Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of Veterans Health Administration Activities at the Robert J. Dole VA Medical and Regional Office Center Wichita, Kansas

Report No. 03-02735-103

March 16, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

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

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

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Page

Executive Summary i

Introduction 1

Facility Profile 1

Objectives and Scope of the CAP Review 1

Results of Review 4

Organizational Strengths 4

Opportunities for Improvement 5

Environment of Care 5

Human Research Studies 6

Medical Care Collections Fund 6

Undelivered Orders and Accrued Services Payable 7

Medical Supply Inventories Management 8

Quality Management 9

Patient Transportation Services 9

Controlled Substances Accountability. 11

Contract Administration 12

Appendixes

A. Acting VISN 15 Director Comments 14

B. VA Medical and Regional Office Center Director Comments 16

C. Monetary Benefits in Accordance with IG Act Amendments 21

D. OIG Contact and Staff Acknowledgments 22

E. Report Distribution 23

Executive Summary

Introduction

During the week of October 6–10, 2003, the OIG conducted a CAP review of Veterans Health Administration (VHA) activities at the Robert J. Dole VA Medical and Regional Office Center (the medical center) Wichita, Kansas. 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 167 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of Review

Information technology security was adequate, and accounts receivable and employee debts were aggressively pursued. To improve operations, VISN and medical center management needed to:

- Correct environment of care deficiencies.
- Comply with all human subjects research stand down requirements.
- Enhance billing and collection procedures.
- Review delinquent obligations monthly and cancel unneeded obligations timely.
- Reduce excess medical supply inventories.
- Enhance QM by improving root cause analysis reviews and provider specific data analysis.
- Strengthen internal controls over patient transportation services.
- Strengthen accountability controls over controlled substances.
- Strengthen contract administration.

VISN 15 and Medical Center Directors' Comments

The Acting VISN 15 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 14–20 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed. This report was prepared under the direction of William Withrow, Director, Kansas City Audit Operations Division and Robert C. Zabel, CAP Review Coordinator, Kansas City Audit Operations Division.

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

Introduction

Facility Profile

Organization. Located in Wichita, Kansas, the medical center provides primary and secondary care and a range of inpatient and outpatient health care services. Primary care is also provided at five community-based outpatient clinics located in Liberal, Dodge City, Hays, Parsons, and Salina, Kansas. The medical center is part of VISN 15 and serves a veteran population of about 106,000 in a primary service area that includes 59 counties in central and western Kansas.

Programs. The medical center provides medical, surgical, and mental health services and maintains 41 acute care beds and 40 nursing home care beds. The medical center also has a sharing agreement with McConnell Air Force Base to provide examination rooms in case of a national emergency. Physician contractual services include anesthesiology, cardiology, and oncology.

Affiliations and Research. The medical center is affiliated with the Kansas University School of Medicine and supports 19 medical resident positions in 4 training programs. Over 150 medical school residents, interns, and students are trained each year. The medical center also has nursing student affiliations with Wichita State University, Butler County Community College, as well as 18 other affiliations involving social work, optometry, audiology, speech pathology, and physician assistants.

Resources. The medical center's Fiscal Year (FY) 2003 medical care budget was $74.5 million, an 11 percent increase over the FY 2002 budget of $67.2 million. FY 2003 staffing through June 2003 was 540.6 full-time equivalent employees (FTEE), including 30 physician and 180 nursing FTEE. FY 2002 staffing was 494.1 FTEE, including 28 physician and 173 nursing FTEE.

Workload. In FY 2003, the medical center treated 27,952 unique patients, an 11 percent increase from FY 2002. For FY 2003, the average daily acute care census was 35.8, and the average daily Nursing Home Care Unit census was 35.5. The outpatient workload was 124,797 visits.

