Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan

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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.
- 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.

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

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Introduction

During the week of September 15-19, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Ann Arbor Healthcare System (referred to as 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 about 170 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

This CAP review focused on 16 areas. As indicated below there were no concerns identified in seven of the areas. The remaining nine areas resulted in recommendations or a suggestion for improvement.

The System complied with selected standards in the following areas:

- Agent Cashier
- Clinical Laboratory Security
- Contracting
- Human Research Studies
- Patient Waiting Times
- Quality Management
- Supply Processing and Distribution

Based on our review of these seven areas, the following organizational strengths were identified:

- An effective QM program.
- Research service compliance with stand down directives.
- Revenues generated from selling support services.
- Reduced patient waiting times.
- Effective credentialing and privileging processes.

Areas that require improvement include:

- Accounts Receivable and Undelivered Orders
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Medical Care Collections Fund
- Part-Time Physicians' Time and Attendance
- Toledo Community-Based Outpatient Clinic Physical Security

To improve operations, the following recommendations were made:

- Correct safety and environmental deficiencies.
- Perform annual nonexpendable equipment inventories and update equipment inventory lists.
- Ensure physicians work their approved tours of duty and strengthen timekeeping controls.
- Improve Medical Care Collections Fund (MCCF) billing timeliness.
- Improve controls over accounts receivable and undelivered orders.
- Strengthen administrative controls over the Government purchase card program and monitor card purchases.
- Improve controlled substances security and control procedures at the Toledo Community-Based Outpatient Clinic (CBOC).
- Improve physical security at the Toledo CBOC.

A suggestion for improvement was made in the following area:

- Enhance controls for information technology security measures.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, Chicago Regional Office of Healthcare Inspections, and Ms. Katherine Owens, CAP Review Coordinator, Chicago Regional Office of Healthcare Inspections.

VISN 11 and System Director Comments

The VISN 11 Director and the System Director agreed with the CAP review findings, recommendations, and suggestion, and provided acceptable improvement plans. (See Appendices A and B, pages 18-26 for the full text of the Directors' comments. We will follow up on the implementation of recommended improvement actions until they are completed.

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

Introduction

Healthcare System Profile

Organization. Located in Ann Arbor, Michigan, the System consists of a tertiary care hospital, an extended care center, and CBOCs in Ann Arbor, Flint, and Jackson, Michigan, and Toledo, Ohio. The System serves a primary service area of 17 counties in southeast Michigan and northwest Ohio. The System's referral service area includes the entire lower peninsula of Michigan.

Programs. The System provides comprehensive primary, medical, surgical, mental health, and geriatric services. It has 100 acute care beds and 45 nursing home care beds, and offers rehabilitation medicine, neurology, and dental services. The System has sharing agreements with the University of Michigan (UM) to provide additional surgical services and endoscopy services.

Affiliations. The System is affiliated with the UM Medical School and supports 110 residents, with over 500 residents, interns, and nursing students trained each year. Additionally, the System has affiliations with over 40 area universities and colleges supporting training in dentistry, dental hygiene, pharmacy, social work, nursing, psychology, speech pathology, and physical therapy.

Research. The System has a large Health Services Research and Development program. During Fiscal Year (FY) 2002, there were 120 active Research Principal Investigators and 349 active research projects. The Geriatric Research, Education, and Clinical Center (GRECC), 1 of only 22 in the VA system, conducts basic biomedical research, applied clinical research, and health systems research in the cost and quality of health care. The GRECC also provides continuing education programs for professionals in geriatrics and develops clinical model care programs. The research funding for FY 2002 from VA, National Institutes of Health, and industry sources totaled over $25.7 million.

Resources. The budget for FY 2002 totaled approximately $141.7 million; the FY 2003 budget totaled approximately $158.3 million. FY 2002 staffing was 1,209 full-time employee equivalents (FTEE); FY 2003 staffing was 1,233 FTEE, which included 106 physician and 393 nursing FTEE.

Workload. In FY 2002, the System treated 31,626 unique patients. For FY 2003 (through June 2003), 32,166 unique patients were treated. Inpatient workload totaled 4,345 discharges for FY 2002. For FY 2003 (through July 2003), inpatient discharges totaled 3,725. The average daily census through July 2003 was 79 for acute care and 31 for the nursing home care unit. The outpatient workload for FY 2002 totaled 213,790 visits. For FY 2003 through June 2003, workload totaled 176,663 outpatient 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 and benefits services. The objectives of the CAP review 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.

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 and Undelivered Orders	Human Research Studies
Agent Cashier	Information Technology Security
Clinical Laboratory Security	Medical Care Collections Fund
Contracting	Part-Time Physicians' Time and Attendance
Controlled Substances Accountability	Patient Waiting Times
Environment of Care	Quality Management
Equipment Accountability	Supply Processing and Distribution
Government Purchase Card Program	Toledo Community-Based Outpatient Clinic Physical Security

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 System employees and 84 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. The survey results were shared with the System's managers.

We also presented three fraud and integrity awareness training sessions for the System employees. About 170 employees attended the training, 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 2001, FY 2002, and FY 2003 through August 2003, and it was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make recommendations and a suggestion for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective action is implemented. The suggestion pertains to an issue that should be monitored by VISN and System managers until corrective actions are completed. For activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable findings.

