



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Battle Creek, Michigan

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 February 2-6, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Battle Creek, MI, which is part of Veterans Integrated Service Network (VISN) 11. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 71 medical center employees.

Results of Review

This CAP review focused on 15 areas. As indicated below, there were no concerns identified in seven areas. The remaining eight areas resulted in recommendations and suggestions for improvement. The medical center complied with selected standards in the following areas:

- Agent Cashier
- Government Purchase Card Program
- Information Technology Purchases
- Medical Care Collections Fund
- Pharmaceutical Cache Program
- Supply Processing and Distribution
- Timekeeping for Part-Time Physicians

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

- Agent Cashier operations were sound.
- Pharmaceutical Cache Program controls were effective.

There were eight areas that needed additional management attention. To improve operations, the following recommendations were made:

- Improve accountability for controlled substances dispensed to or collected from post-traumatic stress disorder (PTSD) inpatients, and document training provided to controlled substances inspectors.
- Conduct a review to determine if a physician should be reported to the National Practitioner Data Bank (NPDB) and appropriate state licensing boards, and improve root cause analyses (RCAs).
- Fully implement the Generic Inventory Package (GIP); reduce levels of engineering, medical, and janitorial supplies; and improve supply inventory accuracy.

- Improve controls over Personal Funds of Patients (PFOP).
- Deobligate and reprogram unused construction funds.
- Ensure that contracting staff prepare price negotiation memorandums (PNMs), conduct price analyses, and better document contracting actions.

Suggestions for improvement were made in following areas:

- Explore with VISN management possibilities for establishing an alternate computer processing site.
- Install an eyewash station in the Veterans Canteen Service (VCS) kitchen.

VISN 11 and Medical Center Directors' Comments

The VISN 11 and Medical Center Directors agreed with the CAP review findings and provided acceptable implementation plans. (See Appendixes A and B, pages 14-20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Freddie Howell, Jr., Director, and William J. Gerow, Jr., CAP Review Coordinator, Chicago Audit Operations Division.

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

Introduction

Facility Profile

Organization. Located in Battle Creek, MI, the medical center is a primary medical and mental health facility that provides inpatient and outpatient health care services. Outpatient care is also provided at community-based outpatient clinics (CBOCs) in Benton Harbor, Grand Rapids, Lansing, and Muskegon, MI. The medical center is part of VISN 11 and serves a veteran population of about 180,000 in a primary service area that includes 23 counties in Michigan.

Programs. The medical center provides acute and long-term psychiatric inpatient care, inpatient medical care, substance abuse treatment, PTSD care, nursing home care, compensated work therapy, primary outpatient care, and home-based primary care. The medical center has 91 psychiatry beds, 30 PTSD residential care beds, and 74 psychiatric residential rehabilitation treatment program and substance and alcohol abuse residential treatment program beds. It also operates 135 nursing home care beds. Outpatient specialties include urology, audiology, optometry, dentistry, and podiatry.

Affiliations and Research. The medical center is not affiliated with a school of medicine but has affiliations with 20 universities, colleges, and technical schools, including Michigan State University, Kellogg Community College, and Olympia Career Training Institute. Affiliated training programs include audiology and speech pathology, dietetics, nursing, optometry, and social work. The medical center does not have a research program.

Resources. The medical center's Fiscal Year (FY) 2003 medical care budget was \$116 million, a 16 percent increase over the FY 2002 budget of \$100 million. Projected FY 2004 expenditures are \$126 million. As of January 31, 2004, staffing was 1,156 full-time equivalent employees (FTE), including 45 physician and 360 nursing FTE.

Workload. In FY 2003, the medical center treated 26,499 unique patients, a 9 percent increase from FY 2002. The FY 2003 inpatient average daily census was 96, the nursing home care average daily census was 105, and the residential care average daily census was 85. In addition, FY 2003 outpatient workload totaled 248,058 visits, a 9 percent increase from FY 2002.

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 medical center 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 patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FYs 2002 and 2003 and FY 2004 through January 2004 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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

Agent Cashier	Personal Funds of Patients
Contracting	Quality Management Program
Controlled Substances	Pharmaceutical Cache Program
Environment of Care	Supply Inventory Management
Government Purchase Card Program	Supply Processing and Distribution
Information Technology Purchases	Timekeeping for Part-Time Physicians
Information Technology Security	Unliquidated Obligations
Medical Care Collections Fund	

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-13). For these activities, we make recommendations or 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 medical center management until corrective actions are completed. For 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 employee and patient satisfaction with timeliness of service and quality of care. Electronic survey questionnaires were made available to all medical center employees, 210 of whom responded. We also interviewed 30 patients. The surveys and interviews indicated high levels of employee and patient

satisfaction and did not disclose any significant issues. The survey and interview results were shared with the Medical Center Director.