Objectives and Scope of the 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 and appropriate and timely benefits. 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 the requirement to refer suspected criminal activity 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. The review covered medical center operations for FY 2002 and FY 2003 through August 31, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Accounts Receivable and Employee Debts	Information Technology Security
Accrued Services Payable	Medical Care Collections Fund
Contract Administration	Medical Supply Inventories Management
Controlled Substances Accountability	Patient Transportation Services
Engineering Supply Inventories Management	Pharmacy Security
Environment of Care	Quality Management
Human Research Studies	Undelivered Orders

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5–13). For these activities, we make recommendations or a suggestion. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. A suggestion pertains to an issue that should be monitored by VISN management until corrective actions are completed. For activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, we did not identify reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees and 171 responded. We also interviewed 30 patients during the review. The surveys and interviews indicated high levels of employee and patient satisfaction and did not disclose any significant issues. The survey results were shared with the medical center managers.

During the review, we also presented 3 fraud and integrity awareness briefings for 167 medical center employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

A separate report on Veterans Benefits Administration activities at the Robert J. Dole VA Medical and Regional Office Center was also issued as a result of the CAP review (Report No. 03-02735-104, dated March 16, 2004).

Results of Review

Organizational Strengths

Information Technology Security Was Generally Effective. The medical center had adequate information technology security to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for computer rooms and equipment was adequate, critical data was regularly backed up and properly stored off-site, contingency and security plans were current and complete, and annual computer awareness training was provided as required.

Accounts Receivable and Employee Debts Were Aggressively Pursued. Fiscal Service staff had established effective controls for pursuing delinquent vendor accounts receivable and employee debts. Fiscal Service and VISN staff performed monthly reconciliations of accounts receivable, and they promptly followed up to collect delinquent receivables. As of June 30, 2003, the medical center had 665 accounts receivable valued at $31,519. We reviewed the collection efforts on 22 receivables valued at $24,659 and found that, for potentially recoverable receivables, Fiscal Service staff aggressively pursued collection by making telephone calls in addition to mailing collection letters.

Opportunities for Improvement

Environment of Care – Patient Safety and Privacy Needed Management Attention

Condition Needing Improvement. Medical center managers needed to ensure that medications and sharp instruments were secured and outdated patient care equipment was removed from the outpatient care areas. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors. Managers also needed to ensure that sensitive patient information was protected. Federal law requires that facilities maintain security and privacy of patient health information. We inspected inpatient units, outpatient primary care and specialty clinic areas, and dining areas. Supervisors generally maintained a clean environment and took actions to correct identified deficiencies.

Medication Security. We found an unsecured medication refrigerator located in an unlocked employee break room in the outpatient care area. The refrigerator contained only medications; however, this condition allowed unauthorized persons access to the break room and the medication refrigerator. The refrigerator was located in the break room because of the lack of a more appropriate space in the crowded outpatient care area. Medications must be secured; and the nurse manager agreed that the refrigerator should be locked at all times.

Unsecured Sharp Instruments and Outdated Equipment. We found unsecured sharp instruments (such as scissors) in outpatient examination rooms. Additionally, outdated prepackaged equipment, which included sharp instruments, was found in an unlocked room accessible through a patient examination room and a hallway. Sharp instruments need to be secured to prevent accidental or purposeful injury to patients, visitors, or staff. Managers need to return outdated equipment to Supply Processing and Distribution for appropriate disposition actions.

Patient Confidentiality. We observed sensitive patient information on a computer screen and printed patient information on the floor in an unoccupied office adjacent to an outpatient waiting room. We also found printed patient information on an unattended desk in the outpatient area. This condition presented opportunities for disclosure of sensitive patient information to individuals who do not have a need to know.

Recommended Improvement Action 1. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that: (a) medications and sharp instruments are secured and outdated equipment is appropriately disposed; and (b) sensitive patient information is secured.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Human Research Studies – Managers Needed to Comply With Human Subjects Research Stand Down Requirements

Condition Needing Improvement. Medical center managers needed to ensure that all VHA Office of Research and Development (ORD) stand down requirements were met. The ORD initiated a 90-day national stand down of human subjects research from March 10 through June 6, 2003, in response to increasing concerns of human subjects safety, and questionable ethical conduct discovered at certain VA research facilities. The stand down did not mean that research activities would cease, but facilities conducting human research would proactively review their human research programs. The purpose of the stand down was to ensure that prescribed protocols were followed, the rights of human subjects were protected, all applicable research employees received required training, and research was conducted in an ethical manner. Facilities' managers were mandated to submit documentation to VHA's ORD attesting to compliance with the stand down requirements.

