Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Illiana Health Care System Danville, Illinois

Report No. 03-00987-172 **August 26, 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 Veterans Affairs (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 April 7–11, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Illiana Health Care System (the system). The purpose of the review was to evaluate selected 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 140 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

System managers established an employee-training program for the prevention of violence. Means tests were administered annually to veterans subject to medical care co-payments and employees who administered the means tests also obtained current patient insurance information. Also, system managers implemented several innovative clinic access initiatives that improved entry into primary and specialty care clinics. In addition, system managers initiated comprehensive organizational efforts that enhanced the overall effectiveness of the Customer Service Program. To improve operations, system managers needed to:

- Correct environment of care deficiencies.
- Improve the management of violent patients by having warning flags accessible to all employees.
- Ensure that position sensitivity levels are established and appropriate background investigations (BI) are accomplished for all employees.
- Enhance QM by improving data analysis.
- Improve controlled substances inspection procedures and strengthen accountability.
- Enhance billing procedures and improve physician documentation.
- Review delinquent obligations monthly and cancel unneeded obligations timely.
- Reduce excess medical supply inventory and strengthen inventory management controls.
- Improve laboratory security.
- Revise the system's Information Technology Contingency Plan to include plans for an alternate processing facility.

VISN 11 and System Directors' Comments

The VISN 11 and System Directors agreed with the findings and recommendations and provided acceptable implementation plans (see Appendices A and B, pages 15-23, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(*Originial signed by*:)

RICHARD J. GRIFFIN
Inspector General

Introduction

System Profile

Organization. Based in Danville, Illinois, the system provides primary and secondary care and a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics (CBOC) located in Decatur, Peoria, and Springfield, Illinois, and West Lafayette, Indiana. The system is part of VISN 11 and serves a population of about 30,000 veterans in a primary service area that includes 30 counties in Illinois and 4 counties in Indiana.

Programs. The system provides primary medical, surgical, mental health, and geriatric services. Geriatric services include rehabilitation, dementia care, palliative care, geropsychiatric care, and extended care in a skilled nursing home setting. The system has 174 acute care beds and 241 nursing home beds. The system also has a sharing agreement with the U.S. Department of Health and Human Services and the U.S. Public Health Service to provide physical examinations, immunizations, and dental services to Army reservists.

Affiliations and Research. The system is affiliated with the University of Illinois College of Medicine and supports 24 medical resident positions in 2 training programs. For fiscal year (FY) 2003, the research program has nine active projects and a budget of $33,682.

Resources. In FY 2002, the system's medical care expenditures totaled $101 million. The FY 2003 medical care budget is $107 million, 6 percent more than the FY 2002 budget. FY 2002 staffing was 1,128 full-time equivalent employees (FTEE), including 49 physician and 352 nursing FTEE.

Workload. In FY 2002, the System treated 29,764 unique patients, a 9-percent increase over FY 2001. The inpatient care workload totaled 3,601 discharges, which included discharges from the nursing home. The average daily acute care census was 87, and the average daily census for the nursing home was 195. The outpatient workload was 209,988 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 facility 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

- Accrued services payable
- Acute medical-surgical units
- Clinical laboratory security
- Controlled substances accountability
- Environment of care
- Fee-basis payments
- Geriatrics and extended care
- IT security
- Management of violent patients
- Means test certifications
- Medical Care Collection Fund
- Patient waiting times
- Primary care clinics
- QM
- Service contracts
- Supply inventory management
- Undelivered orders

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of services and the quality of care. We made electronic survey questionnaires available to all system employees, 186 of whom responded. We also interviewed 30 patients during the review. The surveys indicated high levels of employee and patient satisfaction and did not disclose any significant issues. We discussed the survey results with system managers.

During the review, we also presented five fraud and integrity awareness briefings for system employees. About 140 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 system operations for FY 2002 and FY 2003 through March 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make recommendations and suggestions for improvement. 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 system managers until corrective actions are completed.

Results of Review

Organizational Strengths

Employee Training for the Prevention of Violence Was Established. Since 1997, VA has been moving toward an organized approach to preventing workplace violence. A major component for the prevention and management of violent patient behaviors is employee education. In spite of one shortcoming in implementing the Workplace Violence Program, discussed later in this report, managers had established a well-developed employee training program on violence prevention. We reviewed 12 employees' training records which showed that these employees completed the Veterans Health Administration (VHA) mandated Violence Prevention Stand Down training during FY 2002. Based on the national Prevention and Management of Disruptive Behavior Training (PMDB), the system's Violence Prevention Committee (VPC) developed four 2-hour training modules to address the needs of employees according to their level of patient involvement. Twenty-two percent of the system's employees had completed the training since its implementation in mid-February 2003. The VPC's goal is to have 50 percent of the employees trained by the end of FY 2003, and 100 percent trained by March 31, 2004.