We also presented 3 fraud and integrity awareness training sessions that were attended by 71 employees. The training covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Organizational Strengths

Agent Cashier Operations Were Sound. Agent Cashier funds were accounted for. Physical security of the Agent Cashier's area and equipment was adequate. Safe combinations were appropriately under the custody of the Medical Center Director, and Agent Cashier unannounced audits were performed every 90 days as required.

Pharmaceutical Cache Program Controls Were Effective. VA's Pharmaceutical Cache Program was established to provide emergency medical support to the general public in the event of a natural disaster, emergency, or terrorist attack. The cache is a stockpile of medications, treatment kits, intravenous solutions, and other medical supplies. Medical center staff established the cache in accordance with Veterans Health Administration (VHA) policy. Physical security included an electronic security system, temperature control, and smoke detectors. New carts were used to store pharmaceutical cache drugs. Controlled substances were included in the monthly controlled substances inspections and were stored separately in Drug Enforcement Administration (DEA) approved safes.

Opportunities for Improvement

Controlled Substances – Controlled Substances Needed To Be Accounted for and Training Needed To Be Documented

Condition Needing Improvement. Accountability and security of controlled substances in Pharmacy Service were generally effective. Physical security was adequate, and the number of staff accessing the vault room was within permitted limits. Pharmacy Service staff maintained a perpetual inventory of controlled substances and conducted required DEA biennial inventories. In addition, Pharmacy Service staff conducted required quarterly destructions of expired and unusable controlled substances. However, there were two areas that needed to be improved.

Accounting for Controlled Substances. Controlled substances dispensed to or collected from patients on the medical center's PTSD ward were not properly controlled. Interviews with Pharmacy Service and PTSD ward staff and reviews of PTSD inpatient prescription records and controlled substances destruction records revealed that controlled substances collected at admission, dispensed during admission, or returned to the pharmacy for destruction were not accounted for. Even though patients on the PTSD ward were self-medicating, VHA and medical center policies required that:

- Unused controlled substances that are no longer needed should be returned to the pharmacy and destroyed.
- Controlled substances dispensed to a PTSD patient while on the ward should be accounted for weekly.
- Controlled and non-controlled substances in the possession of a PTSD patient at admission should be collected, sent to the pharmacy, and mailed to the patient's home address.

Controlled substances were not accounted for when returned to the pharmacy for destruction. According to the Chief of Staff and a PTSD ward physician, attending physicians frequently adjust or cancel controlled substances prescriptions for PTSD patients. When this occurs, unused portions of previously prescribed controlled substances should be collected from the patient and returned to pharmacy for destruction.

We reviewed a judgment sample of prescription records for three PTSD patients. Two prescriptions for methylphenidate were dispensed to one patient and subsequently cancelled because the attending physician adjusted the prescriptions. However, there was no documentation on the ward to show that the previously prescribed and unused methylphenidate was returned to pharmacy. In addition, destruction records maintained by Pharmacy Service staff did not agree with the prescription dispensing records for this patient. Neither the patient's name, nor the quantity returned or the indicated dosage could be matched to pharmacy

destruction records. According to VHA policy, ward staff should document the date, strength, quantity, and nurses' signatures for controlled substances turned in for disposition. Without proper accountability, controlled substances are susceptible to diversion.

Although PTSD patients were self-medicating, controlled substances dispensed by the pharmacy to these patients were stored for safe keeping in individual locked boxes on the ward. Each box was accessible only by the patient to whom it was assigned and by a ward nurse. Medical center policy required a weekly inventory of the contents of these boxes. However, the contents of these boxes were not inventoried. Consequently, there was a risk that diversion of controlled substances could go undetected.

According to nursing and pharmacy staff, medications in the possession of PTSD patients at admission, whether VA or privately prescribed, were collected and mailed back to the patients' homes. However, neither ward staff nor pharmacy staff maintained records to show what was collected and mailed.

