Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Black Hills Health Care System

Report No. 03-02996-94

March 1, 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.

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Executive Summary

Introduction

During the week of October 6-10, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Black Hills Health Care System (the Health Care System), which is part of Veterans Integrated Service Network (VISN) 23. 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 131 employees.

Results of Review

Health Care System managers established an effective QM Program, and controls over purchase card transactions were adequate. In addition, Health Care System managers maintained proper accountability of equipment. To improve operations, Health Care System managers needed to:

- Ensure all required background investigations are completed for employees working in clinical laboratories.
- Ensure drivers providing patient transportation services receive annual safe driver training.
- Improve information technology security.
- Strengthen inventory management and controls over controlled substances.
- Improve the accuracy of inventory records.
- Verify data submitted by contract nursing homes.

VISN 23 and Health Care System Directors' Comments

The VISN 23 and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, page 11-14, for the full text of the Directors' comments.) We consider all review issues resolved but may follow up on implementation of planned improvement actions.

This report was prepared under the direction of Michael Guier, Director, Dallas Audit Operations Division, and Jehri Lawson, CAP Review Coordinator, Dallas Audit Operations Division.

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

Introduction

Health Care System Profile

Organization. The Health Care System provides a broad range of inpatient and outpatient services at its Fort Meade and Hot Springs, South Dakota facilities. Outpatient care is provided at 12 community-based clinics located in Eagle Butte, Isabel, McLaughlin, Mission, Pierre, Rapid City, and Winner, South Dakota; Alliance, Rushville, and Scottsbluff, Nebraska; Lame Deer, Montana; and Newcastle, Wyoming. The Health Care System is part of VISN 23 and serves a veteran population of about 38,000 in a primary service area that includes 32 counties in South Dakota, 7 counties in Nebraska, 3 counties in North Dakota, and 3 counties in Wyoming.

Programs. The Health Care System provides medical, surgical, psychiatric, domiciliary, and nursing home care. The Health Care System has 64 hospital beds, 104 nursing home beds, and 160 domiciliary beds. The Health Care System has a sharing agreement with Ellsworth Air Force Base to provide nutrition screening, podiatry, and training to military personnel in nursing and surgery.

Affiliations and Research. The Health Care System is affiliated with the University of South Dakota and supports 2 medical resident positions. In addition, the Health Care System has nursing student affiliations with South Dakota State University, the University of South Dakota, Ellsworth Air Force Base, and the South Dakota Jobs Corps. For Fiscal Year (FY) 2003, the research program had 12 active projects and a budget of $11,687. Important areas of research included cardiac care, hypertension, smoking cessation, prostate cancer education, and depression screening.

Resources. In FY 2003, the Health Care System's medical care expenditures totaled $100.2 million. FY 2003 staffing was 917 full-time equivalent employees (FTEE), including 34 physicians and 241 nursing FTEE.

Workload. In FY 2002, the Health Care System treated 19,363 unique patients, a 7.5 percent increase over FY 2001. The FY 2002 inpatient care workload totaled 2,351 patients treated and an average daily census (ADC) of 41. The ADC for the nursing home was 83 and for the domiciliary was 146 patients. The outpatient workload was 224,221 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. 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 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 Health Care System operations for FYs 2002 and 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; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts Receivable	Information Technology Security
Community Nursing Home Contracts	Laboratory Security
Contract Award and Administration	Patient Transportation Services
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Equipment Accountability	Supply Inventory Management
Government Purchase Card Program	

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-10). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and Health Care System managers until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. We sent electronic survey questionnaires to Health Care System employees, 92 of whom responded. We also interviewed 30 patients during our review. We discussed the survey results with Health Care System managers.