Means Test Procedures Were Effective. Means tests are administered to obtain income information from patients in order to establish their eligibility for medical care. Each year, veterans who may be subject to medical co-payments must complete these means tests. VHA facilities are required to retain signed means test forms in the patients' administrative records. We reviewed 30 patients' means test forms and found that each was completed and signed by the patients within the previous 12 months. Employees who administered the means tests also obtained current patient insurance information. During FY 2002, employees identified 14 percent more patients with billable insurance. As of March 2003, the percentage of patients identified with billable insurance was 46 percent compared to the national average of 28 percent. The system increased its FY 2002 collections by 54 percent to $10.5 million. Even so, system managers could further improve billing procedures as discussed later in this report.

Initiatives to Enhance Access to Primary Care Were Effective. The system implemented several innovative clinic access initiatives to improve patient access to primary and specialty care clinics. Some of the initiatives included open scheduling in specialty clinics, adding temporary appointment slots in primary care clinics, and reviewing primary care clinicians' panels monthly in order to discharge patients who no longer sought VA care. Additionally, managers established a clinic to accommodate patients who presented to the system seeking care but who did not have scheduled appointments. These initiatives enabled the system to schedule primary care appointments for service-connected and established patients within 30 days. At the time of our review, employees reported that there were no new enrollees waiting more than 6 months for initial primary care appointments. Also, four of the five specialty clinics included in VHA's performance measures met or exceeded VHA's timeliness goals for FY 2003.

Enhancement of the Customer Service Program Resulted In Improvement. Poor outcomes on the National Customer Service Survey (NCSS), patient complaints, and weaknesses in

customer service identified using the Baldrige customer service criteria supported the system's need for a comprehensive organizational effort to improve customer service.[1] Managers initiated a training program for employees and managers, strengthened the patient advocate program, and initiated regularly scheduled leadership rounds. Since July 2001, the system's efforts resulted in meeting or exceeding the standard for 12 (92 percent) of 13 of the categories in the NCSS. The system also showed improvement in 18 (90 percent) of 20 of the Baldrige criteria, thereby exceeding VISN and national goals.

[1] The Baldrige National Quality Program, administered by the Department of Commerce, is the nationally recognized gold standard for quality. VHA has decided to assess its strengths and weaknesses and focus on opportunities for further organizational improvement using the Baldrige Health Care Criteria for Performance Excellence.

Opportunities for Improvement

Environment of Care – Areas Needed Management Attention

Conditions Needing Improvement. Managers needed to ensure that environment of care (EOC) deficiencies identified in the Nutrition and Food Service (N&FS) were corrected and that environmental issues were appropriately reported to the EOC Board (EOCB). Managers also needed to ensure that eyewash stations were inspected according to Occupational Safety and Health Administration (OSHA) regulations.

We inspected inpatient units, outpatient areas, and geriatrics and extended care wards. Additionally, we inspected the N&FS main kitchen and the Veterans Canteen Service (VCS) retail store, kitchen, and food service cafeteria.

EOC Inspection and Reporting Processes. VHA environmental management regulations require that facilities maintain a state of physical and biological cleanliness and appearance. We observed several sanitation and maintenance deficiencies in the N&FS main kitchen, such as stained or peeling ceiling tiles, stained or rusted ceiling grids, and soiled light covers in food preparation, active cooking, and storage areas. We also noted significant amounts of dust on air ventilation system covers and sprinkler heads in these areas. There was an accumulation of dirt and debris on floors near baseboards and under stationary and rolling equipment. Improvements in N&FS maintenance were also warranted. For example, we observed ceiling penetrations, and cracked or missing ceramic floor tiles created potential tripping hazards. Two N&FS employee restrooms lacked signage reminding employees to wash their hands, thereby compromising an important infection control practice. Additionally, EOCB minutes showed that EOC deficiencies were not appropriately reported to the EOCB, impeding management's ability to effectively track and trend them. This condition prevented managers from being fully cognizant of environmental issues.

Eyewash Stations. We inspected eyewash stations in the VCS and N&FS kitchens. OSHA requires that eyewash stations be located in areas where employees are exposed to chemicals or corrosive materials that are considered harmful to the eyes. OSHA recommends that these stations be tested weekly. Our review of eyewash station inspection logs revealed that the eyewash stations were tested quarterly.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that:

a. Identified sanitation and maintenance deficiencies are corrected.
b. EOC inspection and reporting processes are improved and that deficiencies are tracked by the EOCB until they are resolved.
c. Eyewash stations are inspected per OSHA guidelines.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that sanitation corrections were made. An abatement plan was initiated to correct maintenance

deficiencies, inspection and reporting processes were improved, and eyewash stations were being tested weekly. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Management of Violent Patients – The Computerized Flagging System Needed Improvement

Conditions Needing Improvement. According to the VA Task Force on Workplace Violence, the essential components of an effective violence prevention program include: identification of points of accountability (responsible persons at the VISN and facility levels), employee education, assessment of environmental security and design of the facility and individual patient care units, alignment of current reporting systems to facilitate tracking and trending, and a method of alerting employees of a patient's potential for violence. We found that the system had many of the essential components in place; however, a computerized alert process that warned all employees about potentially violent patients was not available.