Training for Controlled Substances Inspectors. VHA policy requires that a training program for controlled substances inspectors be implemented and documented. Medical center employee training records did not document that 12 of 26 controlled substances inspectors had received the required training. This included six inspectors at the Grand Rapids CBOC. According to the lead inspector, individualized training was provided to these 12 inspectors. However, the training was not documented in employee training records.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VA Medical Center (VAMC) Director takes action to: (a) implement procedures to account for controlled substances dispensed to and collected from PTSD patients; and (b) document training provided to controlled substances inspectors.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a weekly inventory of controlled substances had been instituted on the PTSD unit and that a pharmacy log had been implemented to record medications returned to the pharmacy. A second log will be developed to record medications brought to the medical center by patients being admitted. The Directors also reported that all controlled substances inspectors have completed training and all training has been documented in an electronic training record system. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Quality Management Program – Managers Needed To Comply with VHA Reporting Requirements and Improve Root Cause Analyses

Condition Needing Improvement. Medical center management needed to conduct a review to determine if a former contract physician should be reported to the NPDB and appropriate state licensing boards. Clinical supervisors also needed to be educated on VHA requirements related to such reporting. In addition, RCAs needed to identify contributing factors for adverse patient

events and close calls, and RCA documentation needed to reflect the extent that recommendations were implemented and monitored for effectiveness.

Reporting. VHA policies require that adverse actions affecting clinicians' clinical privileges (reductions, suspensions, or revocations) be reported to the NPDB and to appropriate state licensing boards. Credentialing and privileging records showed that a contract physician was allowed to resign in January 2004 in lieu of contract termination for substandard clinical performance. The physician's VA clinical supervisor stated that a review of the physician's performance had not been conducted to determine if he met criteria for reporting to the NPDB and to appropriate state licensing boards. This occurred because the clinical supervisor was unaware of VHA's reporting requirements. Medical center managers needed to conduct a review of the physician's performance to determine if the physician should be reported to the NPDB and to appropriate state licensing boards. In addition, medical center managers needed to educate clinical supervisors about VHA reporting requirements.

RCA Reviews. VHA policies require that root causes underlying variations in clinical performance associated with adverse patient events or close calls be identified through an RCA process. From January through December 2003, 3 individual RCAs and 4 quarterly aggregated RCAs¹ were conducted. None of the three individual RCAs identified appropriate root causes for the events being investigated. None of the four quarterly aggregated RCAs adequately identified root causes, defined improvement actions, or established measurable outcomes. In addition, RCA documentation was not sufficient to show that recommended improvements were implemented and monitored for effectiveness.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) a review be conducted to determine if the subject physician should be reported to the NPDB and appropriate state licensing boards, and clinical supervisors are educated on and comply with VHA requirements for reporting to the NPDB and state licensing boards; and (b) RCAs identify root causes for adverse patient events and close calls, define recommended improvement actions, establish measurable outcomes, and document implementation and effectiveness of improvement actions.

The VISN and Medical Center Directors agreed with the recommendations and reported that the medical center has initiated the reporting process as outlined in VHA Handbook 1100.17 for the subject physician. They also reported that training sessions have been held for all clinical supervisors on reporting requirements. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

¹ Individual RCAs are done on all unexpected occurrences of death and serious, and high risk of serious, physical or psychological injury. Aggregated RCAs are done on events (e.g., missing patients, falls, medication errors, and suicide attempts or gestures) that could have resulted in death or serious injury but did not.

Supply Inventory Management – Excess Inventories Needed To Be Reduced and Inventory Accuracy Improved

Condition Needing Improvement. In FY 2003, the medical center spent approximately \$1.4 million on medical, prosthetic, engineering, and janitorial supplies. VHA established goals for reducing supply inventories to 30-day levels and for using GIP and the Prosthetics Inventory Package (PIP) to manage these inventories. GIP was used to manage medical supplies stored in the warehouse, and PIP was used to manage prosthetic supplies. These inventories had only negligible amounts of stock in excess of 30 days, and recorded stock levels were accurate. However, stock levels for engineering supplies, medical supplies maintained in Supply Processing and Distribution (SPD), and janitorial supplies were excessive and recorded stock levels were inaccurate. Inventory managers needed to fully implement GIP to better manage engineering, SPD medical, and janitorial supply inventories.