During the review, we also presented two fraud and integrity awareness briefings for Health Care System employees. These briefings, attended by 131 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strengths

The QM Program Was Comprehensive and Provided Effective Oversight. The Health Care System had an effective QM Program to monitor quality of care using national and local performance measures, patient safety data, and utilization reviews. Service line managers implemented improvement actions based on collected, trended, and analyzed data. They reported service line QM activities to the Executive Committee of the Governing Body, while the Organizational Improvement Coordinator reported facility-wide information. This coordinated effort provided the Health Care System Director with an effective overview of quality of care. The peer review process, which included performance measures, was linked to the reprivileging of patient care providers. The Organizational Improvement Coordinator tracked mortality and morbidity rates in order to identify trends. As part of a network-wide initiative to improve patient care, VISN 23 developed several monitors that allowed the facility to benchmark within the network.

The Government Purchase Card Program Was Effectively Managed. The Health Care System had established effective controls to ensure that purchases were appropriate and were meeting the financial and administrative requirements of the Government Purchase Card Program. Cardholder, approving official, and coordinator responsibilities were properly separated. We found no evidence that purchases exceeded warrant authority thresholds or that purchase cards were used for unauthorized purposes. Also, purchase card reconciliations and approvals were performed timely.

Equipment Accountability Was Effective. Health Care System managers were maintaining proper equipment accountability. We inventoried a judgment sample of 12 equipment items and compared the inventory results to items recorded on Equipment Inventory Listings (EIL) to determine whether managers properly accounted for their equipment. We also traced six items of equipment that we observed in various areas back to the appropriate EILs to ensure that each item was listed on an EIL. Our review showed all 18 items of equipment were properly accounted for and recorded on EILs.

Opportunities for Improvement

Clinical Laboratory Security – Background Investigations Were Needed

Condition Needing Improvement. Human Resources Management (HRM) officials did not initiate background investigations for employees working in clinical laboratories. VA policy requires licensed independent practitioners and other allied health care professionals classified in the "non-sensitive and low risk" position classification level to undergo National Agency Check with Written Inquiries investigations conducted by the Office of Personnel Management. The investigations include Federal Bureau of Investigation fingerprint checks to verify the identities of applicants and screen for criminal histories. HRM officials must initiate these investigations within 14 days of new hires beginning employment and review the investigation results to determine whether the employees are suitable for employment. HRM officials are to document their reviews by completing Certificates of Investigation, which are included in employees' personnel records.

We reviewed the personnel records of 19 employees working in clinical laboratories at the Health Care System. HRM officials had not initiated background investigations for 5 of the 19 (26 percent) employees. According to HRM officials, the five employees began their employment between 1992 and 2001. HRM officials should initiate required background investigations for employees working in clinical laboratories and review the investigation results to ensure that unsuitable persons are not employed in these positions.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director: (a) requires HRM officials to initiate, review, and document background investigations on the five employees identified during our review and (b) requires HRM officials to adhere to required background investigation procedures in the future.

The VISN and Health Care System Directors agreed and reported that background investigations were initiated in October 2003 on the five employees identified during our review. In addition, HRM officials will adhere to required background investigation procedures in the future. The improvement plans are acceptable, but we may follow up on the completion of the planned actions.

Patient Transportation Services – Driver Training Needed to Be Provided to All Drivers That Transported Patients

Condition Needing Improvement. Health Care System managers could enhance the safety of patients transported to and from the Health Care System by ensuring all drivers (employees and volunteers) receive required driver training. VA policy requires managers to develop and implement a Motor Vehicle Safety Program at VA facilities where vehicles are regularly

operated for official business. This program provides drivers safe driving instruction, including the requirement to use safety belts, shoulder harnesses, and defensive driving techniques. VA facilities are required to present at least one annual safe driver training class for employees and volunteers that transport patients. We reviewed the training records for a judgment sample of six drivers (three employees and three volunteers) and found that one driver had not received the required safe driver training. Health Care System managers need to ensure that all drivers who transport patients receive the required safe driver training by reviewing the drivers' training records and providing training as needed.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Health Care System Director implements controls to ensure all employees and volunteers that transport patients receive annual safe driver training.

The VISN and Health Care System Directors agreed and reported that safe driver training was scheduled in January 2004 for the one employee who had not received the training at the time of our review. The improvement plans are acceptable, but we may follow up on the completion of the planned actions.