Results of Review

Organizational Strengths

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

Managers developed and implemented a Safety Checklist Program in the intensive care units that was recognized in the Joint Commission's Journal on Quality Improvement (recently renamed Joint Commission's Journal on Quality and Safety). Twice daily, employees from various disciplines (for example, housekeeping, nursing, and respiratory therapy) completed safety checklists. This program increased employee awareness of safety hazards in their areas and helped to encourage a culture of continuous safety awareness.

Research Service Complied With Stand Down Directives. Veterans Health Administration (VHA) initiated a 90-day national stand down of human subjects research from March 10 through June 6, 2003. The stand down did not mean that research activities would cease but that each facility conducting human research would proactively review their program. The purpose of the stand down was to ensure that the rights of human subjects were protected and that research was conducted in an ethical manner. We interviewed Research Service managers and reviewed the service's policies and procedures, Institutional Review Board minutes, Research Service employees' training records, and appropriate databases. We found that the System's research program was in compliance with the stand down directives.

Research Service employees identified a deficiency in their process of documenting subject consents in patients' medical records. To correct this condition, employees now scan each consent form into the electronic medical record prior to a patient's participation in a research study.

Provision of Support Services Generated Revenue. System managers negotiated 12 selling agreements with the affiliated medical school, other Government agencies, and private organizations to provide health care support services (for example, cardiac nuclear medicine scan interpretation services). The selling agreements included the necessary certifications, legal and technical reviews, and reasonable cost/price analyses.

Revenues exceeded expenses in all of the agreements. From FY 2001 to the time of our review, reimbursements from the agreements exceeded expenses by a total of $851,745.

Patient Waiting Times Were Reduced. System managers significantly reduced patient waiting times and increased patient satisfaction. Managers hired additional clinical employees to meet increased patient demand. Saturday and evening clinics were added in response to the increased workload.

Credentialing and Privileging Processes Were Effective. Physicians obtained continuing education appropriate for the type of care they provided. Providers' clinical privileges were reviewed every 2 years and privileges were granted with adequate input and approval from those providing professional supervision. We reviewed a judgment sample of 20 physicians' credentialing and privileging (C&P) files and determined that C&P documentation for each physician was adequate.

Opportunities for Improvement

Environment of Care – Safety and Environmental Deficiencies Needed To Be Corrected

Conditions Needing Improvement. Managers generally maintained a clean environment and took actions to correct identified deficiencies. However, managers needed to ensure that cleaning chemicals, patient care products, and sharp instruments were secured in patient treatment areas. Managers also needed to ensure that medications were secured and that employees monitored temperatures of refrigerators containing medications on a daily basis. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors. In this regard, three outpatient treatment areas did not ensure auditory privacy for patients, and computer monitors were positioned so that patients and others could read sensitive information.

Security of Cleaning Chemicals, Patient Care Products, and Sharp Instruments. There were unsecured cleaning products and unlabeled containers on housekeeping carts in patient treatment areas. We found unsecured bottles of hydrogen peroxide and isopropyl alcohol, as well as unsecured scissors, hemostats, and tweezers in outpatient examination rooms and on inpatient units. Cleaning chemicals, patient care products, and sharp instruments need to be secured to prevent accidental or intentional injury to patients, employees, and visitors.

Medication Security and Monitoring of Refrigerator Temperatures. We found an open medication cart in the hallway on the surgical unit. A nurse was administering medications in a patient room; however, the cart was left unattended in the hallway. We found that the door to the medication room in the Emergency Department was not locked. During our tour of the Medical Intensive Care Unit (MICU), the Nurse Manager informed us that the housekeeper assigned to the MICU knew the numeric code to open the locked door of the medication room. Housekeeping employees are not authorized to have access to medication rooms and the numeric code was changed that day. Medication carts and medication rooms must be secured at all times to prevent access by unauthorized persons. We noted on several patient care units that employees did not consistently record the temperatures of the refrigerators containing medications. Daily monitoring and documenting of the refrigerator temperatures is required to ensure that the medications are kept at the proper temperature.

Patient Privacy. Patient intake areas in the urgent care and triage room and urology clinic did not ensure privacy while employees were interviewing patients. Also, patients receiving treatment in the hematology and oncology treatment room were able to hear employees converse on the telephone or with other patients. Patients in each of these areas were able to view computer monitors displaying other patients' sensitive information.

Recommended Improvement Action 1. We recommended the VISN Director ensure that the System Director requires that: (a) cleaning chemicals, patient care products, and sharp instruments are secured; (b) medications are secured to prevent access by unauthorized persons, and temperatures of refrigerators containing medications are monitored daily; and (c) patient privacy is maintained in outpatient intake and treatment areas.

The VISN Director and the System Director agreed with the findings and recommendations. Deficiencies have been addressed and controls have been added to provide compliance with policies and procedures governing (a) security of cleaning products, sharp instruments, and medications; (b) temperature monitoring of medication refrigerators; and (c) patient privacy. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Equipment Accountability – Inventories Needed To Be Performed and Equipment Inventory Lists Needed To Be Updated

Conditions Needing Improvement. Employees needed to perform inventories of nonexpendable equipment (equipment costing more than $5,000 with an expected useful life of more than 2 years) and to correct and update equipment inventory lists (EILs). System policy requires that all nonexpendable equipment be physically counted at least once a year. Acquisition and Materiel Management Service (A&MMS) employees are responsible for ensuring that the services perform their own physical inventories of assigned equipment and update EILs when equipment is purchased, moved, or excessed. The services are then required to provide the information to A&MMS employees who are responsible for entering the information into the equipment inventory management database. To determine if the equipment inventory program was effective, we interviewed A&MMS employees and reviewed equipment inventory records. We found that A&MMS employees were not ensuring that annual inventories of nonexpendable equipment were performed. As a result, the EILs were not updated.