OIG report, 6HI-A28-038, Evaluating VHA Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients, March 28, 1996, recommended that VHA develop a computerized flagging system to alert all employees when patients with histories of violence present for treatment. The OIG's Semiannual Report to Congress, October 1, 2002 to March 31, 2003, stated that the recommendation remained unimplemented. We reviewed 10 incidents of patient-perpetrated violence. Alert flags had been placed into the Computerized Patient Record System (CPRS) for each of the 10 patients involved in the incidents. However, alert flags for 7 of the 10 patients had not been placed into the Veterans Health Information Systems and Technology Architecture (VISTA) package. Clinical employees primarily use CPRS, but clerical employees use VISTA exclusively to register and schedule patients for appointments. Because alert flags were not consistently entered into VISTA, clerical employees were not always alerted regarding potentially violent patients.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director develops procedures to place computerized alert flags into VISTA simultaneously with their placement into CPRS.

The VISN 11 and System Directors agreed with the findings and recommendation and reported that computerized alert flags will be placed into VISTA beginning August 1, 2003. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Position Sensitivity Designations and Background Investigations – Procedures Needed Improvement.

Conditions Needing Improvement. Sensitivity level designations[2] for Pathology and Laboratory Medicine Service (PLMS) positions had not been reviewed or updated as required in a July 2002 memo from the Deputy Under Secretary for Health for Operations and Management. BIs were either not completed or not updated for all employees.

VA Handbook 0710 requires that healthcare facilities establish procedures to ensure risk and position levels are assessed and properly designated. We found that managers had not identified clinical laboratory positions where PLMS employees' duties required routine and recurring access to biohazardous materials. Without this identification, current position sensitivity levels could not be reviewed to determine if the appropriate designations existed. We reviewed a sample of employees' Official Personnel Files (OPFs). BIs were either not completed or not updated for all PLMS personnel. We reviewed the OPF of a service manager who was a naturalized United States citizen and found no proof of citizenship. Human Resources Management Service managers obtained the appropriate documents from the employee and provided us with a copy as proof of the employee's citizenship. Additionally, we found no evidence of a proper BI for a senior manager who had been in this position for 3 years. At the time of the initial appointment to VA in 1979, this employee had a position classified as low risk (limited potential for adverse impact involving duties of limited relation to VA's mission). However, the employee's current position was considered high risk, which required a more extensive BI than was initially completed.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director initiates:

a. Procedures to assign appropriate sensitivity designations to all positions in PLMS.
b. Reviews employees' OPFs and requires that appropriate BIs be completed and documented in the OPFs in accordance with VHA guidelines.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that sensitivity designations of PLMS employees will be completed. A review of PLMS employees' OPFs will be accomplished for appropriate security designations and BI documentation, and if not present, will be requested. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

[2] Assigning appropriate sensitivity (risk) designations to positions having national security or public trust responsibilities is mandated in VA Handbook 0710, Personnel and National Information Security. The risk level designation is the description of the degree of potential adverse impact that a position may have on the VA.

Quality Management – Performance Improvement Data Needed Critical Analysis To Identify Trends and Opportunities For Improvement

Conditions Needing Improvement. VHA requires that healthcare facilities establish QM programs that effectively monitor the quality of patient care services and performance improvement activities. Our review of data (e.g., utilization reviews, code blue critiques, surgical case reviews, and patient safety, pharmacy, and patient complaint data), and committee minutes (e.g., Clinical Executive Board, Quality Management Committee, and Patient Safety Committee) showed that managers did not use comparative internal or external data as benchmarks, or analyze data to identify trends. Managers could increase opportunities for improving care and patient care services by using benchmarks and critically analyzing data.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director implements procedures to collect and critically analyze comparative quality review data.

The VISN 11 and System Directors agreed with the findings and recommendation and reported that managers will work with QM employees to identify key data elements for benchmarking, analysis, and identification of opportunities for improvements. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Controlled Substances Accountability – Inspection Procedures and Inventory Management Needed Improvement

Conditions Needing Improvement. VHA policy requires a comprehensive inspection program to account for Schedule II–V controlled substances. System managers needed to establish a stronger program to administer controlled substances to ensure that: unannounced inspection procedures were followed, 72-hour inventories were completed, appropriate stock levels were maintained, refills for controlled substances prescriptions were closely monitored, unusable controlled substances were appropriately destroyed, and controlled substances inspectors (non-Pharmacy Service employees) received formal training for their inspection duties.