Information Technology Security – Security Needed to Be Strengthened

Condition Needing Improvement. Health Care System managers needed to strengthen information technology (IT) security. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, and misuse. Our review showed that recently hired employees received computer security awareness training and experienced users received annual refresher training. In addition, password controls for the Local Area Network (LAN) and the Veterans Health Information Systems and Technology Architecture (VISTA) were adequate. However, we identified four areas that required management attention.

System Access. Health Care System managers did not ensure access privileges were terminated in a timely manner. VA policy requires facilities to terminate access privileges when employees leave the organization. The Health Care System's local policy required Automated Data Processing Application Coordinators, supervisors, and, ultimately, department heads to ensure access privileges of separating personnel were terminated by Information Resources Management (IRM) personnel. We reviewed a judgment sample of 10 employees separated between July 31 and September 30, 2003, and found that 5 of the 10 employees still had LAN access. Seven of the 10 employees still had access to VISTA.

Contingency Plan. The Health Care System's contingency plan could be improved. A contingency plan should address procedures for responding to emergencies, backing up data files and storing backup tapes offsite, ensuring that essential business functions can be conducted after disruption to IT support, and restoring facility processing capability. In addition, the

contingency plan must identify all resources needed to support system functions in the event of a disaster. The Health Care System had developed a contingency plan, but the plan did not include a comprehensive listing of all resources needed to support critical system functions. This listing is essential because it facilitates continuity of operations and helps prevent major disruptions in patient care during an unexpected system failure. In addition, although the Health Care System's contingency plan called for backup tapes to be stored offsite, this was not being done.

Physical Security. Government IT standards require preventive measures such as having plastic covers available to protect IT equipment from water damage. However, equipment was not protected against activation of overhead sprinkler systems in either the Fort Meade or Hot Springs computer rooms.

Background Investigations. VA policy requires that HRM officials ensure that a background investigation of the Information Security Officer (ISO) is done. Although the ISO had been serving in that capacity for almost 2 years, HRM officials had not initiated a background investigation.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director takes actions to: (a) promptly terminate systems access of separated employees; (b) add a listing of all critical IT equipment to the contingency plan; (c) store backup tapes offsite; (d) have plastic covers available to protect IT equipment in computer rooms from water damage; and (e) complete a background investigation of the ISO.

The VISN and Health Care System Directors agreed and reported that the Health Care System would terminate systems access for the separated employees identified in our review by January 2004. The Directors also reported that a listing of all critical IT equipment would be added to the contingency plan and that backup tapes would be stored offsite by January 2004. In addition, the Health Care System is purchasing plastic covers to protect IT equipment in computer rooms and is in the process of completing a background investigation on the ISO. The improvement plans are acceptable, but we may follow up on the completion of the planned actions.

Controlled Substances Accountability – Inventory Management and Selected Controls Needed Improvement

Condition Needing Improvement. Health Care System managers needed to improve inventory management of controlled substances and related internal controls. We reviewed pharmacy accountability policies and records to determine if controls were adequate to prevent the loss or diversion of drugs and to ensure that pharmacy personnel properly accounted for controlled substances. We also observed unannounced monthly inspections and interviewed pharmacy personnel. Our review showed that controls over security and accountability were generally effective. Pharmacy staff maintained a perpetual inventory of all controlled substances. In addition, controlled substances inspectors were adequately trained and properly conducted

monthly inspections of controlled substances. However, we identified three areas that required management attention.

Stock Levels. Veterans Health Administration (VHA) policy requires pharmacies to use the prime vendor inventory management software program to manage inventory levels. The software program was designed to minimize replenishment costs, which includes both order costs and carrying costs. However, Health Care System managers did not use the program to manage inventory levels. Instead, managers relied on their professional judgment and experience to determine how much inventory to stock and when to reorder controlled substances. We compared inventory levels for 10 controlled substances to actual usage data and found that 4 of the 10 controlled substances had inventory levels that, in our view, were excessive. The excessive inventory levels ranged from 30 to 80 days of supply. High inventory levels increase carrying costs, the risk of diversion, and the likelihood that controlled substances will expire.