We found that the last complete inventory of all nonexpendable equipment was conducted more than 2 years ago. A&MMS managers stated that the lack of adequate equipment accountability occurred because an inventory management specialist position was vacant from March 2001 until June 2003. Several weeks prior to our CAP review, the new specialist initiated a program to perform systematic inventories. At the time of our review, services had not conducted sufficient inventories, nor had A&MMS employees verified sufficient inventories to draw conclusions regarding the reliability of the EILs.

As of September 2003, the System had 218 EILs (equipment value = $26.5 million). Additionally, the System had 468 new computers (equipment value = $400,000) in the warehouse that managers planned to place into service but had not been recorded on the

EILs. Until System managers establish an accurate system of equipment accountability, $26.9 million in equipment is at risk for loss or theft.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director requires that A&MMS supervisors perform inventories of nonexpendable equipment annually and update EILs.

The VISN Director and the System Director agreed with the findings and recommendation. Inventories of nonexpendable equipment will be completed. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Part-Time Physicians' Time and Attendance – Physicians Needed To Work Their Approved Tours of Duty and Timekeeping Controls Needed To Be Strengthened

Conditions Needing Improvement. Controls over part-time physicians' time and attendance needed to be improved. Although there was no indication that part-time physicians were paid for more time than they worked, official timecards did not always reflect the tours of duty they actually worked. Timekeepers did not have personal knowledge of either the tours of duty or the number of hours that part-time physicians actually worked. In addition, Fiscal Service employees had not provided annual refresher timekeeper training and had not performed periodic desk audits of timekeeper functions. These conditions existed because System policy and practice did not fully comply with VHA requirements.

Tours of Duty. VHA policy requires that all employees with fixed tours of duty work the tours of duty they are assigned. All VA employees, including physicians, must request modifications to their tours of duty in advance of the beginning of each pay period by obtaining approval from their supervisors. Supervisors must ensure that official time and attendance records are accurate. Because the System's time and attendance policy and practice for part-time physicians did not fully comply with VHA policy, timekeepers periodically submitted inaccurate timecards.

Although all 15 part-time physicians in our sample had established, official, and fixed tours of duty, local policy allowed part-time physicians to deviate from them. Deviations from established tours of duty were submitted to timekeepers on manually prepared time and attendance reports. Local policy required supervisors' advance approval of tour changes. Timekeepers must be informed of the changes as soon as possible, but the policy permitted submittal of these reports as late as the end of each pay period. Also, in our review of Surgical Service, we found no evidence that physicians actually obtained prior approval before changing their established tours. The manually prepared time and attendance reports that physicians submitted to the timekeepers were not countersigned

by their supervisors. We were not presented with any other official record indicating prior approval by supervisors of changes to tours of duties.

In addition, the manually prepared time and attendance reports did not always agree with time and attendance data input by timekeepers. We reviewed time and attendance records of five part-time surgeons for one pay period each, occurring between July and September 2003. In two cases, the tours of duty listed on the official timecards did not agree with the manual time and attendance reports submitted to timekeepers by physicians.

During the week of the CAP review, we attempted to locate 15 part-time physicians assigned to Surgical Service during their scheduled tours of duty. Four physicians were on approved leave and five were where their established tours of duty or timekeeper records indicated they should have been. The remaining six physicians were subsequently accounted for, but were working tours of duty for which timekeepers had no documented approval. In one case, the physician had submitted a manual time and attendance report to his timekeeper indicating scheduled leave for that day, although he had not submitted an official leave request. The physician telephoned us later and reported that he actually worked that morning and had not taken leave. The timekeeper was not aware that the physician had not taken leave and would have submitted an inaccurate timecard based on the manual time and attendance report that the physician had submitted.

Timekeeper Knowledge of Physician Attendance. VA and VHA policies require that timekeepers have personal knowledge of the whereabouts of employees for whom they are responsible. The Surgical Service timekeeper posted the tours of duty that part-time physicians listed on their manually prepared time and attendance reports to official timecards. However, because part-time physicians in Surgical Service typically did not submit these reports to the timekeeper until at or near the end of pay periods, which was allowed by local policy, the timekeeper was unable to monitor part-time physicians' time and attendance.

The Surgical Service timekeeper told us that she rarely knew which physicians were supposed to be on duty at any given time. This timekeeper also told us that some physicians worked different tours of duty virtually every pay period and did not communicate their actual tours until the last day of the pay period. The timekeeper was responsible for time and attendance reporting for 27 part-time physicians. Because the part-time physicians did not adhere to their established tours of duty and did not timely notify the Surgical Service timekeeper of deviations, the Surgical Service timekeeper had no effective means of monitoring their time and attendance.