Unannounced Inspection Procedures. We reviewed Pharmacy Service records for the 12-month period ending February 2003. We identified the following deficiencies:

- Inspections averaged 4 days and some required as many as 6 days to complete. Inspections that require more than 1 day to complete leave the drug counts vulnerable to manipulation.
- Inspections were not complete. During the 12-month period reviewed, 8 of 220 required inspections were not done at the hospital (18 storage locations x 12 months plus 1 storage location x 4 months). At the Peoria CBOC, inspections were not performed for 3 of the 12 months reviewed.

- Inspectors did not count expired and returned drugs stored in the controlled substances destruction container in the inpatient vault.
- Inspectors did not identify expired drugs during inspections of an inpatient ward.
- There was no formal training program for controlled substances inspectors.

An effective controlled substances inspection program is essential to ensure that the potential for diversion of controlled substances is minimized.

72-hour Inventory of Controlled Substances. VHA policy requires that an inventory be performed of all controlled substances and verified by Pharmacy Service every 72 hours. Our review of logs for the inpatient and outpatient controlled substances vaults revealed that during a 3-month period, there were 21 occasions when 72 hours elapsed without inventories being taken. For these 21 occasions, the elapsed times between inventories ranged from 93 to 165 hours and averaged 102 hours. The 72-hour inventory is an important control in identifying discrepancies at early stages when corrective actions are more easily taken.

Excessive Stock Levels. VHA Handbook 1761.2 requires that pharmacies manage their inventories to reduce costs. We compared inventory levels for 10 controlled substances to the pharmacy's actual usage during a recent 30-day period. We found high inventory levels for 6 of the 10 controlled substances, including 3 that had more than 100-day supplies on hand. High inventory levels increase the risk of theft and expiration of controlled substances.

Oxycodone Prescriptions. Local policy requires that a pharmacist document in the patient's medical record why a second prescription for controlled substances was needed for a patient who was issued the same controlled substance less than 20 days earlier. Proper documentation ensures that patients do not receive duplicate or incorrect prescriptions. We identified two patients who received multiple prescriptions of oxycodone within a short time frame. One patient received two 30-day prescriptions that were filled 8 days apart. The other patient received a 30-day supply of oxycodone from the outpatient pharmacy, and 2 days later the pharmacy mailed the patient an additional 15-day supply. In both cases, records lacked pharmacist explanations as to why the second prescriptions needed to be filled.

Witnessing Disposition of Controlled Substances. VHA policy requires that the destruction of unusable and expired controlled substances be witnessed and attested to by a controlled substances inspecting official as well as the Acquisition & Materiel Management Service manager and the Chief, Pharmacy Service, or their designees. The inspecting official witnessing the destruction of the controlled substances is an essential control that provides final certification of the correctness of the controlled substances inventories. We reviewed the destruction records for unusable and expired controlled substances for a 12-month period and found that Pharmacy Service employees disposed of these substances quarterly as required. However, the records did not contain any evidence that an inspecting official witnessed the dispositions as required. During the 12-month period reviewed, more than 24,000 units (tablets, capsules, and vials) of controlled substances involving more than 30 different medications were destroyed without appropriate witnessing by controlled substances inspecting officials.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director makes certain that:

a. Inspectors perform monthly, unannounced inspections in all areas containing controlled substances within 1 day, and that inspectors count all expired and returned drugs.
b. A formal training program for controlled substances inspectors is established.
c. Controlled substances inventories are verified every 72 hours.
d. Excessive inventory levels of controlled substances are reduced.
e. Pharmacists review prior controlled substances prescriptions and document their actions.
f. A controlled substances inspecting official witnesses the destruction of all unusable and expired controlled substances.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that controlled substances inspections will be unannounced and performed in 1 day, controlled substances inspector training will be established, controlled substances inventories will be verified every 72 hours, inventories have been reduced, pharmacists will document reasons for early controlled substances refills, and the destruction of unusable and expired controlled substances will be appropriately witnessed. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Medical Care Collection Fund – Third-Party Insurance Billing Procedures and Physician Documentation Needed Improvement

Conditions Needing Improvement. Improvements in Medical Care Collection Fund (MCCF) intake procedures led to greatly increased collections during FY 2002. Nevertheless, system managers needed to strengthen billing procedures and physician documentation to avoid missed billing opportunities. We found additional billing opportunities totaling $43,317.

Review of Potential Cost Recovery Report. During January 2003, MCCF employees paid 162 fee-basis claims to non-VA providers who provided medical care to patients who had health insurance. Of the 162 claims, 158 (98 percent) were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions, or the care was not billable under the terms of the insurance plans. The remaining four fee-basis payments were for care that was billable to the insurance carriers, but three had not been billed. Even though MCCF employees reviewed Potential Cost Recovery Reports, which identify potentially billable cases, these billings were overlooked. The MCCF manager agreed to review the Potential Cost Recovery Report more systematically to ensure all dates of care are captured. Two additional institutional bills and one professional services fee bill totaling $7,997 were issued as a result of our review.

