Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review
VA Chicago Health Care System
Chicago, Illinois

Report No. 04-00937-196 **August 30, 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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Contents

Executive Summary

Introduction

During the week of April 12 – 16, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Chicago Health Care 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 275 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 12.

Results of Review

This CAP review focused on 18 areas. As indicated below there were no concerns identified in eight of the areas. The remaining 10 areas resulted in recommendations for improvement.

The System complied with selected standards in the following areas:

- Consolidation of Inpatient Services
- Fee Basis Program
- Information Technology (IT) Purchases
- IT Security
- Medical Care Collections Fund
- Part-Time Physician Time and Attendance
- Pharmaceutical Cache Program
- Unliquidated Obligations

Based on our review of these eight areas, the following organizational strength was identified:

- The System effectively coordinated and consolidated inpatient services.

To improve operations, the following recommendations were made:

- Comply with local policies regarding moderate sedation.
- Improve procedures to collect employee debts.
- Improve controls over Government purchase cards.
- Correct safety and environmental deficiencies.
- Strengthen controls over supply inventory management.
- Strengthen controls over controlled substances.

- Improve accountability of Agent Cashier and install panic alarms.
- Improve contract file documentation and administration.
- Enhance QM processes.
- Improve controls over Personal Funds of Patients (PFOP).

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

VISN 12 Director Comments

The Director agreed with the CAP review findings and provided acceptable improvement plans. [See Appendix A, beginning on page 20 for the full text of the Director's comments. The Director's comments were completed following the official renaming of the System on May 25, 2004. The Director's comments refer to the System as the Jesse Brown VA Medical Center (JBVAMC).] We consider all review issues to be resolved, and we will follow up on implementation of planned improvement actions.

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

Introduction

Health Care System Profile

Organization. Located on the west side of Chicago, Illinois, the System consists of a tertiary care hospital and community-based outpatient clinics (CBOCs) in Chicago; Chicago Heights; Beverly, Illinois; and Crown Point, Indiana. The System serves a primary service area of 14 counties in Illinois and Northwestern Indiana.

In February 2002, the VA Secretary approved the Capital Asset Realignment for Enhanced Services (CARES)[1] plan for VISN 12, which included the movement of inpatient services from the then existing Lakeside campus to the West Side campus of the System. This involved closing 90 acute care beds (medical, surgical, neurology, and physical rehabilitation) at Lakeside and opening 56 additional beds at West Side. The approved CARES implementation plan and transition was completed in August 2003. To accommodate the consolidation of inpatient services at the West Side facility, two new inpatient units were opened, two operating rooms were activated, Nuclear Medicine was expanded, and Respiratory Care was remodeled. On May 25, 2004, the Secretary officially renamed the System as the Jesse Brown VA Medical Center.

Programs. The System provides comprehensive primary, medical, surgical, mental health, geriatric, and women's health care services. It has 209 acute care beds and offers radiation therapy, hemodialysis, gynecology, and liver transplants through contracts with the University of Illinois at Chicago (UIC) and Northwestern University (NU) medical centers.

Affiliations and Research. The System has affiliations with the NU Medical School and the UIC College of Medicine. It supports 228 residents and provides rotational training to approximately 900 university residents, interns, and students. There are also nursing education affiliations at the undergraduate and graduate levels with area colleges and universities, as well as affiliations with UIC and Malcolm X College involving dentistry, nutrition, pharmacy, social work, and psychology programs.

The System has a large research program. During Fiscal Year (FY) 2003, there were 149 active research principal investigators and 444 active research projects. The total research funding for FY 2003 from VA, National Institutes of Health, and industry sources was $23.2 million.

Resources. The System's operating budget for FY 2003 was approximately $210 million. The FY 2004 operating budget is also $210 million. Staffing for FY 2003 was

[1] CARES is a comprehensive planning process that evaluates future demand for veterans health care services against current supply, and repositions Veterans Health Administration (VHA) assets to provide more accessible quality health care to more veterans.

2,031 full-time employee equivalents (FTE); FY 2004 staffing is currently 1,937 FTE, which includes 164 physician and 487 nursing FTE.

Workload. The System treated 43,000 unique patients in FY 2002 and 42,460 unique patients in FY 2003. Inpatient workload totaled 9,497 discharges in FY 2003. The average daily acute care bed census was 167 in FY 2003. Outpatient workload totaled 525,000 visits for FY 2002 and 528,000 visits for FY 2003.

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, QM, 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 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 health care facilities use 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:

Agent Cashier
Consolidation of Inpatient Services
Contracting
Controlled Substances
Employee Accounts Receivable
Environment of Care
Fee Basis Program
Government Purchase Cards
Information Technology Purchases
Information Technology Security
Medical Care Collections Fund
Moderate Sedation
Part-Time Physician Time and Attendance
Personal Funds of Patients
Pharmaceutical Cache Program
Quality Management Program
Supply Inventory Management
Unliquidated Obligations

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 243 responded. We also interviewed 30 patients during the review. The survey results were shared with the System's managers.