Use of GIP. Medical center staff had not fully implemented GIP to manage engineering supplies, medical supplies maintained in SPD, and janitorial supplies. Engineering Service staff did not use GIP's turnover and emergency stock level features to help manage engineering supplies. SPD staff used GIP's auto-generation of orders and bar-coding functions but had not implemented its turnover and emergency stock level features. Although Environmental Management Service (EMS) staff had recorded janitorial supply levels in GIP, they did not use any other of GIP's capabilities to manage inventories, such as auto-generation of orders, turnover ratio, and emergency stock levels. Not fully utilizing GIP's capabilities contributed to excess inventory and inaccuracies in reported stock levels.

Excess Inventory. Not fully utilizing GIP's capabilities contributed to excess inventories of supplies. As of January 22, 2004, days of stock on hand reports showed that there was \$250,645 worth of engineering supplies in excess of 30 days. These reports also showed that there was \$36,368 worth of SPD medical supplies and \$16,894 worth of janitorial supplies in excess of 30 days. Maintenance of excess supply inventory tied up funds that could have been used for other medical center needs.

Reported Stock Quantities. Information in GIP did not accurately reflect supply levels on hand. There were inaccuracies ranging from 1 to 50 items among 30 of 54 judgmentally sampled engineering supply line items. Among SPD medical supplies, there were inaccuracies ranging from 10 to 430 items among 17 of 22 judgmentally sampled line items. For janitorial supplies, there were inaccuracies ranging from 8 to 18 items for 4 of 10 judgmentally sampled line items. Inaccuracies in recorded inventory levels can lead either to unanticipated shortages of needed items or to premature purchases of supplies.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) fully implement GIP for engineering, medical, and janitorial supplies; (b) reduce engineering, medical, and janitorial supply inventories to 30-day levels; and (c) improve the accuracy of inventory levels recorded in GIP.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that GIP has been fully implemented for engineering, medical, and janitorial supplies.

They also reported that medical supplies have been reduced to 30-day levels and that engineering and janitorial supplies would be reduced to 30-day levels by August 2004. Staff involved with engineering and janitorial supplies will be trained in the GIP process by the end of May 2004, and all areas of the GIP process will be monitored monthly. The improvement plans were acceptable, and we will follow up on the completion of the planned actions

Personal Funds of Patients – Controls over Patient Funds Needed To Be Improved

Condition Needing Improvement. Fiscal Service staff performed monthly and semi-annual reconciliations of PFOP accounts as required by VA policy. In addition, Medical Administration Service (MAS) staff posted withdrawals and deposits timely. However, MAS staff needed to comply with VA and VHA policies and strengthen controls to prevent overdrawn accounts, to identify patients' competency status, to maintain signature records, and to document authority to release and disburse personal funds.

Overdrawn Accounts. VA and VHA policies require that an MAS PFOP clerk verify that funds are available for withdrawal before authorizing the release of funds from a PFOP account. Not doing so can result in an overdraft, for which, according to VA policy, the clerk will be held responsible. As of December 31, 2003, there were 677 PFOP accounts with a total balance of \$78,341. However, there were 10 accounts that were overdrawn by a total of \$1,009. Interviews with MAS officials revealed that neither the current nor previous PFOP clerks routinely verified fund balances before releasing funds to patients. This resulted in overdrafts.

Fiscal Service staff performed monthly reconciliations of PFOP accounts to ensure that accounts agreed with amounts shown in the medical center's general ledger. These reconciliations showed that, dating back to July 2002, MAS staff were aware of overdrafts but had not taken corrective actions. The oldest of these occurred in December 2000. PFOP clerks should verify fund balances before authorizing the release of funds and supervisors should monitor clerks to ensure that they do. In addition, in accordance with VA policy, PFOP clerks should reimburse PFOP accounts when they authorize the release of funds that result in overdrafts.

Competency Status. VHA policy requires that patients' competency status be annotated on account identification cards. The purpose is to allow a PFOP clerk to quickly determine if a patient's funds are unrestricted or restricted.² Among a judgment sample of 20 PFOP account identification cards, representing a total balance of \$60,961, there were 10 cards representing \$43,701 that listed patients' competency status as "unknown." The competency status of all patients with PFOP accounts needed to be determined and annotated on account identification cards.

² Generally, competent patients have unrestricted access to their PFOP funds. However, access to PFOP funds by incompetent patients is usually restricted in some manner. Restrictions vary from patient to patient depending on a variety of factors including any requirements established by guardians.

