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 VISN and VAMC management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and quality of care. We invited VAMC employees to complete an on-line electronic questionnaire, 165 of whom did so. We also interviewed 30 patients during the review. We discussed the questionnaire and interview results with VISN and VAMC management.

During the review, we also presented 4 fraud and integrity awareness briefings that were attended by 50 VAMC employees. The 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.

Results of Review

Organizational Strengths

The Quality Management Program Was Effective. The VAMC had an effective QM program to monitor and improve the quality of care. QM findings were analyzed to detect trends, and actions were taken to address identified issues. Administrative investigations and root-cause analyses were conducted appropriately and corrective actions implemented. VAMC managers demonstrated support for the QM program through participation in QM committees and root-cause analysis teams and by providing necessary resources to accomplish performance improvement initiatives. Employees were knowledgeable about quality improvement initiatives and participated on task forces to improve patient care activities and health care operations.

Clinical Laboratory Security Was Appropriate. The VAMC had a Level 2 Biosafety Laboratory. Biological agents were properly secured. Supervisors and employees were knowledgeable about security controls, and local policies and procedures were in line with Veterans Health Administration (VHA) guidance. Police Service staff made regular security rounds in the laboratory.

Contracts Were Properly Managed. The VISN 15 Business Office provided contracting support for the VAMC. Contracting records showed that solicitation, negotiation, and award processes were satisfactory. Contracts were properly administered, and contracting officer warrants were appropriate.

Waiting Time for Clinic Appointments Had Improved. Procedures for scheduling initial patient appointments were effective. From October 2001 to December 2002, average wait time for initial appointments decreased from 30 to 10 days for primary care clinics and from 51 to 43 days for specialty clinics.

Medical Supply Inventory Controls Were Effective. The Acquisition and Logistics Service had successfully implemented the Generic Inventory Package software program. As a result, the service maintained supply inventories at minimum levels of quantity and dollar value and achieved a very good turnover rate of about 7 days. Stock levels in the primary and secondary medical supply storage areas were adequate, and the areas were clean and well organized.

Unliquidated Obligations Were Properly Monitored. Fiscal Service staff reviewed unliquidated obligations monthly, contacted the appropriate services to determine the continued validity of obligations, and promptly cancelled obligations that were no longer needed.

Opportunities for Improvement

Management of Violent Patients – Evaluation of Violent Patient Incidents Should Be Improved

Conditions Needing Improvement. VAMC management needed to establish procedures for appropriate clinician involvement in reviewing violent patient incidents and making recommendations for managing patients who exhibit threatening or violent behavior. In August 2001, the VHA Task Force on Workplace Violence recommended that all VA medical facilities strengthen procedures for preventing and responding to violent incidents.

Our review of Police Service and other reports on 10 incidents found that all 10 had been appropriately referred to the Safety Committee for review and action. However, committee minutes did not reflect decisions about the future management of patients who had exhibited aggressive behavior, and there was no evidence of clinical involvement in the management of violent or threatening patients. An interdisciplinary group composed of clinical and administrative staff should review incidents and make recommendations for patient management. Recommendations may include changes in medications, use of computerized warning flags about violent patients, police escorts, discharge of patients, and other administrative or clinical actions. In addition, the Safety Committee should analyze incidents of violent patient behavior to identify opportunities to reduce risks associated with violent patient behavior.

Recommended Improvement Action 1. We recommended that the VISN Acting Director ensure that the VAMC Director (a) implements procedures for involving clinicians in violent patient incident reviews and for developing recommendations on managing patients who exhibit threatening or violent behavior and (b) establishes procedures that will help managers and supervisors recognize and take action on trends in violent patient behavior. The VISN Acting Director agreed and reported that clinicians will be included in future reviews involving decisions about removing warning flags from computerized patient records and Safety Committee meetings will document recommended actions for managing violent patients. The Patient Safety Officer will provide input to the Safety Committee on recognizing and taking actions on trends in violent patient behavior. The VISN Acting Director anticipated that both actions would be completed by June 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Environment of Care – Safety and Environmental Deficiencies Should Be Corrected