During the review, we also presented three fraud and integrity awareness training sessions for the System's employees. About 275 employees attended these sessions, 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 facility operations for FY 2003 and FY 2004 through March 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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 implemented. For those activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable conditions.

Results of Review

Organizational Strength

Consolidation of Inpatient Services Was Effective. The System Director established a CARES Transition Management Team to ensure that the consolidation of inpatient services and associated changes would be carried out in a manner that maintained access to veteran care and enhanced the quality of patient care. The CARES Transition Management Team coordinated the many details involved in planning, preparing, and implementing the consolidation process and associated moves of clinical and administrative services. This endeavor required detailed planning, tremendous coordination, and close and comprehensive monitoring by the team. The success of these efforts was evident by: the relocation of inpatients from Lakeside to West Side in a smooth and orderly fashion in August 2003 without incident or adverse outcome to patients; the feedback received from medical and nursing employees that was overwhelmingly supportive in how the move was planned and conducted; and the two medical school affiliates remaining supportive and engaged throughout this transition.

Opportunities for Improvement

Moderate Sedation – Medical Record Documentation and Patient Monitoring Needed To Be Improved and Cardiopulmonary Resuscitation Certification Needed To Be Maintained

Condition Needing Improvement. Veterans Health Administration (VHA) regulations require that health care facilities establish guidance for providing care to patients receiving all types of anesthesia, including moderate sedation. Moderate sedation is a drug-induced depression of consciousness used to control pain and discomfort associated with minor surgical procedures and diagnostic examinations. Patients who receive moderate sedation retain their ability to respond to verbal and tactile commands unlike patients who receive general anesthesia. No special measures are required to maintain the patients' cardiovascular functioning or spontaneous ventilation during the procedures.

We found the System established appropriate controls over the safe delivery of moderate sedation, but clinical managers needed to ensure that pertinent medical information was documented in patients' medical records. Clinical managers also needed to ensure that patients who receive moderate sedation have their vital signs (blood pressures, pulses, and respiratory rates) monitored until they have fully recovered. Additionally, clinical managers needed to ensure that all employees involved in the care of patients who receive moderate sedation maintain cardiopulmonary resuscitation (CPR) certification.

Medical Record Documentation. We reviewed the medical records of nine patients who received moderate sedation during the 6 months prior to the CAP review. Three medical records (33 percent) contained all of the required documentation. Two medical records were missing documentation regarding vital signs; pre-procedure, intra-procedure and post-procedure notes; and signed consent forms. Additionally, two medical records did not contain documentation regarding who would accompany the patients to their homes at the time of discharge. VHA regulations require that patients discharged be accompanied by a responsible designated adult. We also found that four medical records, including two already mentioned above, did not contain documentation that patient vital signs were taken at 5-minute intervals during their recovery phases. The System's policy governing moderate sedation requires documentation at 5-minute intervals.

Patient Monitoring. We reviewed three patient care areas where moderate sedation was administered. At Lakeside, endoscopy[2] procedures were performed in the Endoscopy Unit located on the ninth floor of the building. Nurse managers told us that once endoscopy procedures had been completed and patients were alert (approximately 5 minutes), patients were transported to the recovery area in the Same Day Surgery (SDS)

[2] Endoscopy is a visual examination of any body cavity using a scope.

Unit located on the first floor. Patients remained in the SDS Unit until they were fully recovered, which could take up to 2 hours.

While registered nurses (RNs) accompanied patients during the transport from the Endoscopy Unit to the SDS Unit, patients' vital signs were not monitored during the transport. VHA regulations require that patients who need to be transported to post-procedure recovery areas have their vital signs continuously monitored during transport. Portable cardiac and oxygen monitoring units that monitor heart rates and oxygen saturation levels would alert RNs to changes in the patients' conditions.

CPR Certification. We reviewed the training records and credentialing and privileging files for five physicians who were privileged to administer moderate sedation. Additionally, we reviewed the training records and scopes of practice for a certified RN anesthetist and two RNs who were involved in the administration or monitoring of patients receiving moderate sedation. We found that one physician had failed to renew the required CPR certification. VHA regulations stipulate that all employees who provide patient care maintain current CPR certification.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that: (a) clinical managers ensure that the medical records of patients who receive moderate sedation include all pertinent documentation; (b) patients' vital signs be monitored during transports to post-procedure recovery areas; and (c) all employees involved in the care of patients who receive moderate sedation maintain CPR certification.

The VISN Director agreed with the findings and recommendations. Managers have established processes to ensure that the medical records of patients receiving moderate sedation include all pertinent documentation. Patients' vital signs are being continuously monitored during transport to post-procedure recovery areas. Managers have established processes to ensure that employees involved in the care of patients who receive moderate sedation maintain CPR certification. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Employee Accounts Receivable – Procedures To Collect Employee Debts Needed To Be Improved

Condition Needing Improvement. Fiscal Service employees at Hines VA Hospital (VAH) were responsible for recording, maintaining, and collecting accounts receivable for the System. Improvements were needed in collecting employee accounts receivable. System employees terminated their employment without processing through Hines VAH Fiscal Service and without paying debts owed VA. Hines VAH Fiscal Service employees did not reconcile employee accounts receivable and did not initiate required collection procedures for delinquent employee accounts receivable. In addition, Hines VAH Fiscal Service employees did not follow up on suspended employee accounts receivable.