Signature Cards. VHA policy requires that patients with funds in PFOP accounts have signature cards on file with PFOP clerks. The purpose is to allow PFOP clerks to verify that signatures on deposit and withdrawal requests are legitimate. There were no signature cards for any of the 677 PFOP accounts. According to MAS staff, the use of signature cards had been discontinued about a year before our review. The use of signature cards should be re-implemented.

Disbursement of Funds after the Death of a Patient. VA and VHA policies require that copies of VA Form 90-2064, "Authority to Release and Ship Effects and Funds," be maintained in PFOP records to document that funds in a PFOP account at the time of a patient's death were disbursed to the proper beneficiary. From January through December 2003, MAS staff authorized the disbursement of \$16,466 from 39 PFOP accounts that had belonged to deceased patients. However, MAS staff did not maintain copies of VA Form 90-2064. Consequently, there was no documentation in PFOP records that the disbursements were made to the proper beneficiaries, although this information was available in other administrative records.

VA and VHA policies also require that copies of VA Form 10-1171, "Notice to Person Designated by Veteran Regarding Personal Effects," be maintained in patient administrative records. The purpose is to document that surviving family members or other beneficiaries of a deceased patient's estate were notified of a disbursement from a deceased patient's PFOP account. Among a judgment sample of 8 patients who died in 2003 (from the 39 patients discussed in the preceding paragraph), there were no VA Forms 10-1171 in administrative records for 2 patients. Consequently, there was no documentation that the patients' beneficiaries had been properly notified of any disbursements.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director takes action to: (a) require that PFOP clerks check account balances before disbursing funds to prevent overdrafts and require that clerks reimburse overdrawn accounts, (b) annotate account identification cards to show patients' competency status, (c) re-implement the use of patient signature cards, and (d) maintain copies of VA Forms 90-2064 and 10-1171 in PFOP and administrative records.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that verifying funds available for withdrawal was initiated at the time the deficiency was reported, and there have been no overdrawn accounts since then. Since the CAP review, the PFOP clerk communicates with ward staff to determine whether an account should be restricted or not and documents the patient's competency status. Signature cards are now created with every new admission and are maintained in the patient funds area. Copies of VA Forms 90-2064 and 10-1171 are now maintained in PFOP and administrative records. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Unliquidated Obligations – Unused Funds from a Construction Project Needed To Be Reprogrammed

Condition Needing Improvement. Fiscal Service staff needed to reprogram unused funds from a construction project that was completed in December 2002. VA policy requires that Fiscal Service staff review unliquidated obligations, follow up with initiating services for obligations that have been inactive for more than 90 days, and determine if they are still needed. As of December 31, 2003, the medical center had 589 obligations totaling \$7.5 million. Of these, 50 obligations totaling about \$2 million had been inactive for more than 90 days. Although Fiscal Service staff stated that they routinely reviewed and followed up on unliquidated obligations, there was no documentation of a review or follow-up on 1 of 10 judgmentally sampled obligations that had been outstanding for more than 90 days. An obligation for \$34,825 remained outstanding for a road and curb repair construction project that had been completed in December 2002.

Obligated funds should be promptly deobligated when they are no longer needed for their original purpose so that they may be reprogrammed for other medical center needs. The Medical Center Director stated that it was her intention to reprogram the \$34,825 for another road improvement construction project.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director deobligates funds for the completed road and curb repair construction project and, if appropriate, reprograms the funds for other purposes.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the \$38,825 in unused funds for the road and curb design project has been deobligated and returned to the appropriation. The improvement plan was acceptable, and we will follow up on the completion of the planned action.

Contracting – Contract Administration and File Documentation Needed to Be Improved

Condition Needing Improvement. Contract prices and terms were reasonable, and contracting officers monitored contracts to ensure that payments to vendors reflected the actual services provided. However, contracting officers needed to improve contract administration and contract file documentation.

Contract Administration. Federal Acquisition Regulations (FAR) require that contracting officers prepare PNMs for all purchase contracts and conduct price analyses for negotiated purchase contracts. Both of these actions help ensure that prices are fair and reasonable. A PNM also documents the facts and considerations controlling the contract, including any significant differences between a contractor's and a contracting officer's positions. We reviewed records for 10 contracts (annual value of \$2.9 million). Nine of these required PNMs and 7 also required price analyses. Records for 3 of these contracts (annual value of \$214,741) showed that

contracting officers had not prepared PNMs and in 2 cases (annual value of \$132,586) also had not conducted price analyses.