Conditions Needing Improvement. Service managers needed to ensure that medications, sharp instruments, and hazardous chemicals were secured, that areas in the VCS and Dining Service main kitchen[1] were clean and maintained, and that safety and infection control practices in all

[1] The Dining Service main kitchen prepared patient meals. Kitchen employees also prepared some food items sold in the VCS food service cafeteria.

areas were monitored. The VAMC Director required monthly inspections of the VAMC and CBOCs, had authorized the hiring of three temporary Environment of Care Service employees to assist in the completion of work projects, and was recruiting for a full-time environmental program manager. Despite these efforts, we found several deficiencies that needed to be corrected.

Safety Deficiencies. We found two unsecured medication carts in the intensive care unit and one unsecured medication cart in the nursing home. VHA regulations require that medications be secured to eliminate the possibility of theft, accidental or purposeful ingestion, or tampering. We found injection needles, scissors, and tweezers in unlocked cabinets and in unattended treatment carts in four patient care areas. We found unsecured cleaning products in six patient care areas. VHA policy requires that potentially dangerous items and hazardous products be secured to minimize the potential for injury.

The VCS food service area did not have an eyewash station. The nearest station was in the Dining Service kitchen, one floor above. The Occupational Safety and Health Administration (OSHA) requires eyewash stations to be located in all areas where employees are exposed to chemicals or corrosive materials that may be harmful to the eyes. OSHA also recommends that stations be tested weekly. The eyewash station in Radiology and Imaging Service had not been tested since September 2002.

Sanitation, Maintenance, and Infection Control Deficiencies in VCS and Dining Service. We found examples of poor sanitation and maintenance and infection control deficiencies in the VCS dining room and in the Dining Service kitchen. For example, there were accumulations of dirt and debris on the floors near baseboards and under equipment in both areas. There were stained and peeling ceiling tiles and rusted ceiling grids above cooking surfaces and in storage areas. There were cracked and missing floor, baseboard, wall, and corner ceramic tiles. Poor lighting in a walk-in refrigerator and a walk-in freezer created fall hazards for employees and reduced the ability to assess food conditions.

Infection control deficiencies included outdated patient food in a refrigerator and no sign in a restroom to remind employees to wash hands before returning to work. We provided a complete list of identified deficiencies to VAMC managers, who took immediate action to correct some of the deficiencies.

Recommended Improvement Action 2. We recommended that the VISN Acting Director require that the VAMC Director ensure that: (a) medications, sharp instruments, and hazardous chemicals in patient care areas are secured; (b) an eyewash station is installed in the VCS food service area; (c) eyewash stations are tested weekly; and (d) the VCS and Dining Service areas are consistently monitored, deficiencies documented, and corrective actions implemented. The VISN Acting Director agreed and reported that as of May 13, 2003, supervisors had instructed their staff to keep sharp instruments and hazardous chemicals in locked or supervised areas. Medication carts will be locked when not in use. The VAMC installed an eyewash station in the VCS food area, and the eyewash station in the radiology area will be included in inspections and testing. In addition, the VCS and Dining Service areas are monitored monthly and deficiencies corrected. Some of the deficiencies noted in the report had been corrected, and the remainder

would be corrected by June 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Information Technology Security – Appropriate Background Investigations for Security Clearances Should Be Obtained

Conditions Needing Improvement. Information technology (IT) security controls were adequate in the areas of security awareness training, contingency planning, risk assessment, virus protection, password controls, computer room security, and backup and recovery of essential data. In addition, the VAMC had an adequate overall security plan and appropriate policies for user access, remote access, and Internet access. However, there were two areas where management could enhance IT security.

