Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Memphis, Tennessee

Report No. 04-00631-190 **August 27, 2004**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

Introduction

During the week of March 15-19, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center, Memphis, Tennessee (the facility). The purpose of the review was to evaluate selected operations focusing on patient care administration, quality management (QM), and financial and administrative management controls. During the review, we also provided fraud and integrity awareness training to 481 employees. The facility is under the jurisdiction of Veterans Integrated Service Network (VISN) 9.

Results of Review

The CAP review focused on 10 areas. As indicated below, there were no concerns identified in two of the areas. Reviews of the remaining eight areas resulted in recommendations for improvement.

The facility complied with selected standards in the following areas:

- Government Purchase Card Program
- Controlled Substances Security

To improve operations, the following recommendations were made:

- Correct patient safety issues in the environment of care.
- Set electronic monitoring devices in the Gastrointestinal (GI) Lab to the "alert" position.
- Improve QM processes for some critical functions.
- Use the Generic Inventory Package (GIP) for inventory management.
- Enhance Automated Information Systems (AIS) security.
- Certify vendor transportation invoices.
- Complete physician conflict of interest forms as required.
- Report timekeeper discrepancies related to part-time physicians.

This report was prepared under the direction of Ms. Victoria Coates, Director, Atlanta Regional Office of Healthcare Inspections, and Ms. Judy Lawhead, CAP Team Leader, Atlanta Regional Office of Healthcare Inspections.

VISN 9 and Facility Directors' Comments

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 11-22 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Facility Profile

Organization. The VA Medical Center in Memphis, Tennessee is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based clinics located in Smithville and Byhalia, Mississippi; Jonesboro, Arkansas; and Savannah, Tennessee. The facility is part of VISN 9 and serves a veteran population of about 196,000 in a primary service area that includes 54 counties in West Tennessee, Northern Mississippi, and Eastern Arkansas.

Programs. The facility provides medical, surgical, mental health, and rehabilitation services. The facility has 273 hospital beds and operates several regional referral and treatment programs, including Lithotripsy and a Spinal Cord Injury Center. The facility has sharing agreements with the State of Tennessee through the Regional Medical Center.

Affiliations and Research. The facility is affiliated with the University of Tennessee Colleges of Medicine, Dentistry, Nursing, Pharmacy, and Allied Health, and supports 115 medical resident positions in 26 training programs. In Fiscal Year (FY) 2003, the facility's research program had 220 projects and a budget of $17.5 million. Important areas of research include connective tissue, infectious diseases, hypertension, diabetes, and cardiology.

Resources. In FY 2003, medical care expenditures totaled $192 million. The FY 2004 medical care budget is $191 million. FY 2003 staffing totaled 1,742 full-time equivalent employees (FTE), including 114.5 physicians and 296 nursing FTE.

Workload. In FY 2003, the facility treated 41,232 unique patients. The facility provided 75,103 inpatient days of care in the hospital. The inpatient care workload totaled 7,334 discharges and the average daily census was 206. The outpatient workload was 330,491 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 and regional office operations focusing on patient care, quality management, benefits, 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 general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered facility operations from October 1, 2002, through February 15, 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

- Environment of Care
- Management of Moderate Sedation
- QM
- Supply Inventory Management
- AIS Security
- Contract Award and Administration
- Compliance with Physician Conflict of Interest Acknowledgement Requirements
- Part-Time Physicians' Time and Attendance
- Government Purchase Card Program
- Controlled Substances Security

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. We sent electronic survey questionnaires to facility employees, 379 of whom responded. We also interviewed 30 patients during our review. We provided the survey results to facility managers.

During the review, we also presented four fraud and integrity awareness briefings for facility employees. These briefings, attended by 481 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are completed.