Inpatient Care Billing. In a sample of 10 inpatient discharges during December 2002, we found 5 cases in which some bills were issued, but additional bills should have been issued. In two cases where multiple institutional charges were billable, MCCF employees overlooked the additional charges. The MCCF manager issued two bills totaling $30,847 during our review. In another case, a professional service fee was not billed because the coding specialist believed that

the care provided (a discharge summary note for a patient's death) could not be coded. As a result of our inquiry, a utilization review nurse determined that a professional service fee was billable for the discharge summary, and the MCCF manager issued a bill for $126 during our review. Three cases (discussed below) lacked sufficient physician documentation to support third-party billing.

Physician Documentation. In three of the five inpatient cases discussed above, additional professional services fees totaling $392 were not billed because physician documentation was insufficient. According to Health Information Management Section (HIMS) managers, revised procedures, such as coding reviews within 15 days of discharge, improved coding timeliness. However, we were told that inadequate documentation by physicians continued to be a coding problem. HIMS managers agreed that concurrent (daily) coding for inpatient admissions could improve physician documentation. Additionally**,** during the 12-month period ending March 31, 2003, 26 physical therapy (PT) bills totaling $3,955 sent to the American Association of Retired Persons (AARP) were closed with no payments received. Medicare policy states that outpatient PT services will be paid only when physicians certify that the patients require the services and plans for furnishing those services are established and periodically reviewed by the physicians. We determined that AARP denied payments in these cases because of insufficient documentation of physician treatment plans.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the System Director makes certain that:

a. MCCF employees carefully review the Potential Cost Recovery Report for billable care and issue bills when appropriate.
b. MCCF employees evaluate billing opportunities for medical care coded by HIMS employees.
c. Processes are developed to obtain proper physician documentation of all patient encounters.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that MCCF managers will review the Potential Cost Recovery Report and conduct periodic reviews of potential billing opportunities. Additionally, a computerized template was developed to assist with physician documentation. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Undelivered Orders and Accrued Services Payable – Unliquidated Obligations Needed To Be Reviewed Monthly

Conditions Needing Improvement. Fiscal Service employees did not systematically review outstanding obligations on a monthly basis and promptly cancel obligations that were no longer needed. VA policy requires Fiscal Service employees to analyze undelivered orders and accrued services payable reports each month to identify outstanding obligations and to contact the requesting services to determine whether the obligations are still needed. If an obligation is not needed, Fiscal Service employees are to cancel it and reprogram the funds.

Undelivered Orders. As of January 31, 2003, there were 327 undelivered orders representing $4.4 million. Of these 327 undelivered orders, 62 orders (19 percent) valued at $191,676 were delinquent (over 90 days old). We sampled 15 delinquent orders involving $111,937 and found that part or all of 7 orders (47 percent) representing $51,537, were no longer valid and should have been canceled.

Accrued Services Payable. As of January 31, 2003, there were 257 accrued services payable totaling $1.6 million. Of these 257 payable issues, 28 payables (11 percent), valued at $81,466, were delinquent. We sampled 20 delinquent payables valued at $79,222. We found that part or all of 14 of the sampled payables (70 percent) representing $16,187 were no longer valid and should have been canceled.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the System Director implements controls to review undelivered orders and accrued services payable each month and to promptly cancel unneeded obligations.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that appropriate managers will conduct regular reviews of undelivered orders and accrued services payable and that unneeded obligations will be cancelled promptly. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed Improvement and Excess Inventories Needed Reduction

Conditions Needing Improvement. We reviewed the system's supply inventory management program, including the Days of Stock on Hand Report from January 31, 2003. We found that Supply, Processing, and Distribution (SPD) Section employees did not properly use the automated Generic Inventory Package (GIP) to manage inventory levels, SPD data in the GIP was inaccurate, and warehouse employees maintained inventory levels that exceeded 30-day supplies. VHA's Inventory Management Handbook mandates the use of the GIP to effectively manage all inventories, and VHA policy states that inventory levels for medical supplies should not exceed 30-day supplies.

SPD - Primary Inventory. Our review showed that SPD had 2,507 inventory items valued at about $447,700. We sampled 10 items stocked in SPD to determine the accuracy of the inventory balances in the GIP. We determined that 9 (90 percent) of the 10 items inventoried did not agree with the inventory balances shown in the GIP. We also found that one item, excessed in 1998, remained in the GIP records. The Chief, SPD stated that when items were issued to using services, or excessed, the issued or excessed items frequently were not recorded in the GIP. Since SPD employees did not consistently update the GIP when supplies were issued from inventory or were excessed, the GIP data did not accurately reflect inventory levels. Therefore, SPD employees could not use the data to manage the inventory. Additionally, the Chief, SPD reported that a wall-to-wall physical inventory had not been performed in 3 years. VHA requires that a wall-to-wall inventory be completed annually.