Security Clearance Background Investigations. VA policy requires appropriate security clearances for specific VAMC positions based on the sensitivity and importance of the information accessed or used by employees in those positions. Security clearances require background investigations, and VA policy requires that the type of investigation match the sensitivity designation assigned to the position. For high-risk positions, a full background investigation covering a 10-year period is required.

We reviewed personnel records for 29 employees whose positions should have been designated high-risk and found that HRM staff had not requested the appropriate background investigation for 27 of the employees. Although HRM staff correctly identified the high risk associated with the positions, they did not request the type of background investigation appropriate to that level of risk. This occurred because HRM staff lacked experience in requesting background investigations. Requesting the appropriate background investigation will help protect the integrity of sensitive VA data.

Position Description Security Clause. Because high-risk positions involve duties that are critical to VA programs, VA policy requires that position descriptions include an information security clause. The clause describes the specific security responsibilities associated with the position. Position descriptions for Information Resources Management (IRM) staff did not contain the required clause, even though the positions were designated as high-risk. During our review, IRM and HRM staff took immediate action to correct these position descriptions.

Recommended Improvement Action 3. We recommended that the VISN Acting Director ensure that the VAMC Director directs HRM staff to (a) obtain the appropriate background investigations for high-risk positions and (b) include the appropriate information security clause in position descriptions for high-risk positions. The VISN Acting Director agreed and reported that Human Resources Management staff had submitted 27 requests for the appropriate background investigation and that by July 2003 Human Resources staff would receive inservice training on security clearance procedures. In addition, as of May 13, 2003, the VAMC had completed action to include security clauses in position descriptions for high-risk positions. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

CBOC Operations – Evansville CBOC Controlled Substances and Agent Cashier Deficiencies Should Be Corrected

Conditions Needing Improvement. Evansville CBOC financial and administrative activities were generally operating satisfactorily. Clinic staff received annual IT security awareness training, and their computer workstations had current anti-virus software installed. Staff consistently obtained means test certifications and health insurance information from patients. The agent cashier cash advance was appropriate, and physical security for the agent cashier office was adequate. Physical security in Pharmacy Service was sufficient for safeguarding employees and controlled substances. However, four aspects of clinic operations needed improvement.

Controlled Substances. Accountability for controlled substances needed to be strengthened. During an OIG-requested controlled substances inspection, we noted that inspectors did not inquire about or inventory controlled substances that were awaiting disposal. Although the drugs were properly secured in a safe in the vault room, there was no inventory record for them. As a result of our review, the pharmacist and the inspectors inventoried the drugs and established an inventory record.

Controlled substances inspectors were not aware that two crash carts contained diazepam, a controlled substance, and did not include the carts in their inspection. There were perpetual inventory records of all drugs the carts contained, but required separate records for the diazepam had not been established. During our review, the pharmacist and inspectors verified the inventory and established a separate controlled substances record.

Agent Cashier Collections. Accounting for undeposited agent casher collections should be improved. When veterans made medical care payments, the agent cashier provided a pre-numbered Field Service Receipt (FSR) for the amount received. During an OIG-requested unannounced audit of agent cashier assets, CBOC auditors properly accounted for the unused FSRs. However, they did not account for used FSRs and the undeposited collections they represented. After the audit, we verified the accuracy of unused FSRs and collections. The CBOC auditors agreed to include used FSRs and undeposited collections in future unannounced audits of agent cashier assets.

Agent Cashier Checking Account Balance. The agent cashier maintained a checking account that was a part of the cash advance, and the VAMC accounting function performed monthly reconciliations of the account balance using bank statements. During the OIG-observed unannounced audit, CBOC auditors properly noted the sequentially numbered unused checks, but they did not perform an independent verification of the account balance. Auditors should obtain a copy of the most recent bank reconciliation and verify the checking account balance.