Results of Review

Opportunities for Improvement

Environment of Care – Several Patient Safety Issues Needed Management Attention

Condition Needing Improvement. Several environment of care deficiencies could compromise patient safety. Managers did not address all deficiencies identified in a Mental Health Environmental Risk Assessment conducted in June 2002 on the locked psychiatry unit. Veterans Health Administration (VHA) and the Joint Commission on Accreditation of Healthcare Organizations policies require facilities to conduct a risk assessment and address patient safety issues. We found the following safety hazards, which posed suicide risks for patients on the locked psychiatry unit:

- Door handles were mounted too high in bathrooms and patient rooms.
- Coat hooks were mounted in the non-seclusion rooms.
- Non-breakaway hanging metal clothing bars mounted under the closet shelves had wide openings through which a device could be fastened.
- Electrical outlets were not always covered.

Management toured the unit and initiated actions to address these concerns.

In addition, we noted safety deficiencies on the medical and surgical wards:

- Two unlocked medication carts were stored in hallways on Unit 3F.
- A housekeeping closet containing cleaning chemicals could not be locked on Unit 4E.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Facility Director takes action to:

a. Address all patient safety concerns identified in the June 2002 Mental Health Environmental Risk Assessment for the locked psychiatry unit.

b. Ensure medication carts and housekeeping closets are properly secured.

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

Management of Moderate Sedation – GI Lab Equipment Should be Properly Engaged

Condition Needing Improvement. Generally, the administration of moderate sedation outside of the operating room was comprehensive and providers were properly credentialed. However, we noted that the alarms on the electronic monitoring devices were not always in the "alert" position during procedures. Facility policy requires automatic monitoring devices with alarms to be set on "alert" to notify providers of critical changes in patient status. Without this measure, providers could not be assured of timely notification of critical changes in patients' conditions or assure timely response to prevent further deterioration in patients' clinical conditions.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Facility Director requires that all electronic monitoring device alarms are set in the "alert" position as required.

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

QM – Oversight of Some Processes Needed Improvement

Condition Needing Improvement. Level 3 peer reviews were not completed timely for 2002 and 2003 cases; there was no documentation to support that formal reviews of adverse events were conducted in the GI Lab; and service chiefs did not complete their annual performance improvement reports timely. The following conditions required management attention:

- All three Level 3 peer reviews from 2002 and 2003 were still open at the time of our visit. The Chief of Staff told us he did not have knowledge of these cases. The involved providers' written responses were not obtained. Service chiefs did not receive semi-annual peer review reports from QM. The facility policy requires completion of peer reviews within 30 calendar days of receipt of appropriate documentation, written response from the involved provider, and semi-annual reports submitted to service chiefs. Without proper completion of the peer review process, managers could not be assured that appropriate credentialing and privileging decisions were made, and that the facility's risk was minimized.
- Neither the GI Section Chief nor the Quality Manager reviewed six serious GI Lab complications for the fourth quarter of fiscal year 2003. Although the Section Chief told us he conducted the reviews, there was no documentation to support his assertions. In addition, he did not report the events to the Quality Management Office as required. Facility policies require review and documentation of all adverse events.

Without proper documentation, managers could not be assured that corrective actions were appropriately implemented.

- Forty-four percent (11 of 25) of clinical and administrative service chiefs had not submitted timely annual assessments of performance improvement (PI) activities at the time of our review. Facility policy requires service chiefs to report annual PI activities to the Quality Leadership Team (QLT) via their October Service Staff Meeting. Annual assessment of PI activities assists managers in determining the effectiveness of corrective actions, compliance with targeted measures, and identification of areas requiring further improvements.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Facility Director requires that:

a. The peer review process is completed per policy.

b. Adverse events are appropriately reviewed and documented.

c. Service chiefs submit timely annual PI assessment reports to the QLT.