Refresher Training and Desk Audits. The Surgical Service timekeeper had not received required annual VHA time and attendance policy and procedures training. VHA policy requires annual refresher training for timekeepers and periodic desk audits of

timekeeping functions. A Fiscal Service supervisor stated that they had not conducted annual timekeeper refresher training as often as required. System management reported that training was last conducted during the April-May 2002 time period. However, the Surgical Service timekeeper missed that session. As a result, she had not attended required training for at least 3 years. Additionally, Fiscal Service employees had not performed annual desk audits of timekeepers' duties and could not remember when they had last conducted them. There was no documentation showing when the last audits were performed.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director requires that: (a) local part-time physician time and attendance policy is further refined to ensure that physicians either work their established tours of duty, or obtain their supervisors' advance approvals before changing tours; (b) timekeepers be informed of supervisors' written advance approval of changes to established tours as soon as possible; and (c) Fiscal Service employees conduct annual refresher training for timekeepers and perform annual timekeeper desk audits.

The VISN Director and the System Director agreed with the findings and recommendations. The policy governing part-time physicians' time and attendance will be refined, timekeepers will be informed of changes to established tours of duty as soon as possible, mandatory annual refresher training for timekeepers was scheduled, and a schedule for performing timekeeper desk audits was developed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Timely Billing For Services Provided Needed To Be Improved

Conditions Needing Improvement. MCCF employees were properly verifying patient insurance, identifying billable episodes of care, and billing for the correct amounts. However, improvement was needed in timely billing for services provided. The "Unbilled Amounts Report" dated September 5, 2003, shows that there were 13,013 claims for episodes of care totaling $7,153,918 that MCCF employees had not processed. The treatment dates range from September 1, 2002, through September 5, 2003. Some bills were delayed nearly a year after the receivable was established before being entered into the Financial Management System. While we were not able to determine how many of the treatments were billable and collectable, actions need to be taken as soon as MCCF employees are notified of treatment provided. No funds can be recovered until the insurance companies have been billed.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director takes action to timely pursue MCCF receivables.

The VISN Director and the System Director agreed with the findings and recommendation. The System is taking action to reduce unbilled amounts. The improvement plan is acceptable, and we will follow up on the planned actions until it is completed.

Accounts Receivable and Undelivered Orders – Controls Needed To Be Improved

Conditions Needing Improvement. Fiscal Service employees needed to reconcile, review, monitor, and aggressively pursue collection of outstanding accounts receivable (AR) and promptly cancel unneeded obligations.

AR Activities. VA policy requires AR general ledger balances to be reconciled monthly with the subsidiary ledgers. Further, VA policy requires AR to be aggressively pursued for collection, and prompt action taken on delinquent receivables (over 90 days) to include referral to a collection agency or write-off.

AR general ledgers were not reviewed or reconciled monthly with subsidiary ledgers as required. At the time of our review, the System had 408 AR (value = $2,382,253). Of these, 239 (59 percent) were more than 90 days old (value = $274,447). We found 57 AR (value = $19,955) for services provided to the Department of Defense (DoD) that had no follow-up collection activity. As a Government agency, DoD is required by law to settle AR with other agencies. Therefore, these receivables have 100 percent collection potential. If no payment is received after the third notice for a Federal AR, Fiscal Service employees should send a fourth demand to the delinquent agency's Chief Financial Officer. This was not done. Follow-up actions were needed on the remaining $254,492 in non-government agency delinquent AR. Fiscal Service employees should consider these AR for referral to consumer reporting agencies, private collection agencies, Regional Counsel, or the Department of Justice for collection. Fiscal Service employees should also pursue follow-up actions on delinquent receivables through telephone calls, offsetting amounts VA owes vendors, and payroll deductions for Government employees.

Undelivered Orders. Fiscal Service employees needed to review and cancel obligations for delinquent undelivered orders to make the funds available for other System needs. A monthly reconciliation of undelivered orders should be performed to identify orders inactive for 90 days or more. Outstanding undelivered orders inactive for more than 90 days should be reported to A&MMS employees for review and verification of the validity of the orders. If the funds are not obligated in the current fiscal year, they are lost. As of August 30, 2003, the System had 53 current-year undelivered orders (value = $38,124) that were more than 90 days old and no longer needed. This occurred because Fiscal Service employees had not performed monthly reviews of undelivered orders to identify obligations that were no longer needed and could be canceled. Fiscal Service managers

agreed to take prompt action to review and, if appropriate, deobligate the orders before the close of the current fiscal year.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director requires: (a) Fiscal Service employees reconcile, review, and aggressively pursue AR for collection; and (b) Fiscal Service employees review delinquent undelivered orders and unneeded orders are canceled and funds are deobligated.

The VISN Director and the System Director agreed with the findings and recommendations. Fiscal Service employees are pursuing AR for collection. Undelivered orders are being routinely reviewed and unneeded orders are canceled, and the funds deobligated. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Administrative Controls and Purchase Monitoring Needed To Be Strengthened

Conditions Needing Improvement. System managers and the Government Purchase Card Coordinator needed to improve the administration of the purchase card program. We reviewed purchase card usage from June 1, 2002, through June 30, 2003, and found that cardholders reconciled purchases timely, purchase cards were deactivated when cardholders separated, monthly account audits were conducted, and cards were properly secured to prevent unauthorized use. None of the 15 merchants in our sample appeared in the Health and Human Services' Excluded Parties Listing System (individuals barred from doing business with the Government). However, there were four areas where management could improve the purchase card program.

Segregation of Duties. VA facilities are required to use Government purchase cards for small purchases of goods and services. The program requires controls to include segregation of key duties and completion of required annual purchase card training. Coordination of the purchase card program was a primary duty assigned to Fiscal Service. The Government Purchase Card Coordinator was also the primary Billing Coordinator and the Dispute Officer. The Coordinator's duties also included conducting monthly cardholder statement audits. According to VA policy, key positions must be properly segregated to prevent a single individual from having the ability to initiate, record, reconcile, review, and approve purchase card transactions. During our review, the billing coordinator and dispute officer duties were reassigned.