Suggested Improvement Actions. We suggested that the VISN Acting Director ensure that the VAMC Director implements controls to: (a) maintain an inventory of expired and returned controlled substances awaiting disposal and include them in controlled substances inspections, (b) inventory controlled substances in crash carts, and (c) include collections and verification of the agent cashier's checking account balance in unannounced audits of agent cashier assets. The

VISN Acting Director agreed and reported that an inventory record of drugs awaiting disposal was established and that by May 2003 procedures would be modified to include such drugs in controlled substances inspections. In addition, all controlled substances were removed from crash carts. Beginning in May 2003, agent cashier audits will include agent cashier collections and verification of the cashier's checking account balance. The implementation actions are acceptable, and we consider the issues resolved.

Medical Care Collections Fund – Follow-Up on Insurance Billings Should Be Strengthened and Billing Delays Reduced

Conditions Needing Improvement. The MCCF program was generally operating satisfactorily. VAMC staff verified patient insurance, identified billable episodes of care, and billed the appropriate amounts. For the first quarter of FY 2003, the collection rate on third party bills was 24 percent, and during all of FY 2002, the collection rate was 31 percent. However, MCCF staff needed to pursue third party receivables more aggressively and bill insurers more promptly.

Follow-Up on Outstanding Insurance Billings. As of February 2003, there were 23,250 outstanding insurance receivables (value = about $4.4 million), excluding receivables referred to the VA Regional Counsel. Of these, 11,522 (50 percent, value = about $1.7 million) were more than 90 days old. We reviewed 15 receivables (value = $56,250) that had been outstanding for more than 90 days. Follow-up on most of these was good. MCCF staff sent multiple collection letters and followed up with telephone calls. However, three receivables (value = $16,531) required more aggressive follow-up. For 3 months or more preceding our review, there had been no follow-up. The MCCF manager cited a high volume of work and inadequate staffing as the reason for not aggressively following up on some receivables.

Based on discussions with the MCCF manager and the Chief Financial Officer, we estimated that more aggressive pursuit of receivables could improve the collection rate by about 1.5 percent. This would provide the VAMC with additional revenue of about $24,862 ($1,657,468 in outstanding receivables over 90 days old x 1.5 percent = $24,862).

Billing Delays. During the first quarter of FY 2003, the VAMC had about 4,300 unbilled outpatient cases with a total value of about $1.2 million. Based on a judgment sample of 15 insurance receivables that were over 90 days old, the average time to initiate a bill after an episode of care was 103 days. VAMC data showed that during the first quarter of FY 2003 the average time was 88 days for all insurance billings. For FY 2003, the VHA goal for initial billings was 65 days. The MCCF manager and the Chief Financial Officer acknowledged that there was a backlog of unprocessed bills and ascribed this to a staff vacancy. This vacancy was filled in January 2003, which should help decrease the backlog of billings.

Suggested Improvement Action. We suggested that the VISN Acting Director ensure that the VAMC Director takes action to (a) pursue MCCF receivables more aggressively by following up with insurance companies more frequently and (b) eliminate the backlog of unprocessed insurance bills and bill promptly. The VISN Acting Director agreed and reported that an additional employee has been hired, which will allow closer scrutiny and follow-up of bills and

that, as of April 25, 2003, aged receivables over 90 days were reduced from 50 percent of the total to 31 percent. In addition, by June 2003 the VAMC would develop procedures that will result in timelier bill generation. The implementation actions are acceptable, and we consider the issues resolved.

Government Purchase Cards – Reconciliation, Certification, and Audit Deficiencies Should Be Corrected

Conditions Needing Improvement. Certain purchase card reconciliation, certification, and audit practices needed improvement. The VAMC had 23 purchase cardholders and 17 approving officials. Cardholders generally reconciled purchase card transactions timely, and the Purchase Card Coordinator performed required monthly audits of statistical samples of cardholder accounts. However, cardholders and approving officials did not always ensure that purchased goods and services had been received before reconciling and certifying transactions, and some cardholders needed additional training on reconciliation procedures. The Chief Financial Officer did not review the results of monthly audits, and staff had not been performing required quarterly audits. In addition, approving officials did not always certify transactions timely.