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

Supply Inventory Management – Inventory Controls Should Be Improved

Condition Needing Improvement. The facility's inventory controls needed improvement. Facility staff had designated 11 primary inventory points (Anesthesiology, Cardiology, Dental Lab, Environmental Management Service, Engineering, Hemodialysis, Primary Lab 25, Supply Processing and Distribution, Surgery, Radiology, and Warehouse). GIP had not been implemented in three of the primary inventory points (Cardiology, Dental Lab, and Radiology) and the remaining eight inventory points were not using scanners to document their inventory counts. The GIP automated inventory control system assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand. The following areas required management attention:

Inventory Balances. GIP inventory balances did not agree with our physical inventory counts taken during March 15-18, 2004. We selected 184 items valued at about $203,690 out of a total of 2,033 stock items valued at about $687,970 to determine the accuracy of GIP inventory balances. Our review disclosed that balances recorded in GIP for 155 of 184 items (84 percent) were inaccurate or the items could not be located. The results of the inventory were:

- 93 items (50 percent) were under-reported (quantities on hand were higher than recorded inventory balances).
- 42 items (23 percent) were over-reported (recorded inventory balances were higher than quantities on hand).
- 20 items (11 percent) could not be located.
- 29 items (16 percent) agreed with the physical count.

Excess Stock On Hand. Based on our physical inventory counts for the items in our sample, 89 sample items valued at $52,203 exceeded a 30-day supply. VHA guidelines consider inventory balances of more than a 30-day supply to be excessive. Using the sample results, we estimate that 983 of the 2,033 items on hand had stock valued at about $176,000 in excess of the 30-day supply level.

Items With No Demand. There were 1,010 items totaling about $255,750 that were "seldom use" or "no use" items. There had been no demand for these items in over 365 days. Some of the items were designated as emergency or seasonal items. However, facility staff had not reviewed the items to determine if there was a continued need for them. Facility staff should review these items to ensure that they are still required to meet facility needs.

These conditions occurred because facility staff had not fully implemented GIP. Three primary points did not have computerized bar code labels identifying inventory stock items. The remaining eight primary points had labels identifying the inventory stock items but did not use scanners when conducting inventories, resulting in some inventory balances not being entered or being incorrectly entered into GIP. Computerized bar code labels identify each item within the inventory. A bar code reader is used to scan the label to identify the item and then the quantity is entered into the scanner. After inventorying stock items, the information in the scanner is uploaded into GIP, and reorder quantities are generated.

Recommended Improvement Action(s) 4. The VISN Director should assure that the Facility Director ensures that:

a. A physical inventory of all primary inventory points and update of GIP records is performed.

b. Stock levels are reviewed to determine if items exceed 30-day stock levels and appropriate action is taken to reduce the stock levels.

c. "Seldom use" or "no use" items are reviewed and removed from inventory if necessary.

d. Inventory stock items are labeled and scanners are used to document inventory counts.

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

AIS – Security Needed Improvement

Condition Needing Improvement. The facility's AIS security required management attention. The facility's Veterans Health Information Systems and Technology Architecture (VISTA) contingency plan was not complete, and facility staff did not receive required computer security awareness training. VA policy requires that VA facilities develop a contingency plan, incorporating specified elements, to facilitate effective disaster recovery and continuity of operations.

VISTA Contingency Plan. The VISTA contingency plan did not include:

- Defined roles and responsibilities for disaster recovery team members.
- Pager, cellular, and home telephone numbers of disaster recovery team members.
- Hardware and software configurations of major AIS.
- An alternate processing site to be used in a catastrophic situation.
- Detailed system recovery procedures.

Since the VISTA contingency plan did not include required elements, managers could not ensure effective response to catastrophic situations or assure recovery of the facility's AIS.

Computer Security Awareness Training. All facility employees did not receive the required annual computer security awareness training during FYs 2002 and 2003. Our review showed that computer security awareness training was provided to 1,561 (84 percent) of the 1,854 employees during FY 2002 and 1,310 (68 percent) of the 1,928 employees (full and part-time) during FY 2003. In addition, as of March 18, 2004, only 159 (7 percent) of the 2,019 employees had received the training during FY 2004. VHA policy requires that annual computer security awareness training be provided to all facility employees. While we were onsite, the Information Security Officer provided us with a plan that showed all employees would receive computer security awareness training before the end of FY 2004.