The FAR also requires that contracts exceeding \$5 million undergo a business review by VA's Office of Acquisition and Materiel Management staff before award. The purpose is to help ensure that such contracts meet all FAR and VA Acquisition Regulations (VAAR) requirements. Medical center contracting staff did not obtain a business review for a clinical services contract for primary medical and mental health care at one of the medical center's CBOCs (contract-life value of \$6.2 million).

Contract File Documentation. The FAR and VAAR require that contracting files document all contracting actions. Records for 6 of 10 contacts lacked some documentation. Records for three competitively bid clinical services contracts (annual value of \$1.5 million) lacked documented justification for the type of contract awarded. The records of one contract (annual value of \$217,283) lacked documentation that the contractor had obtained required liability insurance coverage. The records of a leasing contract (annual value of \$47,846) did not identify the contracting officer's technical representative. Finally, the records of a selling agreement contract (annual value of \$12,000) lacked documentation that market research had been performed and that a fair local market price had been determined.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires contracting staff to: (a) prepare PNMs, conduct price analyses, and obtain business reviews when required before awarding contracts; and (b) include required documents in contracting files.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that beginning in February 2004, all new contracts would be audited by another contracting officer to ensure complete documentation and adherence with the FAR and VAAR. The improvement plans were acceptable, and we will follow up on the completion of the planned actions.

Information Technology Security – An Alternate Computer Processing Site Was Needed

Condition Needing Improvement. Information technology security controls were satisfactory in the areas of contingency planning, risk assessment, security awareness training, backup of essential data, and computer room security. The medical center had an adequate security plan, and the types of background investigations performed were appropriate for the sensitivity designations assigned to key positions. However, the medical center did not have an alternate computer processing site.

A facility must be able to shift its computer operations to an alternate processing site if a disaster disables the main location. An alternate site should be far enough away from the main processing site to avoid disasters that could shut down the main system. The Information

Security Officer stated that he did not believe that using another medical center as an alternate site was feasible because the other medical center's computer operations could be negatively impacted. Instead, medical center management had submitted an application through the Capital Asset Realignment for Enhanced Services program for a new building that would house an alternate processing site and be located on the far side of the medical center campus from the main processing site.

Suggested Improvement Action 1. We suggested that the VISN Director and the Medical Center Director explore possibilities of establishing an alternate computer processing site pending completion of a proposed new building.

The VISN and Medical Center Directors agreed with the finding and suggestion and reported that the medical center's Information Technology Systems Manager responsible for technical implementations is participating in the VISN 11 Alternate Processing Site Workgroup. The workgroup is scheduled to have an alternate site processing plan in place by the end of FY 2004. The improvement plan was acceptable, and we consider the issue resolved.

Environment of Care – An Eyewash Station in the Veterans Canteen Service Kitchen Would Improve Employee Safety

Condition Needing Improvement. Medical center managers effectively managed the environment of care. However, employee safety would be improved with the installation of an eyewash station in the VCS kitchen. The Occupational Safety and Health Administration requires that employees who work with chemical agents, such as cleaning supplies, have access to an eyewash station in the event of an accidental splash of chemicals into the eyes. There was no eyewash station in the existing VCS kitchen and there was no plan to install one in a planned new VCS kitchen area that was scheduled to open in March 2004. After our review, a portable eyewash station was installed in the existing VCS kitchen. The Chief of EMS stated that an eyewash station would be purchased and installed in the new VCS kitchen.

Suggested Improvement Action 2: We suggested that the VISN Director ensure that the Medical Center Director requires that an eyewash station be installed in the new VCS kitchen.

The VISN and Medical Center Directors agreed with the finding and suggestion and reported that a new eye wash station was installed in the new VCS kitchen in March 2004. The improvement plan was acceptable, and we consider the issue resolved.

VISN 11 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 17, 2004

From: Director, Veterans Integrated Service Network 11

Subject: Combined Assessment Program Review Battle Creek, Michigan

To: VA Office of Inspector General

1. Attached please find Battle Creek VA Medical Center's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact Dee Seekins, Health System Specialist, at (269) 966-5600, extension 6105.