Warehouse - Posted Stock Inventory. According to the January 31, 2003 Days of Stock On Hand Report, the warehouse had 166 inventory line items valued at about $49,000. We inventoried five items stocked in the warehouse, and our physical count matched GIP inventory records for all five items. However, all five items had inventory levels greater than 30-day supplies. Of the 166 line items in inventory, 104 (63 percent) had more than 30-day supplies. The value of inventory in excess of a 30-day supply was $27,117.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the System Director requires that the GIP be fully implemented, stock levels are reduced to 30-day supplies, and wall-to-wall inventories are conducted annually.

The VISN 11 and System Directors agreed with the findings and recommendations and reported that the GIP will be fully implemented, stock on hand will be reduced to 30-day supplies, and that a wall-to-wall inventory had been performed, and inventories will be conducted annually. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Clinical Laboratory – Access Controls Could Be Enhanced

Condition Needing Improvement. The system had a biosafety level-II (BSL-II) laboratory located in its clinical microbiology laboratory. The laboratory had a limited number of biological agents that were used for culture media, and agents were appropriately stored and secured. Laboratory managers and employees were knowledgeable about security and access control requirements, and had updated policies and procedures to reflect VHA's guidance. Police and Security Service (P&SS) employees made regular security rounds in the area. Keys allowing access to the laboratory were restricted to five laboratory employees. P&SS also had a key, which the service strictly controlled. PLMS managers told us that they requested funding for the purchase of a key-card access system[3] for the clinical laboratory to track entries, but that funding was not approved. The installation of a key-card or a similar system would enhance security of the clinical laboratory. This action would also be consistent with recommendations made in a prior OIG report.[4]

Suggested Improvement Action. We suggested that the VISN Director approve the purchase and installation of a key-card access system for the clinical laboratory.

The VISN 11 Director agreed with the suggestion and reported that a key card access system is being reviewed. The Chief, PLMS centralized the storage of biological agents to one room, and access to this room is limited to three PLMS employees. The improvement plans are acceptable.

[3] A system that requires the use of a bar coded key-card to access a secured area. When the card is swiped or inserted into the door mechanism, the system electronically records the date, time, and individual entering the area.

[4] Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities, Report Number 02-00266-76, dated March 14, 2002.

Information Technology Security – An Alternate Processing Facility Was Needed.

Condition Needing Improvement. The system's IT Contingency Plan did not designate an alternate processing facility to provide backup services in the event that primary facilities were severely damaged or could not be accessed.

Suggested Improvement Action. We suggested that the VISN Director ensure that the System Director takes action to include an alternate processing facility in the IT Contingency Plan.

The VISN 11 and System Directors agreed with the suggestion and reported that the IT contingency plan was modified to include an alternate processing facility. The improvement plan is acceptable.

Appendix A

VISN 11 Director Comments

DEPARTMENT OF

VETERANS AFFAIRS Memorandum

Date: June 10, 2003

From: Network Director, VISN 11 (10N11)

Subj: Combined Assessment Program Report Response – Illiana Health Care System

To: VA Office of the Inspector General

1. I have received and reviewed the attached draft report from the Department of Veterans Affairs Office of Inspector General Combined Assessment Program Review of the VA Illiana Health Care System, Danville, Illinois from the April 7-11, 2002 review and their response.

2. The facility concurs with the eight recommendations and two suggestions included in the report. I am pleased with the findings of this review, and will ensure the recommendations and suggestions have been implemented by the target completion dates.

3. Thank you for providing us with constructive feedback in a timely manner. If you have any questions, please contact Nancy Wallace, VISN Quality Management Officer at 734-930-5942.

/s/

Linda W. Belton

Attachment

Recommended Improvement Action 1

We recommend that the VISN Director ensure that the System Director requires that:

a. Identified sanitation and maintenance deficiencies are corrected.
Concur. See VAIHCS Director's action plan.
b. EOC inspection and reporting processes are improved and that deficiencies are tracked and trended by the EOCB until they are resolved.
Concur. See VAIHCS Director's action plan.
c. Eyewash stations are inspected per OSHA guidelines.
Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 2

We recommend that the VISN Director ensure that the System Director develops a process to place computerized alert flags into VISTA simultaneously with their placement into CPRS.
Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 3

We recommend that the VISN Director ensure that the System Director initiates:

a. Procedures to assign appropriate sensitivity designations to all positions in PALMS.
Concur. See VAIHCS Director's action plan.
b. Review of employees OPFs and requires that appropriate BIs, following VHA guidelines are completed and documented in employee's files.
Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 4

We recommend that the VISN Director ensure that the System Director implements procedures to collect and critically analyze comparative quality review data.
Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 5

We recommend that the VISN Director ensure that the System Director makes certain that:

a. Inspectors perform monthly unannounced inspections in all areas containing controlled substances within 1 day, and that inspectors count all expired and returned drugs.