Adequacy of Training. Purchase card training was documented for key program officials, cardholders, and approving officials. However, 11 of 126 cardholders (9 percent) and 5 of 67 approving officials (7 percent) had not completed mandatory annual purchase card

training. During our review, managers directed all cardholders and approving officials to complete the training or their purchase card privileges would be suspended.

Monitor Purchases. Approving officials did not ensure that all purchases were appropriate. To circumvent the $2,500 purchase limitation, 4 cardholders split 8 purchases totaling $27,508 into 24 transactions. VA policy prohibits split purchases. Three of the 4 cardholders are included in the 11 discussed above as requiring annual training on procedures for making purchases with Government purchase cards.

Monitor Issuance of Temporary Warrants. We identified three improper purchases valued at $14,639. On November 4, 2002, a temporary warrant was issued to a cardholder to increase the cardholder's single purchase limit of $2,500 to $25,000. However, the cardholder failed to pass the acquisition training required to maintain the warrant. Although the temporary warrant expired on May 2, 2003, three purchases ranging from $2,511 to $6,064 were authorized and charged to the card after the temporary warrant expiration date. One item was purchased on July 30, 2003, and the other two on August 19, 2003. The cardholder's spending limit was not decreased back to $2,500 (the maximum per purchase limit without a warrant) until August 29, 2003.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the System Director takes actions to: (a) segregate the key duties of the purchase card program, (b) ensure that cardholders and approving officials complete the required training, (c) ensure that purchases are monitored to prevent cardholders from splitting purchases and exceeding their assigned limits, and (d) monitor the expiration dates of temporary warrants.

The VISN Director and the System Director agreed with the findings and recommendations, and submitted plans to segregate the key duties of the purchase card program, ensure that cardholders and approving officials complete required training, and ensure that purchases are monitored to prevent cardholders from splitting purchases and exceeding assigned limits. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability at the Toledo Community-Based Outpatient Clinic – Security And Control Procedures Needed To Be Improved

Conditions Needing Improvement. Accountability of controlled substances at the Toledo CBOC Pharmacy Service was generally effective. The number of employees with access to the pharmacy narcotics vault was within permitted limits. Pharmacy Service employees maintained a perpetual inventory of controlled substances and conducted required Drug Enforcement Administration biennial inventories. Pharmacy

Service employees had also conducted required quarterly destructions of expired and unusable drugs. However, there were four conditions that needed corrective actions.

Accuracy of Controlled Substances Inspections. An OIG-caused unannounced inspection of Toledo CBOC pharmacy controlled substances revealed that counts of two drugs, Propoxyphene, 650 milligram tablets, and Oxycodone HCL, 40 milligram tablets, were not in agreement with the balances shown on the inventory control sheets. Further review disclosed that these drugs were dispensed to patients, but a Pharmacy Service employee did not properly annotate the control sheets to show that the controlled substances were removed from the narcotics vault. We also found 14 non-controlled substances in the narcotics vault that needed to be removed and stored in the general pharmacy area.

Controlled Substances Inspectors. System managers needed to ensure that monthly controlled substances inspections were performed in accordance with VHA policies. During the OIG-caused unannounced inspection of the Toledo CBOC pharmacy, we determined that System inspectors did not identify and remove expired controlled substances and damaged (crushed or broken) medications from inventory. Additionally, they needed to verify the amount of controlled substances received from the warehouse and placed into the pharmacy's inventory. The System inspectors were not reconciling receiving reports to stock on hand to determine whether there were any shortages or overages. The Controlled Substances Security Officer reported reviewing the amounts received and reconciling the amounts placed in stock, but controlled substances inspectors should also perform reconciliations as part of their inspections.

The inspectors did not routinely reconcile "Security Prescription Forms" (VA Form-10-2577) on hand to the records maintained in Pharmacy Service. Pharmacy Service employees were not signing for the prescription forms received. By comparing the forms on hand in the narcotics vault to a logbook maintained in the pharmacy, we determined that there were no missing forms. Pharmacy Service employees needed to properly account for forms received to detect and prevent the loss, theft, or illegal dispensing of controlled substances.

Unannounced Controlled Substances Inspections. VHA policy requires that monthly controlled substances inspections be unannounced and random. System inspectors notified Pharmacy Service employees of upcoming inspections prior to their arrival. The inspections were delayed or postponed if Pharmacy Service employees were too busy to assist the inspectors. This practice could compromise the accountability and security of controlled substances. Additionally, the timing of monthly controlled substances inspections established a predictable pattern and reduced their effectiveness in detecting and preventing potential loss or theft of controlled substances. The inspectors conducted 26 of the last 27 inspections during the last 2 weeks of each month. The timing of the inspections should be more random.

Alarm Response Time. We tested the response time of a contract security employee by activating the panic alarm in the Pharmacy Service waiting area. The response time was 12 minutes. We were told that the security employee did not respond quickly because he knew the alarm was being tested.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the System Director requires that: (a) controlled substances inventories accurately reflect the balances on hand and all controlled substances are accounted for, (b) inspections are properly conducted, (c) advance notices and delays of unannounced inspections are eliminated and inspections are randomly scheduled, and (d) security employees respond promptly to all alarms in Pharmacy Service.