Recommended Improvement Action(s) 5. The VISN Director should ensure that the Facility Director takes action to require that:

a. Contingency plans are comprehensive and contain required elements to ensure effective contingency planning.

b. Annual computer security awareness training is provided to all facility staff.

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

Contracts – Invoices for Transportation Services Were Not Properly Certified Before Payment

Condition Needing Improvement. The facility paid $310,600 for non-emergent ($263,860) and ambulance ($46,740) patient transportation services from October 1, 2002, through February 15, 2004. Mileage charges totaled $87,636 for non-emergent transportation and $27,622 for ambulance transportation. Our review identified overpayments of about $20,000 for mileage charges during this period.

According to the contracts, the vendor was to be paid a base amount for each trip within the Memphis city limits and an additional mileage charge for each mile traveled outside of the city limits. We reviewed a judgment sample of 60 trips (30 from each contract) and found that the vendor incorrectly charged for mileage within the city limits for the non-emergent and ambulance transports.

- A sample of 30 non-emergent patient transports with mileage charges totaling $4,400 showed that 685 (20 percent) of the 3,430 miles charged were within the city limits, resulting in overcharges totaling $17,527 ($87,636 X 20 percent).
- A sample of 30 ambulance patient transports with mileage charges totaling $14,070 showed that 362 (9 percent) of the 4,020 miles charged were also within the city limits, resulting in overcharges totaling $2,486 ($27,622 X 9 percent).

Based on these results, we estimate that the facility overpaid the vendor on both contracts about $20,013 of the $310,600 paid for mileage since October 1, 2002. The overpayments occurred because the Contracting Officer's Technical Representative (COTR) did not properly monitor the contracts, nor did the COTR verify that the vendor's invoices complied with contract terms prior to certifying the invoices for payment. While the contracts stated that the Rand McNally Standard Mileage Guide would be used to determine mileage, the guide only showed mileage from the Memphis city center to another city center, rather than mileage traveled between the Memphis city limits and the destination. Further, the COTR did not know the location of the city limits in order to determine the correct mileage.

The VISN 9 ASC awarded the non-emergent and ambulance patient transportation contracts; therefore, we made recommendations directly to the VISN Director to correct the contracting matters.

Recommended Improvement Action(s) 6. The VISN Director should ensure that:

a. The VISN 9 ASC staff reviews all payments made to the vendor and recovers overpayments, including overpayments identified by our review.

b. The Facility Director takes action to ensure that the COTR verifies mileage before certification of vendor invoices.

c. The VISN 9 ASC staff considers alternatives for developing a verifiable payment system for mileage with the current vendor.

The VISN Director agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Physician Conflict of Interest – Acknowledgement Forms Were Not Completed

Condition Needing Improvement. The completion of physician conflict of interest acknowledgment forms required management attention. We reviewed ten physician personnel folders and found that none of the physicians had signed an Acknowledgment Form (VA Form 10-21009) confirming that they had received, read, and agreed to abide by the guidance pertaining to the conflict of interest aspects of contracting for scarce medical services. VA policy requires that the Chief of Staff and each physician, clinician, allied health supervisor, or manager receive a copy of VHA Handbook 1660.3 and sign the acknowledgment form. Prior to our visit, facility management had not established a process to ensure that physicians and other required staff had signed the acknowledgement form. While we were onsite, facility management gave physicians copies of the handbook and required them to sign and return the forms to Human Resources Service. Facility management also implemented a process that required all new physicians to receive the handbook during new employee orientation and sign and return the acknowledgement form to Human Resources Service.

Recommended Improvement Action(s) 7. The VISN Director should ensure that the Facility Director takes action to require that each physician, clinician, allied health supervisor, or manager receives a copy of VHA Handbook 1660.3 and signs the acknowledgement form.

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

Part-Time Physician Timekeeping – Timekeeping Discrepancies Were Not Reported to Timekeepers' Supervisors

Condition Needing Improvement. Timekeepers' discrepancies should be reported to timekeepers' supervisors. The Employee Accounts Section is responsible for performing periodic desk audits of all timekeepers to ensure that time and attendance reports are properly prepared, maintained, and supported by subsidiary records. The Fiscal Officer is to report unsatisfactory timekeeping practices and conditions to the timekeepers' supervisors through the Facility Director.