Concur. See VAIHCS Director's action plan.

b. A formal training program for controlled substance inspectors is established.

Concur. See VAIHCS Director's action plan.

c. Controlled substances inventories are verified every 72 hours.

Concur. See VAIHCS Director's action plan.

d. Excessive inventory levels of controlled substances are reduced.

Concur. See VAIHCS Director's action plan.

e. Pharmacists review prior controlled substances prescriptions and document their action.

Concur. See VAIHCS Director's action plan.

f. A controlled substances inspecting official witnesses the destruction of all unusable and expired controlled substances.

Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 6

We recommend that the VISN Director ensure that the System Director makes certain that:

a. MCCF employees carefully review the Potential Cost Recovery Report for billable care and issue bills when appropriate.

Concur. See VAIHCS Director's action plan.

b. MCCF employees evaluate billing opportunities for medical care coded by HIMS employees.

Concur. See VAIHCS Director's action plan.

c. Processes are developed to obtain proper physician documentation of all patient encounters.

Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 7

We recommend that the VISN Director ensure that the System Director implements controls to review undelivered orders and accrued services payable each month and to promptly cancel unneeded obligations.

Concur. See VAIHCS Director's action plan.

Recommended Improvement Action 8

We recommend that the VISN Director ensure that the System Director requires that GIP be fully implemented, stock levels are reduced to 30-day supplies, where appropriate; and wall-to-wall inventories are conducted annually.

Concur. See VAIHCS Director's action plan.

Suggested Improvement Action

We suggest that the VISN Director approve the purchase and installation of a key card access system for the clinical laboratory.

Concur. See VAIHCS Director's action plan.

Suggested Improvement Action

We suggest that the VISN Director ensure that the System Director takes action to include an alternate processing facility in the IT Contingency Plan.

Concur. See VAIHCS Director's action plan.

Appendix B

VA Illiana Health Care System Director Comments

Environment of Care (EOC)

Recommended Improvement Action 1

We recommend that the VISN Director ensure that the System Director requires that:
a. Identified sanitation and maintenance deficiencies are corrected.

Concur.

Sanitation corrections have been made and sanitation is being maintained. Signage is in place. An abatement plan for all identified maintenance deficiencies has been developed. Replacement of main kitchen ceiling and identified floor tiles is being planned and will be placed out for contract. Targeted completion date is December 31, 2003. (Project #SL-03-11)

b. EOC inspection and reporting processes are improved and that deficiencies are tracked and trended by the EOCB until they are resolved.

Concur.

Improvements to EOC inspection program and reporting Systems are being made through policy updates and practice. Processes are being improved to assure identified deficiencies are tracked, trended and reported until resolution. Policy revision expected to be completed by August 1, 2003.

c. Eyewash stations are inspected per OSHA guidelines.

Concur.

Eyewash stations will be tested weekly. A review of eyewash station logs will be added to the EOC rounds checklist for ongoing facility wide monitoring. Eyewash stations will be tested weekly starting by July 1, 2003.

Management of Violent Patients

Recommended Improvement Action 2

We recommend that the VISN Director ensure that the System Director develops processes to place computerized alert flags into VISTA simultaneously with their placement into CPRS.

Concur.

VAIHCS will utilize the VISTA alert functionality to implement a CWAD alert for clerical employees who register and schedule patients for appointments who do not regularly use CPRS for identification of violent patients. Target date is August 1, 2003. This is a local modification that only partially corrects the problem and needs national attention. We have just been apprised that the national directive on patient record flags is anticipated for release in the near future with training to begin potentially in August.

Position Sensitivity Designations and Background Investigations

Recommended Improvement Action 3

We recommend that the VISN Director ensure that the System Director initiates:
a. Procedures to assign appropriate sensitivity designations to all positions in PALMS.

Concur.

Sensitivity designations of all assigned PALMS staff will be made by June 30, 2003.

b. Reviews of employees OPFs and requires that appropriate BIs, following VHA guidelines are completed and documented in employee's files.

Concur.

A review of all PALMS employees OPFs will be made for appropriate security designations and BI documentation and if not present will be requested by June 30, 2003.

Quality Management

Recommended Improvement Action 4

We recommend that the VISN Director ensure that the System Director implements procedures to collect and critically analyze comparative quality review data.

Concur.

Management will work with Quality Management to identify key data elements for benchmarking, analysis and identification of opportunities for improvements. This process is ongoing with demonstrated evidence of progress by September 1, 2003.