Our review showed that actions to comply with ORD requirements were still needed. We found that one member of the Institutional Review Board (IRB) overseeing human subjects research needed to complete education requirements. Additionally, there was no evidence to support that senior managers notified a principle investigator (PI) of the ORD requirement to officially seek approval from the IRB to conduct research at the medical center, or of the PI's responsibilities in following prescribed research ethical standards.

Recommended Improvement Action 2. We recommended that the Acting VISN Director ensure that the Medical Center Director requires the IRB member overseeing human subjects research to complete the prescribed training requirement and the PI to be notified of ethical responsibilities and accountability related to human subjects research.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries

Condition Needing Improvement. The medical center increased Medical Care Collections Fund (MCCF) collections from $6.4 million in FY 2002 to $8.8 million in FY 2003 (exceeding its FY 2003 collection goal of $7.7 million). However, MCCF managers could further improve MCCF program results by identifying and billing veterans' health care insurers for fee-basis care[1] and increasing collections by making follow-up telephone calls. Our review focused on the first 3 quarters of FY 2003 and included assessments of MCCF billings to and collections from veterans' health care insurers.

[1] Fee-basis care is medical care provided to veterans by non-VA providers. VA reimburses the non-VA providers for the care.

Fee-basis Care. We reviewed 78 inpatient fee-basis care payments for 56 veterans, totaling $430,000, and 1,878 outpatient fee-basis care payments for 10 veterans, totaling $95,000. We found that all of the inpatient payments and 1,308 of the outpatient payments, valued at $38,000, could have been billed to veterans' health care insurers. At the time of our review, MCCF employees had not billed the insurers for any of these payments. However, they planned to identify fee-basis care payments made during the last 12 months and retroactively bill those payments. Based on Fee Services' estimated 55 percent collection rate, MCCF staff could have collected about $257,400 [($430,000 + $38,000) x 55 percent] on these payments.

Collection Efforts. MCCF staff could increase collections from health care insurers by making follow-up telephone calls. As of October 6, 2003, the medical center had 199 MCCF third-party receivables with a total value of $2.2 million. We reviewed a judgment sample of 10 third-party receivables valued at $353,000 and found that MCCF employees did not make any follow-up telephone calls. Guidance provided by VHA's Chief Business Office suggested that follow-up telephone calls for unpaid bills begin 30 days after the issuance of the bill to verify that the insurer received the bill and to determine the reason the bill remains unpaid.

Recommended Improvement Action 3. We recommended that the Acting VISN 15 Director ensure that the Medical Center Director: (a) requires that MCCF staff issue bills to health care insurers when appropriate for fee-basis care, and (b) improves MCCF accounts receivable collection efforts by requiring follow-up telephone calls with insurers after the bill remains unpaid for 30 days.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Undelivered Orders and Accrued Services Payable – Controls Over Unliquidated Obligations Needed Strengthening

Condition Needing Improvement. Fiscal Service employees did not perform monthly reviews of outstanding obligations. 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 should cancel it and reprogram the funds. We found delinquent orders and payables that needed to be canceled and the funds deobligated as summarized below.

Undelivered Orders. As of August 31, 2003, the medical center had 300 undelivered orders totaling $2.4 million. Of these, 34 orders totaling $278,628 were delinquent (over 90 days). We reviewed all 34 delinquent orders and found that 12 orders totaling $20,550 were no longer needed and should have been canceled.

Accrued Services Payable. As of August 31, 2003, the medical center had 285 accrued services payable totaling $3.2 million. Of these, three payables totaling $27,597 were delinquent. We reviewed the three payables and found that two payables totaling $27,470 were no longer needed and should have been canceled.