The VISN Director and the System Director agreed with the findings and recommendations and submitted plans to ensure that controlled substances inventories reflect the balances on hand, inspections are properly conducted, advance notices and delays of inspections are eliminated, and inspections are randomly scheduled. Additionally, security employees were instructed to promptly respond to all alarms. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physical Security at the Toledo Community-Based Outpatient Clinic – Building, Patient Information, and Equipment Security Needed To Be Improved

Conditions Needing Improvement. During our review of controlled substances accountability at the Toledo CBOC, we identified several deficiencies in physical security. Managers needed to ensure that the Toledo CBOC had adequate security coverage, door alarms remained operational, and patient information and equipment was secured.

Security Employee Coverage. The contract security employee's tour of duty was from 9:00 AM to 5:30 PM, but patients could enter the CBOC as early as 7:30 AM. Therefore, during the first 90 minutes, no security employee was present at the security desk. On the first day of our visit, the security employee arrived at 10:45 AM, and the following day, at 9:15 AM. There was no provision for substitute security coverage during the security employee's absence. In the event of an emergency, the lack of security support could present a potential patient and employee safety hazard.

Door Alarms. We tested the alarms for emergency and non-emergency doors and found that the alarms were disconnected. While CBOC managers told us that they were unaware of this condition, a clerical employee informed us that the alarms had been disconnected for at least a year. We also noted that patients and other visitors routinely used the front door, which was located next to the security desk and clearly marked

"Emergency Exit Only." These conditions allowed free access to the clinic by persons who may not have legitimate business there. During our review, System managers said that door alarms would be connected at the CBOC within 2 weeks.

Patient Record and Equipment Security. We found that unauthorized individuals could easily enter the patient medical file room undetected. During our review we observed that every morning the file room, located behind the registration desk, was left unlocked with no employees present. We entered the file room without being detected by employees at the registration desk, patient file room clerks, or the security employee. We also found unprotected patient medical records in patient care areas. Additionally, our inspection showed that non-expendable equipment was vulnerable to theft. We inspected the audiology clinic, the radiology and nuclear medicine clinic, the eye clinic, and the patient x-ray file room. In each area we found unlocked rooms containing computers and portable medical equipment. We walked through the clinical areas five times before a CBOC employee asked us about the purpose of our visit.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the System Director requires that: (a) a security employee is present during all clinic hours, (b) doors are properly equipped with alarms and alarms are activated, and (c) patient records and rooms containing equipment are adequately secured.

The VISN Director and the System Director agreed with the findings and recommendations and submitted plans to ensure that a security employee is present from 7:00 AM to 6:00 PM, doors are equipped with active alarms, and patient records and rooms containing equipment are secured. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Controls Needed To Be Enhanced

Conditions Needing Improvement. Information technology (IT) security controls were adequate in the areas of security awareness training, risk assessment, virus protection, password controls, backup of essential data, and computer room security. The System had an adequate security plan, and the type of background investigations performed was appropriate for the sensitivity designations assigned to key positions. However, there were four areas where management needed to enhance IT security controls.

Storage Site for Backup of Critical Data Processing Information. The storage site for the System's backup of critical data processing information was located too close to the main computer processing site. A backup storage site was used to house the facility's operating data that had been recorded on tapes or other devices. The System's backup storage site was located in a building next to the main processing site. While the two sites were in different buildings, both could be exposed to the same potential disaster. Additionally, a waste pipe ran through the closet where the backup tapes and other devices were kept, creating the potential that a leak could damage or destroy them.

System managers should relocate the backup storage site to a more distant and less vulnerable location.

Contingency Plans. The System's contingency plans for its Veterans Health Information Systems and Technology Architecture (VistA) system and local area network were generally adequate. However, the contingency plans listed only generic locations for alternative meeting places in case of an emergency. Additionally, there were no listings of business, home, or cellular phone numbers for key employees. The Information Security Officer (ISO) should revise the plans to include business, home, and cellular telephone numbers for key employees, and the locations for alternative meeting places.

Alternate Data Processing Site. The System did not have an alternate computer-processing site. A facility must shift its computer operations to an alternate processing site if a disaster disables the main location. This alternate site should be far enough away from the main processing site to avoid disasters that could potentially shut down the main system. The ISO should select a location where the System can shift its computer operations if a disaster occurs.

Monitoring Access to VistA. The System's ISO did not monitor failed attempts to access VistA. The failed attempts occurred because of individuals entering incorrect passwords and/or login titles. The System had software that monitored these failed attempts, but no one reviewed the data. The ISO should monitor and identify failed and unauthorized attempts to access VistA.

Suggested Improvement Action. We suggested that the VISN Director ensure that the System Director takes actions to: (a) move the backup storage site to a more distant and less vulnerable location; (b) revise the contingency plans to include evening, night, weekend, and holiday contact information and the location of an alternative meeting place; (c) select an alternate processing site for System computer operations if a disaster occurs; and (d) monitor failed and unauthorized attempts to access VistA.

The VISN Director and the System Director agreed with the findings and suggestions and submitted plans to move the backup storage site to a less vulnerable location, revise the contingency plans, select an alternate processing site for computer operations in case of a disaster, and monitor failed and unauthorized attempts to access VistA.