During FY 2003, Employee Accounts Section staff conducted 27 desk audits of 14 time and attendance units and identified 32 discrepancies such as inconsistencies between scheduled and actual tours worked and the lack of employee and supervisor signatures certifying time sheets as correct. However, the Fiscal Officer did not report the results of the audits to the unit timekeepers' supervisors through the Facility Director as required by VA policy.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the Facility Director requires the Fiscal Officer to report identified timekeeper discrepancies in accordance with policy.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 29, 2004

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the VA Medical Center Memphis, Tennessee, Project# (2004-00631-HI-0078)**

To: Director, Operational Support Divison (53B)
Thru: Director, Management Review and Administration

1. Attached please find VAMC Memphis' response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted March 15 - 19, 2004.

2. I concure with with the Medical Center Dircector's comments and action plans.

3. If you have any questions or need additional information, please contact Vivieca Wright, Staff Assistant to the Network Director at 615-340-2380.

(original signed by:)

John Dandridge, Jr.

Network Director

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 6. The VISN Director should ensure that:

a. The VISN 9 ASC staff reviews payments for current contracts with this vendor to collect potential overpayments and those overpayments identified by our review.

c. The VISN 9 ASC staff considers alternatives for developing a verifiable payment system with the current vendor.

Concur **Target Completion Date:** See Below

a. The ASC will review all the invoices/payments made from 11/1/02-present, for both contracts, absent the 60 invoices already audited, in order to determine if additional overpayment occurred in excess of the $20,013 specified in the report.

· A Bill for Collection will be issued and amount due deducted from future invoices if feasible.

· New contract requirements are currently in development for awards effective October 1, 2004. To be Completed By January 31, 2005.

c. Central Office has reviewed current ambulance and special needs transportation specifications and is considering two options for the new procurement:

(1) Establish a flat rate per mile, plus a pick-up fee; or

(2) Establish a mile radius around the VA with a flat rate, plus additional mileage beyond the radius, using an available on-line mileage program to validate claims prior to payment. An analysis is being conducted to determine the most advantageous pricing method and most efficient verification process for the Government. To Be Completed by August 31, 2004.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2004

From: Director, VA Medical Center (614/00)

Subject: **Combined Assessment Program Review of the VA Medical Center Memphis, Tennessee, Project# (2004-00631-HI-0078)**

To: Assistant Inspector General for Healthcare Inspection

Thru: Director, Mid South Network, VISN 9 (10N9)

1. Attached please find VAMC Memphis' response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted March 15-19, 2004.

2. If you have any questions regarding the information provided please contact Mary Jean Erwin, Director of Quality Management and Improvement. Ms. Erwin can be reached at (901) 577-7489.

(original signed by:)

PATRICIA O. PITTMAN

Medical Center Director

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should assure that the Facility Director takes action to:

a. Address all patient safety concerns identified in the June 2002 Mental Health Environmental Risk Assessment for the locked psychiatry unit.

b. Ensure medication carts and housekeeping closets are properly secured.

Concur **Target Completion Date:** See Below

a.

· Showerheads – In 1C are Speakman Adjusta-Spray Watersaver Model S-2460-A, which is designed such that you cannot tie anything to them and are marketed as vandal-resistant. The Specification sheet on the showerheads was provided to Quality Management on April 6, 2004 and faxed to the OIG.

· Shower Curtains – Changed to Break Away Curtain such as the Imperial IFC-69. Completed July 7,2004.

· Closet Clothes hanger bars were removed from all closets. Completed March 18, 2004.

· All bathroom towel hooks that were located too high were removed or relocated. Completed March 18, 2004.

· Door Pulls/handles that posed a risk were repositioned and risk eliminated. Completed March 18, 2004.

· Tamper proof screws installed with exception of door hinges. Completed July 16, 2004.