Recommended Improvement Action 4. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that outstanding obligations are reviewed monthly with adequate follow-up and unneeded obligations are promptly canceled.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Medical Supply Inventories Management – Some Inventory Items Needed To Be Reduced

Condition Needing Improvement. Logistics staff needed to reduce excess inventories of medical supplies and make better use of automated controls to more effectively manage supply inventories. VHA policy establishes a 30-day stock level goal and mandates that facilities use the Generic Inventory Package (GIP) to manage medical supply inventories. GIP assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand.

Although Logistics staff used GIP to manage medical supply inventories, the inventories located in the eight primary inventory control points exceeded the 30-day standard. As of July 2003, the total medical supply inventory consisted of 1,608 items with a stated value of $142,944. To test the reasonableness of the inventory value, we reviewed a judgment sample of 32 medical supply items with a total value of $5,949. For 8 of the 32 sampled items, stock on hand exceeded 30-day supplies, with inventory levels ranging from 31.3 to 1,200 days of supply. For these 8 items, the value of stock exceeding 30 days was $618, or 10.4 percent of the total value of the 32 sampled items. The excess stock occurred because Logistics staff was not adjusting GIP stock levels to meet the 30-day standard. By applying the 10.4 percent of excess stock for the judgmentally sampled items to the entire medical supply inventory, we estimate that the value of excess stock was about $14,866 (10.4 percent x $142,944 stated value of the medical supply inventory).

Recommended Improvement Action 5. We recommended that the Acting VISN Director ensure that the Medical Center Director requires Logistics staff to adjust medical supply stock levels to meet the 30-day standard.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Quality Management – Root Cause Analysis Reviews and Provider Specific Data Analysis Needed Improvement

Condition Needing Improvement. QM managers needed to ensure that root cause analysis (RCA) reviews consistently identify the contributing causal factors (root causes) for reportable occurrences such as adverse patient events or close calls. We also found that QM managers needed to adequately document the extent to which RCA recommendations were implemented. In addition, QM managers needed to develop benchmarks as measurement standards for provider specific data used in re-privileging providers.

Root Cause Analysis Reviews. VHA regulations require that RCA reviewers identify root causes underlying variations in performance associated with adverse patient events or close calls. We reviewed the results of seven RCAs and found that three did not identify appropriate root causes for the events that were investigated. Additionally, evidence was inadequate to support that some RCA recommendations for improvements were implemented and monitored for effectiveness.

Provider Specific Data. VHA requires that the re-privileging process includes an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on provider specific performance improvement activities. Re-privileging is the process of granting privileges to a provider who currently holds privileges within the facility. During our review of credentialing and privileging files, QM managers provided us a form that indicated provider specific data was collected and reviewed; however, there was no documented benchmark to which the data was compared. For example, a file showed that a provider had performed 170 procedures, had 30 reportable occurrences, and 3 post-operative deaths. We could not determine the significance of the information due to the lack of documented benchmarks.

Recommended Improvement Action 6. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that: (a) RCA teams identify appropriate root causes for reportable occurrences such as adverse patient events or close calls; (b) documentation supports that improvement actions recommended by RCA teams are implemented and monitored for effectiveness; and (c) provider specific data is compared to appropriate measurement standards to ascertain accurate provider performance at the time of re-privileging.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Patient Transportation Services – Internal Controls Needed Strengthening

Condition Needing Improvement. Medical center managers needed to ensure that required driver screening re-verification and training is provided, annual safe driver training is provided to

all employees and volunteers who transport patients, and equipment placed in vehicles during transport is secured.