Appendix A

VISN 11 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 9, 2003

From: Acting Network Director, VISN 11 (10N11)

Subject: Draft Report – CAP Review of the VA Ann Arbor HCS, Project Number 2003-02729-HI-0345

To: Director, Chicago Regional Office of Healthcare Inspections

Thru: Management Review Service (10B5)

1. Attached please find VA Ann Arbor Healthcare System's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact Nancy Wallace, Quality Management Officer VISN 11 at (734) 930-5942.

/s/
Pamela Reeves, M.D.

Attachment

Appendix B

VA Ann Arbor Healthcare System Director Comments

Environment of Care

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

a) cleaning chemicals, patient care products, and sharp instruments are secured.

Response: Concur. The issue is mainly of individual staff noncompliance with policies and procedures. Staff has been re-educated on appropriate policies and procedures. Monitoring of compliance will continue; appropriate corrective action will be initiated when non-compliance is found. ***Recommend closure.***

b) medications are secured and temperatures of refrigerators containing medications are monitored daily.

Response: Concur. Electronic thermometers for all medication refrigerators have been purchased, and a new monitoring system has been implemented. Maximum and minimum temperatures for the previous 24 hours are recorded during daily checks. The thermometers have alarms set to alert staff if the temperature is out of the desired range. In the rare event a daily check is missed, the memory on the thermometer enables an assessment of the medication storage conditions since the previous check, and the safety of the medications. ***Recommend closure.***

c) **patient privacy is maintained in outpatient intake and treatment areas.**

Response: Concur. Staff has been re-educated on appropriate policies and procedures. Monitoring of compliance will continue; appropriate corrective action will be initiated when non-compliance is found. ***Recommend closure.***

Of note, the VAAAHS was surveyed by JCAHO on October 20-22, 2003, during which all the above environmental issues were reviewed. The healthcare system received no Type 1

recommendations with the following scores: HAP – 97; Behavioral Health – 99; Long-term Care – 98.

Equipment Accountability

Recommended Improvement Action 2. The VISN Director ensure that the System Director requires that A&MMS supervisors perform inventories of nonexpendable equipment annually and update EILs.

Response: Concur. Of the 211 EILs 65% of the inventories have been performed and updated. The remaining 35%, predominately Research, will be completed by 2/1/04. ***Closure targeted for 2-04.***

Part-time Physician Time & Attendance

Recommended Improvement Action 3. The VISN Director ensure that the System Director requires that

a) local part-time physician time and attendance policy is further refined to insure that physician either work their established tours of duty or obtain their supervisors' advance approval before changing tours.

Response: Concur. The policy will be further refined. Please note there was no overpayment for time not worked by physicians and no adverse impact on wait time or patient satisfaction (noted on page 5 of this report). The change in policy will reduce the number of corrections and late requests. ***Closure targeted for 2-04.***

b) timekeepers be informed of supervisors' written, advance approval of changes to established tours as soon as possible.

Response: Concur. ***Closure targeted for 2-04.***

c) Fiscal Service conduct annual refresher training for all timekeepers, and perform annual timekeepers' desk audits.

Response: Concur. Timekeeper training was performed during April/May 2002 and September 2003; individual

training is held on an ongoing basis. Mandatory annual training is scheduled for January 2004. ***Closure targeted for 2-04.***

Training is conducted for each new timekeeper before granting VistA access to the T&L menu. In addition, a SynQuest training module is being developed and will be mandated for all timekeepers annually. A schedule for performing timekeeper desk audits has been developed and will begin no later than January 2004. ***Recommend closure.***

Medical Care Collections Fund

Recommended Improvement Action 4. The VISN Director ensure that the System Director takes action to timely pursue MCCF receivables.

Response: Concur. The VISN CFO and Revenue Manager were working with the healthcare system for a significant period before the IG survey. The Unbilled Amounts have been reduced from $7,153,918 to $3,831,294. AR amounts have been steadily decreasing, although continued focus is required in this area. The Trend Report is worked aggressively on a weekly basis to follow-up on all accounts less than 91 days old. At the 91st day, accounts are transferred to OSI, an outside billing agency. All Tri-Care accounts are under review for billable status or cancellation. Tri-Care reimburses VAAAHS for specialty care only. The VISN is considering consolidating many of these programs at one or two medical centers to take advantage of staff expertise and economies of scale. ***Recommend closure.***

Controls over Accounts Receivable and Undelivered Orders

Recommended Improvement Action 5. The VISN Director ensure that the System Director requires:

a) Fiscal Service employees reconcile, review, and aggressively pursue AR for collection.

Response: Concur. Fiscal Service staff currently pursues all avenues available to collect accounts. Staff follows up with telephone calls or other options, in addition to the letters,

which are generated every 30 days. If a bill is not collected within 90 days, the debt is referred to the Treasury Offset Program (TOP). Current government employee debts are payroll deducted if not paid in a timely manner. ***Recommend closure.***

b) Fiscal Service employees review delinquent undelivered orders; unneeded orders are canceled and funds are deobligated.

Response: Concur. Undelivered orders are routinely reviewed. Items over 90 days are reviewed for appropriateness and determination to close the order. In addition, the financial indicators report is currently green reflecting staff are doing well in keeping the UDOs current. ***Recommend closure.***

Government Purchase Card Program

Recommended Improvement Action 6. The VISN Director ensure that the System Director take actions to:

a) segregate the key duties of the purchase card program.

Response: Concur. Duties were reassigned at the time the issue was identified during the audit. ***Recommend closure.***

b) ensure that cardholders and approving officials complete the required training.