· A Minor construction project, to completely renovate all inpatient Psychiatry Wards, is being submitted for Design in FY 05 and Construction in FY 06.

b.

· Ongoing training and education have been provided.All Facility Management staff members were instructed to keep housekeeping closets secured. Completed in March, 2004.

· An additional reminder was provided at staff meetings. Completed April 15 and June 15, 2004.

· Nursing staff members have been reminded about securing medication carts. Accomplished during JCAHO rounds for the past several months. There were no JCAHO recommendations regarding this issue during the recent JCAHO survey July 12 – 16, 2004.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Facility Director requires that all electronic monitoring device alarms are set in the “alert” position as required.

Concur **Target Completion Date:** See Below

All GI Lab equipment has been checked and electronic monitoring device alarms are set in the "alert" position as required. Completed week of April 12-17, 2004.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Facility Director requires that:

a. The peer review process is completed per policy.

b. Adverse events are appropriately reviewed and documented.

c. Service chiefs submit timely annual PI assessment reports to the QLT.

Concur **Target Completion Date:** See Below

a. All level 3 peer reviews, previously identified have been closed. The current peer review policy/practice is being revised utilizing the draft national handbook to ensure timely completion of the process. To Be Completed By October 31, 2004.

b. Procedure complications are being reported to QM and are being reviewed quarterly. Results of these reviews are being shared with Service Chiefs and the Clinical Practice Group.

· The first report reviewing 6 months of data was provided to service chiefs and the Clinical Practice Group. Completed June 2004.

· Reports to the Clinical Practice Group will be presented every 6 months.

c. QLT policy changed to reflect:

(1) Annual reporting to the Executive Management Board. Revision made in QLT policy and approved. Completed April 7, 2004.

(2) Annual PI Report will be requested from services Oct 1 each year and due to QLT by December 15 each year. Requests to be sent to Services By October 1, 2004.

Recommended Improvement Action(s) 4. The VISN Director should ensure that the Facility Director ensures that:

a. A physical inventory of all primary inventory points and update of GIP records is performed.

b. Stock levels are reviewed to determine if items exceed 30-day stock levels and appropriate action is taken to reduce the stock levels.

c. "Seldom use" or "no use" items are reviewed and removed from inventory if necessary.

d. Inventory stock items are labeled and scanners are used to document inventory counts.

Concur **Target Completion Date:** See Below

a.

· All Primary inventory points are being inventoried with updates of GIP.

· All areas will have Primary inventory points established and running GIP with updates available as information is assembled. To Be Completed By September 1, 2004.

b.

· Stock levels are being reviewed to determine if items exceed 30-days and appropriate action take. To Be Completed By September 1, 2004.

c.

· Seldom use or no use items reviewed and removed from inventory when appropriate. To Be Completed By September 30, 2004.

d.

· All areas to be reviewed for scanning procedures and labels correctly identified. To Be Completed By September 1, 2004.

Recommended Improvement Action(s) 5. The VISN Director should ensure that the Facility Director takes action to require that:

a. Contingency plans are comprehensive and contain key elements to ensure effective contingency planning.

b. Annual computer security awareness training is provided to 100 percent of facility staff.

Concur **Target Completion Date:** See Below

a. Each service has been required to review and update their contingency plan as required by VA Policy 6210.

The yearly update is in progress. All service level contingency plans to be completed by July 30, 2004.

b. Each service was given a target for the service to complete the Cyber Security Awareness training.

· Training is progressing.

· Several services that have already reached 100%.

20 Service – 100%

6 Services – 97 to 85%

5 Services – 85% or Below

Overall on July 14, 2004 - 88.5%

Recommended Improvement Action(s) 6. The VISN Director should ensure that:

b. The Facility Director takes action to ensure that the COTR verifies mileage before certification of vendor invoices.

Concur **Target Completion Date:** See Below

b.

· COTR currently assigned to the procurements specified in the audit will be provided the mandatory COTR training by August 31, 2004.