Driver Screening Re-Verifications. VA regulations require that supervisors responsible for Motor Vehicle Operator (MVO) employee and volunteer drivers ensure that drivers receive physical examinations, verify that drivers' licenses are current, and ensure that drivers maintain safe driving records. Additionally, volunteer drivers must provide proof of automobile insurance. These components of driver screening should be accomplished at a minimum of every 4 years. We interviewed the MVO supervisor and the Chief, Voluntary Service, and reviewed Official Personnel Folders, volunteer files, and health records for two employee and three volunteer drivers. We found that none of the screening re-verification components were accomplished for the two employee drivers. Our review showed that Voluntary Service supervisors require volunteer drivers to provide proof of current drivers' licenses and insurance, and Volunteer Service began ensuring drivers had physical examinations in June 2003. However, re-verifications of safe driving records were not being performed.

Driver Training. VA regulations require that medical facilities develop and implement a Motor Vehicle Safety Program when vehicles are operated for official business. Medical facilities are also required to present at least one formal safe driving program per year for employees and volunteers who transport patients. We reviewed training records for three employees and three volunteer drivers who transport patients. Annual safe driving training was not provided for any of the individuals in the sample.

Patient Transport. We accompanied a driver on a patient transport and observed that employees placed a patient's walker in the vehicle without securing it. In the event of a quick stop or sharp turn, the walker could have shifted and caused injury to a passenger. Action should be taken to ensure that drivers are reminded to secure patient care equipment.

Recommended Improvement Action 7. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that: (a) screening of employee and volunteer drivers is re-verified according to VA regulations; (b) employees and volunteers who transport patients receive annual safe driver training; (c) documentation of training is maintained; and (d) drivers are reminded to adequately secure all patient care equipment during transports.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Controlled Substances Accountability – Selected Controls and Destruction of Excess and Outdated Controlled Substances Needed Improvement.

Condition Needing Improvement. Pharmacy Service managers needed to strengthen controls to fully comply with VHA policy and help ensure accountability of controlled substances. The following deficiencies were identified.

Monthly Unannounced Controlled Substances Inspections. VHA policy requires the Controlled Substances Coordinator to ensure that monthly inspections are completed in each area that stores controlled substances. Our review of the Monthly Unannounced Controlled Substances Inspection reports during a 13-month period ending June 2003 found that some areas containing controlled substances were not inspected. In November 2002, inspections were not conducted for the Intensive Care, Ward 2-West, Radiology, and the Nursing Home Care Unit areas. In addition, the Surgery, Post-Anesthesia Care Unit, and Endoscopy inspections were not performed in August and December 2002 and February 2003. The monthly inspections are an important control in identifying discrepancies at an early stage when corrective actions are more easily taken.

72-hour Inventories of Controlled Substances. VHA policy requires a perpetual inventory of all controlled substances that is verified by Pharmacy Service at a minimum of every 72 hours. Our review of the Main Pharmacy Vault found that during the 3-month period ending August 31, 2003, there were seven occasions when 72 hours elapsed without inventories being performed. For these seven occasions, the elapsed time between inventories ranged from 96 to 144 hours. The 72-hour inventory is also an important control in identifying discrepancies at an early stage.

Quarterly Destruction of Excess and Outdated Controlled Substances. VHA policy requires that excess and outdated controlled substances that are returned to the pharmacy be properly stored and destroyed under the control of Pharmacy Service staff. The inspecting official is to verify that drug destructions are completed at least quarterly and document the destructions on the Monthly Unannounced Controlled Substances Inspection reports. Our review of destruction documents indicated that excess and outdated controlled substances were not being destroyed quarterly. Destruction of excess and outdated controlled substances occurred in January, March, and August 2003. No destructions were performed during calendar year 2002.

Recommended Improvement Action 8. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that: (a) monthly unannounced controlled substance inspections be performed in all areas, (b) all controlled substances inventories are verified at least every 72 hours, and (c) all excess and outdated controlled substances are destroyed quarterly.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plans. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are implemented.

Contract Administration – Documentation of Contract Processing Needed Strengthening

Condition Needing Improvement. The Acting VISN Director needed to ensure that VISN contracting officers include documentation of all contract processing requirements in the contract files in accordance with Federal Acquisition Regulations (FAR) and VA policy. VISN contracting staff located at the VA medical center in Leavenworth, Kansas process and award contracts for VISN 15.