Reconciliation and Certification Practices. VA policy requires that cardholders and approving officials have evidence that ordered goods or services had been received before reconciling or certifying purchase card transactions. According to the Purchase Card Coordinator and one logistics official, VAMC cardholders believed they were required to reconcile transactions as soon as the VA Financial Service Center in Austin, TX transmitted transaction charges, whether or not there was evidence that the goods or services had been received. We reviewed a judgment sample of 10 reconciled and certified transactions and found that there was insufficient documentation to verify the receipt of ordered goods and services in 7 of these transactions.

Some cardholders needed to be trained in reconciliation procedures. One cardholder incorrectly created "dummy" purchase orders whenever she was unable to match a purchase card charge with a purchase order. She then reconciled the charges against the dummy purchase order instead of determining the proper purchase order to reconcile against. A review of training records for the 23 cardholders showed that 20 had not had training since at least December 2001. Refresher training in purchase card use and in reconciliation procedures should be provided to cardholders.

Audits of Cardholder Accounts. VA Financial Service Center staff provide a monthly random sample of purchase card transactions that are to be audited by VAMC staff. VA policy requires that the Chief Financial Officer review the results of these audits to verify their accuracy. This was not done for the audits conducted from October 2002 through January 2003. In addition to the monthly audits, VA policy requires that VAMC staff conduct quarterly audits of all cardholder accounts not already covered by the monthly audits. These quarterly audits had not been done since April 2002.

Approving Official Certifications. VHA policy requires that approving officials certify that purchase card transactions are legal and proper and that the goods or services have been

received. Certifications should be completed within 14 days after reconciliation. From October 1, 2001, to November 30, 2002, there were 13,660 reconciled purchase card transactions, of which 1,026 (7.5 percent) were not approved within the 14-day requirement.

Purchase Card Coordinator Duties. Coordination of the purchase card program was a collateral duty assigned to an accounting technician in the VAMC's Business Office. In addition to accounting technician and purchase card coordinator duties, this employee was also assigned to monitor reconciliations and certifications of purchase card transactions and to perform monthly and quarterly audits of cardholder accounts. We believe that some of the problems described above may have been the result of insufficient staff resources devoted to the purchase card program. For example, the coordinator may have been unable to conduct required quarterly audits of cardholder accounts because she had more duties assigned than she could reasonably perform. VAMC management needs to evaluate whether one employee can effectively perform all of these duties.

Suggested Improvement Actions. We suggested that the VISN Acting Director ensure that the VAMC Director takes action to: (a) provide refresher training on reconciliation and certification procedures to cardholders and approving officials, (b) require that audits of purchase cardholder accounts are performed and reviewed, (c) require that approving official certifications are done timely, and (d) evaluate the responsibilities of the Purchase Card Coordinator position. The VISN Acting Director concurred and reported that additional training for cardholders and approving officials began in April 2003 and will conclude in September 2003.

As of May 13, 2003, quarterly audits were being conducted, and the Chief Financial Officer will review future random sample audits. Reconciliation and certification requirements had been reinforced in training and e-mails to staff, and the Chief Financial Officer had directed the Purchase Card Coordinator to compile a list of unreconciled items for review every week. By September 2003, reconciliation requirements would be included in performance requirements. Lastly, a new position had been approved that will be assigned Purchase Card Coordinator duties. The implementation actions are acceptable, and we consider the issues resolved.

Controlled Substances – Certain Accountability and Security Procedures Should Be Improved

Conditions Needing Improvement. Accountability and security for Pharmacy Service were generally effective, but security of mail-out prescriptions needed improvement, and required controlled substances inventories needed to be conducted. Physical security was adequate, and the number of staff accessing the vault room was within permitted limits. Pharmacy staff maintained a perpetual inventory of controlled substances and conducted required Drug Enforcement Administration biennial inventories. Monthly controlled substances inspections were properly conducted. Pharmacy staff had conducted required quarterly destructions of expired and unusable drugs and had obtained credits for drugs returned to manufacturers.