Response: Concur. All cardholders and approving officials completed the annual training while the audit was ongoing. Documentation was provided prior to the exit of the auditors. ***Recommend closure.***

c) ensure that purchases are monitored to prevent cardholders from splitting purchases and exceeding their assigned limits.

Response: Concur. The Detailed Account Cycle Report is reviewed monthly. The report shows all the charges that came in for the month for each cardholder. Any items that could potentially be a split order are identified, and the cardholder is requested to provide documentation and explain

the charges. The form is required to be signed by both the cardholder and approving official before being returned to the office. The cardholders and approving officials are reminded not to split orders. ***Recommend closure.***

d) monitor the expiration dates of temporary warrants.

Response: Concur. Temporary warrants will be more closely monitored and spending limits adjusted accordingly in a timely fashion. Currently, we do not have any temporary warrants outstanding.

Of note, the auditor's narrative report stated that an individual with a temporary warrant made three purchases exceeding $2,500 after the expiration date of the temporary warrant. At this time, we have only been able to identify one item that exceeded the $2,500 limit; appropriate corrective action has been taken. ***Recommend closure.***

Controlled Substances at Toledo CBOC

Recommended Improvement Action 7. The VISN Director ensure that the System Director requires that:

a) controlled substances inventory accurately reflects the balance on hand, and all controlled substances are accounted for.

Response: Concur. The controlled substances unaccounted for during the audit were due to prescriptions being filled after the inventory reports were printed. The prescriptions were removed from inventory as required, and the computer balance accurately reflected the balance on hand.

We will add to our inspection procedures for busy areas the requirement that an activity report be run if there is a discrepancy to determine if prescriptions had been filled since the inventory report. ***Recommend closure.***

b) inspections are properly conducted.

Response: Concur. VAAAHS has implemented new inspection procedures in full compliance with VHA Handbook 1108.2, Inspection of Controlled Substances, dated

August 29, 2003. Security Prescription Forms (VA Form 10-2577) accounting procedures have been revised to enable instantaneous verification of balances and improve accountability. ***Recommend closure.***

c) advance notices and delays of unannounced inspections are eliminated, and inspections are randomly scheduled.

Response: Concur. Since the survey, the timing of inspections is coordinated for the three pharmacies (Ann Arbor Inpatient, Ann Arbor Outpatient, and Toledo CBOC) for a simultaneous, unannounced, random inspection. All inspectors have received training in the new process, and three additional inspectors have been added to the team. At least quarterly, the controlled Substance Security Officer will observe or participate in inspections at the Toledo CBOC to ensure adherence to these procedures. ***Recommend closure.***

d) security employees respond promptly to all alarms in Pharmacy Service.

Response: Concur. The security employee has been instructed to respond promptly to all alarms. ***Recommend closure.***

Security coverage at the Toledo CBOC

Recommended Improvement Action 8. The VISN Director ensure that the System Director requires that:

a) security personnel are present during clinic hours.

Response: Concur. The contracting officer has been informed to increase security guard coverage from 0700 hours to 1800 hours weekdays. She is negotiating with the security company to increase the coverage to the above hours. ***Recommend closure.***

b) doors are properly equipped with alarms and alarms are activated.

Response: The alarms on the two end Emergency Exit doors have been connected and all the side exterior doors now have alarms.

Of note, the Toledo CBOC building meets and met prior to the IG audit all Physical Security Requirements as outlined in VA Handbook 0730, Appendix B, dated August 11, 2000. All exterior doors have locking devices and, except for the main entrance doors, remain locked at all times. ***Recommend closure.***

c) patient records and rooms containing equipment are adequately secured.

Response: Concur. Inner hallway doors leading to the record room and equipment storage rooms are now kept closed and secured. ***Recommend closure.***

Information Technology Security

Suggested Improvement Action. The VISN Director ensure that the System Director takes actions to:

a) move the backup storage site to a more distant and less vulnerable location.

Response: Concur. Discussions are currently underway with the VISN 11 CIO about the feasibility of storing most recent copies of backup tapes at their location, which is approximately four miles from the Ann Arbor Medical Center. ***Closure targeted for 1-04.***

b) revise the contingency plans to include evening, night, weekend, and holiday contact information and the location of an alterative meeting place.

Response: Concur. The ISO is currently revising the contingency plans to include this information. ***Closure targeted for 1-04.***

c) select an alternate processing site for System computer operations if an emergency occurs.

Response: Concur. We are investigating options with the national Office of Information. ***Closure targeted for 2-04.***

d) monitor failed and unauthorized attempts to access the System computer network.

Response: Concur. Our network group is obtaining quotes on products that can consolidate failed access attempts on the network or servers. Our systems group is examining available VMS command files that can produce daily VMS failed access logs, and is working with the national Office of Information on how best to do this within VistA/CPRS/BCMA. ***Closure targeted for 2-04.***

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5a	Fiscal Service employees need to pursue AR for services provided to DoD.	$19,955.00
5b	Fiscal Service employees need to de-obligate unneeded orders.	$38,124.00
	Total	$58,079.00

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Freddie Howell, Jr., Director, Chicago Office of Audit Paula Chapman Mark Collins Patricia Conliss Kenneth Dennis Russell Dunkerley Kevin Gibbons Terrye Hall Raymond Jurkiewicz Katherine Owens Cherie Palmer Leslie Rogers William Wells

Appendix E

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