Contracting officers are required to establish files containing documentation of significant contract processing requirements to include legal and technical reviews, Price Negotiation Memorandums (PNMs), support for community nursing home rates, contract option year justifications, and Contracting Officer's Technical Representative (COTR) letters. We found deficiencies in 4 of 11 contract files reviewed.

- VA policy requires that competed contracts with an estimated value of $1.5 million or more have legal and technical reviews. The anesthesiology services contract was competed, and the total estimated value including 4 option years was $2 million. However, legal and technical reviews were not requested.

- The FAR requires a PNM to describe important elements of the contract negotiation process, including an explanation of how the prices were determined to be reasonable. The estimated value of the hemodialysis contract, including 3 option years, was $600,000, but a PNM was not prepared.

- VA policy regarding community nursing home contracts established benchmark percentages for different skill levels of care. The Medicaid rate plus an appropriate percentage when needed determines the per diem rates. One nursing home contract had six skill level per diem rates. One rate was determined with the appropriate benchmark percentage, and the remaining five rates were determined with a percentage that was below the benchmark percentage. However, there was no documentation to support why those particular percentages were used.

- The FAR requires a written justification to explain why exercising an option year is in the best interest of the Government. The cardiac surgery, anesthesiology services, and community nursing home services contracts, valued in total at over $5.3 million annually, had no written justifications for the option years.

- VA policy requires that a COTR be assigned in writing to monitor contract performance to ensure that services are provided in accordance with contract terms. A social worker had been performing the duties of the COTR for one nursing home contract since May 2003, when the assigned COTR took another position. However, there was no documentation officially assigning the social worker as the COTR.

Suggested Improvement Action. We suggested that the Acting VISN Director ensure that VISN contracting officers include documentation of contract processing requirements in the contract files as required by the FAR and VA policy.

The Acting VISN Director agreed with the findings and suggestion and provided acceptable improvement plans. We consider the issues resolved.

Acting VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 8, 2004

From: Acting Network Director, VISN 15, Kansas City, Missouri

Subject: **Combined Assessment Program (CAP) Review of the Robert J. Dole VA Medical and Regional Office Center Wichita, Kansas**

To: Assistant Inspector General for Auditing

1. I have reviewed the draft report, as well as the facility's response. I concur with your findings, your recommendations, and the actions the facility has taken and will be taking to comply with your recommendations.

2. Your suggestions related to the VISN contracting operation were noted. Our actions related to the suggestions are outlined following this memorandum.

3. I appreciate the time and effort that your office has taken to conduct this review. It will assist us as we strive to continue to improve our processes and our care to America's veterans.

Peter L. Almenoff, M.D., FCCP

Acting VISN 15 Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestion in the Office of Inspector General Report:

OIG Suggestion(s)

Suggested Improvement Action.

We suggest that the VISN Director ensure that VISN contracting officers include documentation of contract processing requirements in the contract files as required by the FAR and VA policy.

Action has been taken, through in-service training of the contracting officers, to ensure that all VISN contracting officers are aware of the FAR and VA policy requirements related to contracts, to ensure that all required documents will be included in the future.

In addition, a peer review process has been implemented. After a contract has been completed, it will be reviewed by a second contracting officer to verify that all required documents are contained in the file.

VA Medical and Regional Office Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 7, 2004

From: Director, Robert J. Dole VAMROC, Wichita, Kansas (589A7/00)

Subject: **Combined Assessment Program (CAP) Review of the Robert J. Dole VA Medical and Regional Office Center Wichita, Kansas**

To: Acting Network Director, VISN 15 (10N15)

1. The Dole VA agrees with the IG findings and appreciates the opportunity to improve our service to veterans and their dependents.

2. In response to the findings and recommendations of the Combined Assessment Program (CAP) the following actions were taken.

3. We want to thank all of the people involved in the CAP review and we do appreciate the courtesy and professionalism that was afforded us throughout the process.