(original signed by:)

Linda W. Belton

Attachment

VA Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 7, 2004

From: Director, VA Medical Center Battle Creek, Michigan

Subject: Combined Assessment Program Review Battle Creek, Michigan

To: Network Director, VISN11 (10N11)

1. Attached please find Battle Creek VA Medical Center's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact Dee Seekins, Health System Specialist, at (269) 966-5600, extension 6105.

(original signed by:)

Alice L. Wood

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the VAMC Director takes action to:

(a) Implement procedures to account for controlled substances dispensed to and collected from PTSD inpatients.

Concur **Target Completion Date:** Phase I – Ongoing monitoring of the effectiveness of self administration medication program. Phase II – Targeted for May 21, 2004.

Response: The BCVAMC PTSD program is not an inpatient program. Inpatients operate under separate policies and procedures, and most VA policies regarding controlled substances are specifically for inpatient settings. These patients are outpatients, and the program is a residential treatment program. "Self Medication" is the term used by Veterans Health Administration (VHA) for inpatients only, and it is specifically referenced as such in VHA and local policy. Inpatients in this program take their own medications under highly supervised conditions. There is a national VA Self Medication policy for inpatients and the BCVAMC policy reflects national policy. Outpatients in residential treatment programs self administer medication.

Phase I: The PTSD Program officials implemented a weekly inventory of all controlled substances on the PTSD unit. Once the inventory is obtained any discrepancies are discussed with the involved patient and treatment team. Regarding all incoming patients, the nursing staff collect all medications brought to the Medical Center by PTSD patients. These medications are then forwarded to the pharmacy for disposition. This process is not fully refined, however, a quality management indicator has been developed to track discrepancies on how patients self-administer their medications.

Phase II: The implementation of a pharmacy log, which will include a listing of all medications and the date the medication is returned to pharmacy. A second log will be developed to record medications brought to the Medical Center by patients being admitted.

(b) Document training provided to controlled substances inspectors.

Concur **Target Completion Date:** April 2004

Response: All controlled substance inspectors have completed two types of training: 1) VHA certification training through the Internet. 2) Training on station specifically for inspection at BC VAMC and the Grand Rapids Clinic. All training has been documented in SynQuest.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) A review be conducted to determine if the subject physician should be reported to the NPDB and appropriate state licensing boards and clinical supervisors are educated about and comply with VHA requirements for reporting to the NPDB and state licensing boards.

Concur **Target Completion Date:** 1. May 2004 2. May 19, 2004

Response: BCVAMC offers the following clarification of the noted findings of the OIG CAP regarding the question of contract physician reporting. The Service Chief was fully aware of the reporting mechanism. The case in question had not been presented to the Professional Standards Board (PSB) and was scheduled for the February 5, 2004, which was the same week the OIG was here. The physician in question was on the PSB agenda for discussion. Previous to the OIG visit, Battle Creek has dealt with other physician cases where a clinical provider resignation was reviewed and the reporting process was completed.

1. Action: The Service Chief has completed a review on the subject physician and recommended initiation of the reporting process. BCVAMC has initiated the reporting process as outlined in VHA Handbook 1100.17, National Practitioner Data Bank Reports, and VHA Handbook 1100.19, Credentialing and Privileging.

2. Action: A training session regarding VHA reporting requirements was conducted by the station attorney for all clinical supervisors. A follow-up training is scheduled for completion on May 19, 2004. Additionally, all clinical supervisors have received VHA Handbooks 1100.17, National Practitioner Data Bank Reports and 1100.18, Reporting and Responding to State Licensing Boards.

(b) RCAs identify root causes for adverse patient events and close calls, define recommended improvement actions, establish measurable outcomes, and document implementation and effectiveness of improvement actions.

Concur **Target Completion Date:** July 2004

Response: The BCVAMC RCA process is currently under review. The Medical Center Director will ensure training is conducted for the Patient Safety Coordinator, Quality Manager, and associated staff to assure the RCA process is correctly implemented. The recommendations for the reporting process of including established measurable outcomes has been implemented and will be continued in all future RCAs. RCA documentation recommendations for implementation and monitoring will be addressed during the above mentioned review process.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) Fully implement GIP for engineering, medical, and janitorial supplies.