Controlled Substance Accountability

Recommended Improvement Action 5

We recommend that the VISN Director ensure that the System Director makes certain that:
a. Inspectors perform monthly unannounced inspections in all areas containing controlled substances within 1 day, and that inspectors count all expired and returned drugs.

Concur.

The policy is being changed to assure that all inspections are unannounced and comply within 1 day. Target completion is June 30, 2003. All expired and returned controlled substance drugs are counted.

b. A formal training program for controlled substance inspectors is established.

Concur.

Formal controlled substance inspector training will be established by August 1, 2003.

c. Controlled substances inventories are verified every 72 hours.

Concur.

Pharmacy standard operating procedures have been modified to assure controlled substances inventories are verified every 72 hours. (Pharmacy policy attached; see page5, item 1, outpatient, addressing frequency of controlled substance inventories.)

d. Excessive inventory levels of controlled substances are reduced.

Concur.

Inventory levels of four of the six controlled substances have been reduced. The remaining two drugs will be reduced by June 30, 2003.

e. Pharmacists review prior controlled substances prescriptions and document their action.

Concur.

Written policy has been established and implemented to assure documentation of reason for the controlled substance refill. (Pharmacy policy attached; see page 3, item 1 addressing controlled substances refills.)

f. A controlled substances inspecting official witnesses the destruction of all unusable and expired controlled substances.

Concur.

Policy has been changed to assure a controlled substance inspecting official witnesses the destruction of all unusable and expired controlled substances. (Pharmacy policy attached; see page 7, item 5 addressing witnessing destruction.)

Medical Care Collection Fund

Recommended Improvement Action 6

We recommend that the VISN Director ensure that the System Director makes certain that:

a. MCCF employees carefully review the Potential Cost Recovery Report for billable care and issue bills when appropriate.

Concur.

MCCF manager is reviewing Potential Cost Recovery Report for billable care and the appropriate issuance of bills beginning immediately.

b. MCCF employees evaluate billing opportunities for medical care coded by HIMS employees.

Concur.

MCCF manager is conducting periodic reviews of potential billing opportunities from medical care coded by HIMS employees to ensure claims have been completed appropriately.

c. Processes are developed to obtain proper physician documentation of all patient encounters.

Concur.

A computerized template has been drafted to prompt physician documentation including certifying and recertifying therapies on a recurring basis. Plans to conduct focused concurrent coding are being developed to assist improvement of physician documentation in the medical record on Medical Service inpatients. Target date for implementation is June 30, 2003.

Undelivered Orders and Accrued Services Payable-Unliquidated Obligations

Recommended Improvement Action 7

We recommend that the VISN Director ensure that the System Director implements controls to review undelivered orders and accrued services payable each month and to promptly cancel unneeded obligations.

Concur.

Chief Fiscal Service and Chief of Accounting are conducting monthly reviews of undelivered orders and accrued services payable to identify outliers and if needed corrective actions are taken. Also, unneeded obligations are reviewed regularly and cancelled promptly as needed.

Supply Inventory Management

Recommended Improvement Action 8

We recommend that the VISN Director ensure that the System Director requires that GIP be fully implemented, stock levels are reduced to 30-day supplies, and wall-to-wall inventories are conducted annually.

Concur.

SPD will fully implement GIP. A night SPD room (B-58-335) is being established to facilitate accurate item sign out. Target date for completion is July 31, 2003. SPD stock levels have been studied. Stock on hand will be reduced to a 30-day supply as used with a target day of November 30, 2003. A wall-to-wall inventory was conducted on May 16 and 17, 2003 and will be conducted annually. A report for the record is due to the Director by July 1, 2003.

Clinical Laboratory Access Control

Suggested Improvement Action

We suggest that the VISN Director approve the purchase and installation of a key card access system for the clinical laboratory.

Concur.

A key card access System is being reviewed. In the meantime Chief, Pathology and Laboratory Medicine Service (PALMS) has centralized the storage of the limited amount of biological agents used in the laboratory to one room (B58-137). Access to this room is limited to three PALMS employees.

Appendix B

Information Technology Security

Suggested Improvement Action

We suggest that the VISN Director ensure that the System Director takes action to include an alternate processing facility in the IT Contingency Plan

Concur.

The IT Contingency Plan is being modified to include an alternate processing facility. This will be finalized by July 15, 2003.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the VA Illiana Health Care System

Report Number: [XX–XXXX–XX]

Recommendation	Explanation of Benefits	Better Use of Funds
6	Better use of funds by ensuring all billable care is billed.	$43,317
7	Better use of funds by monitoring delinquent obligations and canceling unneeded obligations timely.	$67,724
8	Better use of funds by reducing medical supply inventories to 30-day supplies.	$27,117
	Total	$138,158

Appendix D

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