Controlled Substances Mail-Out Procedures. The VAMC needed to improve the security of mail-out prescriptions. The VAMC used a private package delivery company to deliver

controlled substances to patients. However, pharmacy staff relinquished control of these packaged controlled substances before the delivery company picked them up. Depending on pharmacy workload and the time of day, pharmacy staff delivered packaged controlled substances either to the telephone switchboard or to the emergency room reception area where the packages laid in open and unsecured containers until picked up by the delivery company.

According to VAMC police staff, there had been no reported thefts or losses of controlled substances awaiting pickup. However, there was a risk of loss or theft of controlled substances because they were outside appropriate control for varying lengths of time in areas with uncontrolled employee and public access. The risk would be reduced if pharmacy staff maintained control of these packages until picked up by the delivery company. The company should be instructed to pick up the packages directly at the pharmacy.

Required Controlled Substances Inventory. VA policy requires that when there is a permanent change of the Pharmacy Service Chief a controlled substances inventory be conducted by the person assuming the chief's position. On September 30, 2002, the departing Pharmacy Service Chief and the incoming Acting Chief satisfactorily conducted such an inventory at the parent facility. However, they did not conduct an inventory at the Evansville CBOC pharmacy.

Suggested Improvement Actions. We suggested that the VISN Acting Director ensure that the VAMC Director takes action to (a) have controlled substances picked up at the pharmacy by the delivery company and (b) include the Evansville CBOC in required controlled substances inventories when there is a permanent change in the Pharmacy Service Chief's position. The VISN Acting Director agreed and reported that the delivery company now picks up mail-out controlled substances directly from pharmacy personnel. With the assignment of a new Pharmacy Service Chief, the Evansville CBOC was included in a controlled substance inspection. The implementation actions are acceptable, and we consider the issues resolved.

Audiology Clinic – Hearing Aids Should Be Dispensed More Quickly

Conditions Needing Improvement. The OIG received an anonymous allegation that the Audiology Clinic had a 3-month backlog of hearing aids waiting to be dispensed to patients. The allegation was substantiated. The backlog of undispensed hearing aids needed to be reduced.

Audiology Clinic staff ordered hearing aids from VA's Denver Distribution Center, which shipped them to the VAMC for testing and fitting. However, there was about a 3-month backlog of undispensed hearing aids because the Audiology Clinic clerk had not had time to enter data into VA's Remote Order Entry System database. We believe that a part-time temporary clerk, working at any location in the VAMC, could enter the data, which would help reduce the backlog substantially. VAMC management should use this or another option to reduce the backlog.

Suggested Improvement Actions. We suggest that the VISN Director ensure that the VAMC Director takes action to reduce the backlog of undispensed hearing aids. The VISN Acting Director agreed and reported that the VAMC had taken action to reduce the backlog of

undispensed hearing aids and that, as of May 2003, the backlog had been reduced significantly. In addition, bimonthly reviews are being conducted to prevent future backlogs. The implementation actions are acceptable, and we consider the issues resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
N/A	Pursuing MCCF accounts receivable more aggressively could improve collections by about 1.5 percent.	$24,862
	Total	$24,862

Appendix B

VISN 15 Acting Director Comments

Department of Veterans Affairs

Memorandum

Date: May 13, 2003

From: Acting Director, VA Heartland Network (10N15)

Subj: Response/Action Plan to IG CAP Report (Project No. 2003-0760-R4-053)

To: Assistant Inspector General for Auditing (52)

1. I have carefully reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) review of VA Medical Center in Marion, Illinois. I concur in principle with the findings and have included statements regarding resolution or action plans for each recommendation.

2. The Medical Center Director and appropriate facility program officials have also thoroughly reviewed the report and determined the overall findings and recommended improvement actions appear reasonable. Many corrective actions were immediately resolved or initiated upon identification during the review. Other actions are in process and will be completed in the near term.