Tom Sanders

THOMAS J. SANDERS, CHE

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

OIG Recommendations:

a**. Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) medications and sharp instruments are secured and outdated equipment is appropriately disposed; and (b) sensitive patient information is secured.**

(a) Medications and Sharp Instruments: Facility-wide education, utilizing APIC's power point presentation on "Sharps Safety" (see Attachment 1), is being provided at all clinical program staff meetings. This education endeavor will be completed by February 28, 2004. Medication and sharps security and outdated equipment have been added to the weekly Environmental Rounds Inspection Checklist to ensure increased vigilance regarding sharps and medications during Environmental Rounds Inspections.

Outdated Equipment: Team leaders are emphasizing the need to continuously monitor outdated equipment and inappropriate storage of supplies/equipment. These issues are also being monitored more closely during Environmental Rounds Inspections.

(b) Sensitive Patient Information: Security of patient information is addressed at employee orientation and in mandatory annual refresher training. In addition, regularly scheduled walk-throughs are being conducted and user awareness is being heightened through monthly e-mails from our ISO to all staff stressing the importance of safeguarding patient information.

Recommended Improvement Action 2. We recommend that the Acting VISN Director ensure that the Medical Center Director requires the IRB member overseeing human subjects research to complete the prescribed training requirement and the PI to be notified of ethical responsibilities and accountability related to human subjects research.

The IRB member completed all prescribed training on October 9, 2003. The PI was formally notified of the ethical responsibilities and accountability related to human subjects research on October 10, 2003.

Recommended Improvement Action 3. We recommend that the VISN 15 Director ensure that the Medical Center Director: (a) makes certain that MCCF staff issue bills to health care insurers when appropriate for fee-basis care, and (b) improves MCCF accounts receivable collection efforts by requiring follow-up telephone calls with insurers after the bill remains unpaid for 30 days.

(a) MCCF on Fee Basis Care: A Revenue Generation Team has been implemented to provide oversight and guidance to all revenue generation activities. A Billing and Collections Task Force has been created to provide monthly oversight to MCCF activities, to include non-VA care co-payments and collections. This task force reports its progress to the Revenue Generation Team on a monthly basis. The Revenue Generation Team reports to Leadership Council.

(b) Follow up Telephone Calls: While follow-up telephone calls were being made, the Patient Accounts Manager is ensuring that all accounts in excess of 30 days in Accounts Receivable are followed via telephone calls. The delinquent AR reports are run monthly and more closely monitored to ensure a quicker follow-up on those accounts. The Billings and Collections Task Force also reviews this activity.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director makes certain that outstanding obligations are reviewed monthly with adequate follow-up and unneeded obligations are promptly canceled.

The "open 1358 report" is now being run monthly so more timely action can be taken. An Accounting Technician position has been filled to accomplish adequate follow-up and ensure unneeded obligations are promptly cancelled.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires Logistics staff to adjust medical supply stock levels to meet the 30-day standard.

Items are being reviewed each month for deletion or to make excess stock available to other stations. Some stock will be on hand over 30 days because of very low usage. Some stock will be over 30 days because it must be purchased by the case or box. For example, a case (100 ea) of bandages may have a very low usage. The overall turnover rate for hospital medical supplies consistently meets and/or exceeds the minimum turnover rate requirement.

The processes for reducing all other items over 30 days are as follows:

a. The "Automatic Level Setter" is currently being run for each Primary. Levels are being reviewed and changed based upon this report.

b. The "Days Of Stock On Hand Report", "Stock Status Report" and the "Inactive Items Report" are being run at the end of each month, reviewed, and adjustments made when indicated.

c. Items are being sorted by total dollar amount, with the highest being reviewed first.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) RCA teams identify appropriate root causes for adverse patient events; (b) documentation supports that improvement actions recommended by RCA teams are implemented and monitored for effectiveness; and (c) provider specific data is compared to appropriate measurement standards to ascertain accurate provider performance at the time of re-privileging.