Concur **Target Completion Date:** April 2004

Response: A site visit was made to the Battle Creek Medical Center by the VISN 11 Chief Logistic Officer, to review the progress of GIP implementation. During a recent review by the VHA Clinical Logistic Office it was determined that the GIP inventories for Engineering, Environmental Management Service, and Medical met the criteria as "implemented" since that review, and based on the same criteria, Med/Surg is also considered fully implemented. (b) Reduce engineering, medical, and janitorial supply inventories to 30-day levels.

Concur **Target Completion Date:** August 2004

Response: Medical supplies have been reduced and inventories have been within the 30-day level. Additional equipment, scanners, and printers are in the process of being purchased to assist in meeting the remaining GIP mandates. Battle Creek has submitted an action plan for the mandated inventory areas that are not yet compliant. The action plan was approved by the VISN 11 Chief Logistic Officer, Medical Center Director, and Network Director. (c) Improve the accuracy of inventories recorded in GIP.

Concur **Target Completion Date:** May 2004

Response: Staff involved with engineering and janitorial supplies will be trained on the GIP process by the end of May 2004. All areas under the GIP process will be monitored monthly for compliance. This will be done through the monthly performance improvement reports.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the VAMC Director takes action to:

(a) Require that PFOP clerks check account balances before disbursing funds to prevent overdrafts and require that clerks reimburse overdrawn accounts.

Concur **Target Completion Date:** February 2004

Response: Immediate implementation of verifying funds available for withdrawal was initiated at the time the deficiency was reported. Since the inspection there have been no overdrawn accounts. For each withdrawal of a PFOP account a balance check is made against that account to verify funds are available. A copy of the PFOP account is attached to the appropriate document used for withdraw so Fiscal Service may also verify funds available.

(b) Annotate account identification cards to show patients' competency status.

Concur **Target Completion Date:** February 2004

Response: Since the review, the PFOP clerk communicates with ward staff on whether the accounts are restricted or unrestricted, and documents the patient competency status. The documentation of accounts is now in compliance with VHA policy.

(c) Re-implement the use of patient signature cards.

Concur **Target Completion Date:** February 2004

Response: With every admission signature cards are created and maintained in the patient funds area. The re-institution of signature cards is now in accordance with VHA policy.

(d) Maintain copies of VA Forms 90-2064 and 10-1171 in PFOP and administrative records.

Concur **Target Completion Date:** February 2004

Response: Immediately following the review the practice of maintaining VA forms 90-2064 and 10-1171 in the PFOP and in the administrative record was implemented.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director de-obligates funds for the completed road and curb repair construction project and, if appropriate, reprograms the funds for other purposes.

Concur **Target Completion Date:** May 2004

Response: The \$38,825 for road and curb design has been de-obligated and returned to the appropriation.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires contracting staff to:

(a) Prepare PNMs, conduct price analyses, and obtain business reviews when required before awarding contracts.

Concur **Target Completion Date:** February 2004

Response: All new contract files will be audited by another contracting officer prior to issuance of the solicitation and/or upon contract award to ensure complete documentation and adherence with all FAR and VAAR requirements. No contract action will be initiated without proper, written justification for the type of contract requested. All contract documentation will be completed immediately as the procurement progresses.

(b) Include required documents in contracting files.

Concur **Target Completion Date:** February 2004

Response: New files are being documented as required by FAR/VAAR as the procurement progresses. Current certificates of insurance are and will be maintained in the contract file. Contracting Officers will ensure all required legal/technical and business reviews are conducted in accordance with FAR and VAAR.

OIG Suggestion(s)

Suggested Improvement Action 1. We suggest that the VISN Director and the Medical Center Director explore possibilities of establishing an alternate computer processing site pending completion of a proposed new building.

Concur **Target Completion Date:** September 2004

Response: The Battle Creek Information Technology Systems Manager responsible for the technical implementations is an active participant in the Veterans Integrated Service Network (VISN) Alternate Processing Site Workgroup that is chaired by the VISN 11 Information Security Officer. The workgroup is scheduled to have a high level alternate site-processing plan in place by the end of the Fiscal Year.

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the Medical Center Director requires that an eyewash station be installed in the new VCS kitchen.

Concur **Target Completion Date:** March 2004

Response: New eyewash was installed prior to the opening of the new VCS kitchen.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefits</u>	<u>Better Use of Funds</u>
3b	Reducing medical, engineering, and janitorial supplies would make funds available for other uses.	\$303,907
5	Reprogramming unused construction funds would make them available for other uses.	34,825
	Total	\$338,732

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