3. I appreciate the cooperative efforts undertaken by both OIG and medical center staff to ensure delivery of high quality medical services and benefits to veterans.

PETER L. ALMENOFF, M.D., FCCP

Attachment

Appendix B

1. Management of Violent Patients

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the VAMC Director: A. Implements procedures for involving clinicians in violent patient incident reviews and for developing recommendations on managing patients who exhibit threatening or violent behavior. B. Establishes procedures that will help managers and supervisors recognize and take action on trends in violent patient behavior.	A. Concur: Clinicians were involved in reviewing violent patient incident reviews, but were not involved in removing computerized warning flags from patient records after one year of inactivity. Clinicians will be included in future reviews when removing computerized warning flags from the patient records. Patient Safety Committee meetings will document the recommended actions for managing patients exhibiting threatening or violent behavior. These actions will be formed with the assistance of mental health professionals, Patient Safety Officer and VA Police. B. Concur: Patient Safety Officer will provide quarterly input to the Safety Committee on recognizing and taking actions on trends in violent patient behavior.	A. June 2003 B. June 2003

Appendix B

2. Environment of Care

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director require that the VAMC Director ensure that: A. Medications, sharp instruments, and hazardous chemicals in patient care areas are secured. B. An eyewash station is installed in the VCS food service area. C. Eyewash stations are tested weekly. D. The VCS and Dining Service areas are consistently monitored, deficiencies documented, and corrective actions implemented.	A. Concur: Supervisors have instructed their staff to keep all sharp instruments and hazardous chemicals in locked or supervised areas at all times. These items have been added to the Environment of Care Rounds' monthly checklists. Additionally, medication carts will remain locked when not in use. During medication administration, the cart will be within reach of the nurse administering medications. These procedures have been communicated to nursing staff and will be monitored by the Nurse Manager. B. Concur: Although we could not find an OSHA requirement to install an eyewash in the VCS food service area, due to the types of products used, we agree that an eyewash is a good idea and an eyewash has been installed. C. Concur: Eyewash stations are checked by our Environmental Management Program weekly. Radiology eyewash is included in the testing. A program operating procedure will be issued outlining specifically the inspection and testing requirements. D. Concur: The VCS and Dining Service area is now monitored monthly, deficiencies documented and corrective actions implemented. The monthly reviews are conducted by the VCS Supervisor or designee, Maintenance and Operations Foreman and Environmental Management Program Manager. Medical center policy memorandum will be updated to reflect the enhanced inspection changes. Additionally, weekly inspections are being done by Canteen work leaders or VCS Supervisor. Hand washing signs have been installed in restrooms used by VCS employees. Outdated food was disposed immediately upon discovery during the OIG review. Corrections were also made to the floor, baseboard, wall and corner ceramic tiles. Ceiling tile and grids have been replaced and painted in the storage and kitchen areas. Other suggested improvements are in are in process of completion	A. Complete B. Complete C. June 2003 D. June 2003

Appendix B

3. Information Technology Security

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the VAMC Director directs HRM staff to: A. Obtain the appropriate background investigations for high-risk positions. B. Include the appropriate information security clause in position descriptions for high-risk positions.	A. Concur: During the OIG review Human Resources consulted with the auditor and identified appropriate type of background investigations needed for high risk positions. Twenty-seven positions were submitted for processing. Human Resource staff will be given inservice training on security clearance procedures to ensure correct processing of clearances in the future. B. Concur: Information security clauses for Information Resource Management (IRM) staff were processed as position description updates during the OIG review. Other high risk positions were subsequently updated with security clauses. Human Resources and IRM managers will evaluate all new IRM position descriptions to ensure inclusion of appropriate security clauses.	A. July 2003 B. Complete