(a) Appropriate root cause identification: By providing the RCA teams more guidance and direction during the team process, team training in root cause analysis has been intensified. The RCA Facilitator is present during all interviews done by the team. In addition, after the initial Just-In-Time training, the Facilitator meets with the team after their data collection is completed to ensure that the team is on track with the right data. After the team has identified the root cause, the facilitator meets with the team again to review the findings and provide further guidance, if needed.

(b) Implementation and monitoring of recommended actions: The final reports of all RCA action teams are presented by the team to the Director, Chief of Staff, and all parties involved in the specific recommendations to ensure that all parties understand and accept the recommendations. A Patient Safety/Risk Management oversight committee has been established and minutes will show the status of follow-up actions.

(c) Provider Specific Data Standards: A section for analysis of data has been added to the provider-specific data form. The supervising physician is required to complete this section and include documented measurement standards (benchmarking) for comparisons when indicated.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) screening of employee and volunteer drivers is re-verified according to VA regulations; (b) employees and volunteers who transport patients receive annual safe driver training; (c) documentation of training is maintained; and (d) drivers are reminded to adequately secure all patient care equipment during transports.

(a) Screening of Employee and Volunteer Drivers: A verification-screening tool has been developed in EXCEL to track all verifications required per VA regulations. Volunteers and employees are included on the same verification screening tool. The Voluntary Service Assistant is monitoring the screening tool for compliance.

(b) Driver Training: The screening tool also includes driver training. Driver Training has now been completed by 31/50 volunteer drivers and 2/3 employee drivers. The remaining drivers will complete their training by March 1, 2004.

(c) Documentation: The screening tool documents verification of the training. The Voluntary Service Assistant, who alerts the drivers when they are due for their annual review, monitors training documentation.

(d) Securing Patient Care Equipment During Transports: Bungee cords have been purchased for the drivers to secure all patient care equipment during transport and have been placed in the vehicles. The drivers have been instructed that all patient equipment is to be secured prior to departure. Signs are posted in patient transport vehicles as a reminder to secure equipment.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) monthly unannounced controlled substance inspections be performed in all areas, (b) all controlled substances inventories are verified at least every 72 hours, and (c) all excess and outdated controlled substances are destroyed quarterly.

(a) Monthly Inspections: Unannounced inspections are scheduled and are being performed monthly. The Controlled Substance Security Officer (CSSO) is sending notices to all inspectors the third week of each month. An audit of the completed inspections is being performed before the last two workdays of each month. If there are any incomplete inspections, the CSSO contacts the inspector, their supervisor, and Program Director to ensure completion of the inspection.

(b) Inventory Verification every 72 Hours: Pharmacy is inventorying all controlled substances at least every 72 hours. Documentation logs are maintained and monitored by the Pharmacy Team Leader.

(c) Quarterly Destruction of Outdated Controlled Substances: Controlled substances are being destroyed quarterly. Documentation logs are maintained and monitored by the Pharmacy Team Leader.

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Issuing bills when appropriate for fee-basis care.	$257,400
4	Monitoring delinquent obligations and promptly canceling unneeded obligations.	48,020
5	Reducing excess medical supply inventories.	14,866
	Total	$320,286

OIG Contact and Staff Acknowledgments

OIG Contact	Robert C. Zabel (816) 426-7100
Acknowledgments	Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections Katherine Owens, Healthcare Inspections Team Leader Joseph J. Duffey Lynn A. Scheffner Dennis A. Capps Robin M. Frazier James L. Garrison Oscar L. Williams C. Russell Lewis Timothy V. Halpin Patricia A. Hudon Leslie Rogers Paula J. Chapman Terrye L. Hall Randall Snow Michelle Porter

Report Distribution

VA

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
VISN Directors
Medical Center Directors

Non-VA

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
General Accounting Office
Office of Management and Budget
The Honorable Sam Brownback, U. S. Senate
The Honorable Pat Roberts, U. S. Senate
The Honorable Todd Tiahrt, U. S. House of Representatives
The Honorable Jerry Moran, U. S. House of Representatives
The Honorable Jim Ryun, U. S. House of Representatives
The Honorable Dennis Moore, U.S. House of Representatives

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.