Access to Controlled Substances. VHA policy requires that facilities limit access to controlled substances storage areas to less than 10 employees within a 24-hour period. Our review showed that 21 individuals had access to the pharmacy's controlled substances storage vault at Fort Meade within a 24-hour period, while 10 had access at Hot Springs.

Appointment of Inspectors. VHA policy requires that facilities appoint controlled substances inspectors in writing for a term not to exceed 3 years. The eight inspectors at Fort Meade had not been appointed in writing. In addition, four of the eight inspectors at Fort Meade had served for terms longer than 3 years during their current appointments.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Health Care System Director requires pharmacy managers to: (a) use the prime vendor inventory management software program to manage inventory levels of controlled substances; (b) limit access to controlled substances storage areas to less than 10 employees within a 24-hour period; and (c) appoint controlled substances inspectors in writing for terms not to exceed 3 years.

The VISN and Health Care System Directors agreed and reported that the prime vendor inventory management software program will be implemented by March 2004 to determine if it will be useful in managing controlled substances, which have unpredictable and inconsistent usage. In addition, pharmacy managers have limited access to controlled substances storage areas to less than 10 employees within a 24-hour period and appointed controlled substances inspectors in writing for terms not to exceed 3 years. The improvement plans are acceptable, and we consider the issues resolved.

Supply Inventory Management – Accuracy of Inventory Records Needed Improvement

Condition Needing Improvement. Health Care System managers did not ensure that supply personnel maintained accurate inventory records. VHA policy requires that medical facilities

use the automated Generic Inventory Package (GIP) to manage inventories. Managers should use the automated system to establish stock levels, analyze usage patterns, and determine order quantities. At the time of our review, the Health Care System stocked 1,373 line items valued at about $208,000. We observed physical inventories for a judgment sample of 26 line items valued at about $7,500 and compared actual quantities on hand to quantities reported in GIP inventory records to determine whether managers were using accurate data to manage their inventories. Our review showed that the quantities recorded in GIP inventory records were inaccurate for 6 of the 26 (23 percent) line items, with 5 shortages totaling about $600 and 1 overage totaling $52. Without accurate inventory records, managers cannot readily establish reorder points and maintain appropriate stock levels.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Health Care System Director requires (a) managers to emphasize the need to maintain accurate inventory records and (b) supply personnel to reconcile differences and correct inventory discrepancies as appropriate.

The VISN and Health Care System Directors agreed and reported that managers are emphasizing the need to maintain accurate inventory records. In addition, supply personnel are taking appropriate actions to reconcile inventory differences. The improvement plans are acceptable, and we consider the issues resolved.

Community Nursing Home Contracts – Contracting Personnel Should Verify Data Submitted by Contract Nursing Homes

Condition Needing Improvement. VA medical facilities contract with community nursing homes to provide care for certain eligible veterans. Generally, VA policy limits contract rates to the applicable Medicaid rates plus a factor of not more than 15 percent for ancillary services, such as drugs and laboratory tests. Medicaid rates are established by the states based upon the levels of care required by the patients and the costs incurred by the nursing homes. Patients placed in community nursing homes by the Health Care System may be classified in as many as 44 levels of care based upon their medical conditions and their ability to perform activities of daily living. In FY 2003, the Health Care System spent about $310,000 for contract nursing home care.

Health Care System contracting personnel, in compliance with VA policy, negotiated contract nursing home rates equal to the Medicaid rates plus 15 percent. However, contracting personnel relied on the nursing homes to determine the levels of care required. Also, contracting personnel relied on the nursing homes to provide accurate cost data and did not verify that the nursing homes provided VA the same cost data that were used by the states to establish the Medicaid rates. To ensure that VA pays appropriate rates for contract nursing home care, Health Care System personnel should review patients' medical records and evaluate the reasonableness of patient classifications reported by the nursing homes. In addition, contracting personnel should

verify that the nursing homes provide VA the same cost data that were used to establish the Medicaid rates.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Health Care System Director: (a) requires Health Care System personnel to evaluate the reasonableness of patient classifications reported by the contract nursing homes and (b) requires contracting personnel to obtain cost data used by the states to establish Medicaid rates for nursing home care.