· Additionally, VISN 9 ASC will be providing mandatory COTR training to all appointed/ designated COTRs within the VISN not previously trained by June 30, 2005. To Be Completed By August 31, 2004.

Recommended Improvement Action(s) 7. The VISN Director should ensure that the Facility Director takes action to require that each physician, clinician, allied health supervisor, or manager receives a copy of VHA Handbook 1660.3 and signs the acknowledgement form.

Concur **Target Completion Date:** See Below

· Human Resource Management Service (HRMS) will aggressively obtain signed forms from 100% of physician staff to place in OPF.

· HRMS already has begun the process. Most recent report July 9, 2004, showed nearly 100% completion except for Fee Basis providers. The form was mailed out to Fee Basis providers. Expect full compliance by August 13, 2004.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the Facility Director requires the Fiscal Officer to report identified timekeeper discrepancies in accordance with policy.

Concur **Target Completion Date:** See Below

1. Action Plan:

· In-depth training for Surgical Service timekeepers.

Completed April 6, 2004.

· Refresher training for all physician-included T&L's

· Desk Audit Routing Part-Time Physician Timekeeping Guidelines

· Moving non-core hours – can be moved within the PP.

· Core hours cannot be moved – must work or be charged leave

· If employee does not work all tour hours in pay period, then leave must be charged for time absent

· All hours must be scheduled prior to the beginning of the pay period. Any changes to the scheduled tour must be approved in writing prior to the beginning of the pay period.

· Core time cannot be less than 25% of scheduled hours in pay period

· Certification of core sheets must be completed on all signature lines

· Post timecards daily

· Monitor exceptions

· Effective immediately, as audits are performed any discrepancies will be routed to the Director through service chief and Chief of Staff. Follow-up action will be taken.

2. Actions Taken:

·All service-level issues have been addressed. Certification of Core sheets being completed every pay period. All exceptions being dealt with promptly.

· All physician contained T&L's (timekeepers) were retrained by May 1, 2004.

· Desk audit findings are routed to service chief and summarized for Top Management.

3. All of the following actions began in the Pay Period beginning March 21, 2004.

· Effective immediately, the following process will be put into place for all part time physician providers:

· Annual Leave – Military Leave or Pre-scheduled Sick Leave – A copy of the approved paper leave request or a copy of the VistA T&A entry showing the approved request is required and will be sent as an attachment to the weekly or monthly T&A report submitted to the Chief of Staff's office.

· Sick Leave – Should the physician have emergency leave or unplanned sick leave, documentation showing approval will be submitted as soon as the physician returns to duty.

· Authorized Absence (AA) – For AA to attend conferences, etc., copies of the documentation submitted by the physician when submitting the request, as well as documentation of approval by the service chief, will be submitted as an attachment to the weekly or monthly T&A report submitted

· Leave Without Pay (LWOP)– If the physician is noted to not be present for core time duty, and not in an official leave status (i.e., AL, SL, ML or AA), he/she will be considered in a LWOP status. Documentation will be required for any LWOP incident and will be forwarded as an attachment to the weekly or monthly T&A report submitted to the Chief of Staff's office. Should the physician have emergency leave or unplanned sick leave, documentation showing approval will be submitted as soon as the physician returns to duty.

· All T&L Timekeepers (213, 780, 400, 410, 383, 530, 750, 751, 752, 753, 754) will follow the process by using the correct form, and forwarding the form through their respective service chief, then to the Chief of Staff and the Medical Center Director for signatures.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
4b	Reduce items to 30-day stock levels	$176,000
6a	Recovery of overpayments to the transportation service contractor	$20,000
	Total	$196,000

Appendix D

OIG Contact and Staff Acknowledgments

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Acknowledgments	James R. Hudson, Director, Atlanta Office of Audit Floyd Dembo, Audit Manager Judy Lawhead, OHI Team Leader Leon Roberts, Audit Team Leader Ann Batson George Boyer Harvey Hittner Michael Keen Jeanne Martin Tina Mitchell Carroll Montalva Wilma Wong

Appendix E

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