Appendix B

4. CBOC Operations

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the VAMC Director implements controls to: A. Maintain an inventory of expired and returned controlled substances awaiting disposal and include them in controlled substances inspections. B. Inventory controlled substances in crash carts. C. Include collections and verification of the agent cashier's checking account balance in unannounced audits of agent cashier assets.	A. Concur: These drugs are properly secured in a safe in the vault room. An inventory record was established at time of review and is being maintained with ongoing inventory of controlled substances awaiting disposal. Internal procedures will be modified for inspections to include a review of controlled substances awaiting disposal. B. Concur: All controlled substances have been removed from crash carts. C. Concur: Although the recommendation is not an identified procedure in VA Handbook 4010, the recommendation is considered appropriate and will be included in future agent cashier audits to perform.	A. May 2003 B. Complete C. May 2003

Appendix B

5. Medical Care Collections Fund

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the VAMC Director takes action to: A. Pursue MCCF receivables more aggressively by following up with insurance companies more frequently. B. Eliminate the backlog of unprocessed insurance bills and bill promptly.	A. Concur: Aggressive follow-up should result in the reduction of outstanding receivables. An additional person has been hired which allows for closer scrutiny and follow-up of all bills. As of April 25, 2003, the aged receivables over 90 days are 31% of all receivables. B. Concur: Medical center staff is investigating the various steps of the bill process to develop a procedure that will result in timelier bill generation.	A. Complete B. June 2003

Appendix B

6. Government Purchase Cards

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the VAMC Director takes action to: A. Provide refresher training on reconciliation and certification procedures to cardholders and approving officials. B. Require that audits of purchase cardholder accounts are performed and reviewed. C. Require that approving official certifications are done timely. D. Evaluate the responsibilities of the Purchase Card Coordinator position.	A. Concur: Additional training for cardholders and approving officials began in April 2003. The warehouse receives most deliveries to the medical center. On May 5, 2003, the warehouse began processing a receiving report on all purchase card orders. Receiving reports will be signed when the goods are delivered. Additional training has been provided concerning the need to ensure that goods or services have been delivered prior to reconciling the order. B. Concur: Some quarterly audits have been conducted, although not all. Quarterly audits are now being done. The Chief Financial Officer designee has reviewed the random sample audits from VA Financial Service Center. Upon review of the Handbook, there is no specific indication that this responsibility can be delegated, therefore, the Chief Financial Officer will review future audits. C. Concur: This requirement for reconciliations and certifications is reinforced in training, e-mail messages and individual phone calls. The Chief Financial Officer has directed the Purchase Card Coordinator to compile a list of unreconciled items for review every week. The Purchase Card Coordinator has also been directed to work with the Human Resources Liaison to ensure that reconciliation responsibilities are included in all appropriate performance requirements. D. Concur: A new position has been approved that will be assigned Purchase Card Coordinator duties as well as internal auditing duties.	A. September 2003 B. Complete C. September 2003 D. December 2003

Appendix B

7. Controlled Substances

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the VAMC Director takes action to: A. Have controlled substances picked up at the pharmacy by the delivery company. B. Include the Evansville CBOC in required controlled substances inventories when there is a permanent change in the Pharmacy Service Chief's position.	A. Concur: Control procedures have been modified. The delivery company now receives the controlled substances directly from Pharmacy personnel. This procedure prevents unnecessary relinquishment of controlled substances and maintains chain of custody. B. Concur: This has been accomplished with the assignment of new Pharmacy Service Chief. VA policy for permanent change of the Pharmacy Service Chief will be strictly adhered to should a new permanent change occur in the future.	A. Complete B. Complete

Appendix B

8. Audiology Clinic

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the VAMC Director takes action to reduce the backlog of undispensed hearing aids.	Concur: VAMC has taken immediate action to reduce the backlog of undispensed hearing aids by utilizing other clerical personnel. Forty-three hearing aids are currently pending certification. In prioritizing clerical workloads, the data is entered in the VA's Remote Order Entry System database in a more timely fashion. Bi-monthly reviews are being conducted to prevent future backlogs.	Complete

Appendix C

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