The VISN and Health Care System Directors agreed and reported that Health Care System personnel are now evaluating the reasonableness of patient classifications reported by contract nursing homes. In addition, contracting personnel are obtaining the cost data used by the states to establish appropriate Medicaid rates for nursing home care. The improvement plans are acceptable, and we consider the issues resolved.

Appendix A

VISN 23 and Health Care System Directors' Comments

Department of Veterans Affairs **Memorandum**

Date: December 18, 2003

From: Director, VISN 23

Subject: Response to OIG CAP Review at VA Black Hills Health Care System

To: Director, Dallas Audit Operations Division

Please find attached the comments from the Director, VA Black Hills Health Care System on pages 12-14.

/S/

ROBERT A. PETZEL, M.D.

Health Care System Director's Comments to Office of Inspector General 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)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Health Care System Director: (a) requires HRM officials to initiate, review, and document background investigations on the five employees identified during our review and (b) requires HRM personnel to adhere to required background investigation procedures in the future.

Concur **Target Completion Date:** October 2003

a) HRM has initiated the background investigations on the five employees identified during the review.

b) HRM will adhere to required background investigation procedures in the future.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Health Care System Director implements controls to ensure all employees and volunteers that transport patients receive annual safe driver training.

Concur **Target Completion Date:** January 2004

The one employee who had not had annual safe driver training is scheduled. This will be routinely scheduled.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Health Care System Director takes actions to: (a) promptly terminate systems access of separated employees; (b) add a prioritized listing of all critical IT equipment to the contingency plan; (c) store backup tapes offsite; (d) have plastic covers available to protect IT equipment in computer rooms from water damage; and (e) complete a background investigation of the ISO.

Concur **Target Completion Date:** January 2004

a) Separated employees have had systems access terminated.

b) Adding a prioritized listing of all critical IT equipment to the contingency plan will be accomplished by January 2004.

c) Storing backup tapes offsite will be accomplished by January 2004.

d) Plastic covers are being ordered to protect IT equipment in computer rooms from water damage.

e) Completion of a background investigation of the ISO this is in progress.

OIG Suggestion(s)

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the Health Care System Director requires pharmacy managers to: (a) use the prime vendor inventory management software program to manage inventory levels of controlled substances; (b) limit access to controlled substance storage sites to less than 10 employees within a 24-hour period; and (c) appoint controlled substance inspectors in writing for terms not to exceed 3 years.

Concur **Target Completion Date:** March 2004

a) The prime vendor inventory management software program to manage inventory levels of controlled substances will be implemented to determine if it will be applicable to this class of drugs due to unpredictable and inconsistent usage of controlled substances.

b) Limiting access to controlled substance storage sites to less than 10 employees within a 24-hour period-has been completed.

c) Appointing controlled substance inspectors in writing for terms not to exceed 3 years-has been completed.

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the Health Care System Director requires (a) managers to emphasize the need to maintain accurate inventory records and (b) supply personnel to reconcile differences and correct inventory discrepancies as appropriate.

Concur **Target Completion Date:** June 2004

a) Managers emphasizing the need to maintain accurate inventory records-has been completed

b) Having supply personnel reconcile differences and correct inventory discrepancies as appropriate-is in process. Supply personnel will enter all inventory primary and secondary into GIP.

Suggested Improvement Action 3. We suggest that the VISN Director ensure that the Health Care System Director: (a) requires appropriate Health Care System personnel to evaluate the reasonableness of patient classifications reported by the contract nursing homes and (b) requires contracting personnel to obtain cost data used by the states to establish Medicaid rates for nursing home care.

Concur **Target Completion Date:** December 2003

a) Staff working with contract homes will require appropriate Health Care System personnel to evaluate the reasonableness of patient classifications reported by the contract nursing homes.

b) Contracting staff will require contracting personnel to obtain cost data used by the states to establish Medicaid rates for nursing home care.

OIG Contact and Staff Acknowledgments

OIG Contact	Jehri Lawson (214) 253-3304
Acknowledgments	William Bailey
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Appendix C

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