Employee Accounts Receivable. As of February 29, 2004, there were 275 accounts receivable for current and former employees totaling $251,228. We reviewed a judgment sample of 46 receivables totaling $150,486, resulting from overpayment of health benefits[3] and travel expenses. Actions to collect accounts receivable were not adequate for 43 (93 percent) accounts totaling $146,867. There were three contributing factors. Clearance procedures were not adequate to collect debts owed at the time System employees terminated, transferred, or separated from VA. Monthly reconciliations were incomplete or not performed and did not identify outstanding accounts receivable. Lastly, collection procedures did not follow established VA procedures.

Clearance Procedures. VA policy requires that employees complete clearance procedures using VA Form 3248, "Employee Clearance From Indebtedness," before termination, transfer, or separation from employment. System employees who terminated employment did not clear through Hines VAH Fiscal Service. Consequently, some employee debts were not discovered before the employees' departures.

As of February 29, 2004, there were 25 accounts receivable for former employees who owed VA $118,575. Although the System used a checklist form to help ensure that required clearance steps were completed for departing employees such as turning in equipment, turning in badges, or revoking computer system access, determining whether employees had other outstanding debts was omitted from the checklist.

Monthly Reconciliations. VA policy requires that accounts receivable general ledger balances recorded in VA's Financial Management System (FMS) be reconciled monthly with subsidiary records in the Integrated Fund Control Point Activity, Accounting, and Procurement (IFCAP) system. Among the 46 employee accounts receivable sampled there were 17 (37 percent) employee related accounts receivable that were not recorded in IFCAP subsidiary records.

- Fifteen accounts receivable for present and former employees, totaling $23,893, were the result of overpayments for health benefits made between FYs 2001 and 2003.
- Two accounts receivable, totaling $6,092, were the result of overpayments to one employee for permanent change of station travel expenses made May 23 and July 17, 2000.

Hines VAH Fiscal Service employees stated that they thought that Austin Finance Center employees were responsible for recording these accounts receivable and, therefore, had taken no action. Because these 17 accounts receivable were not reconciled to and recorded in IFCAP, Hines VAH Fiscal Service employees took no action to collect them.

[3] For example, when VA pays benefits for an employee during which time that employee is in a non-pay status, an overpayment may occur if the employee does not return to work timely.

Collection Procedures. VA policy requires prompt and aggressive follow-up collection action on accounts receivable and establishes the use of uniform collection procedures. Hines VAH Fiscal Service employees did not use the required collection methods to identify and pursue 23 delinquent employee accounts receivable totaling $40,158. For example:

- Six current employee debts totaling $11,273 could have been recouped through salary offset.
- Seven former employee debts totaling $7,339 should have been referred to the Treasury Offset Program (TOP) for collection.
- Ten former employee debts totaling $21,546 that had been referred to TOP had no follow-up.

Suspended Accounts Receivable. According to VA policy, if an employee requests a waiver of indebtedness, collection action on the debt may be suspended for up to 6 months pending a decision on the request. VA policy requires that Fiscal Service employees conduct a review at the end of the suspension period to determine if the receivable should be canceled or if collection action should resume.

As of February 29, 2004, there were three accounts receivable, valued at $4,869, that were overdue for one current employee and two former employees because collection actions had been suspended. According to the Accounting Supervisor, collection notices were suspended between October 2000 and April 2001. Collection action on all three accounts was suspended because debtors had submitted waiver requests. However, there was no documentation to show evidence of waiver requests for the two former employees. Hines VAH Fiscal Service employees had not followed up on the status of the current employee's waiver request to determine if a decision was made. Consequently, the collection notice remained in suspense.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that: (a) the System Director revises clearance procedures to include Hines VAH Fiscal Service as a clearance point for employees who are terminated, transferred, or separated; (b) Hines VAH Fiscal Service employees reconcile employee accounts receivable; (c) Hines VAH Fiscal Service employees use required collection methods; and (d) Hines VAH Fiscal Service employees follow up on decisions regarding requests of waiver for suspended employee accounts receivable.

The VISN Director agreed with the findings and recommendations. Managers are revising the System's policy to expand the actions of the Agent Cashier to process employee clearances. Fiscal managers will work with appropriate employees under their direction to ensure that employee debts are properly reconciled and all collection measures are followed. The debt identified as currently suspended will be unsuspended and collection pursued. The VISN Director's improvement plans meet the intent of our

recommendations and are acceptable. We will follow up on planned actions until they are completed.

Government Purchase Cards – Certain Purchase Card Controls Needed To Be Improved

Condition Needing Improvement. As of March 31, 2004, the System had 115 Government purchase cardholders, 44 approving officials, and 162 purchase card accounts. During the first 4 months of FY 2004, cardholders executed 7,630 purchase card transactions totaling $4.8 million. Cardholders and approving officials performed reconciliations and approvals timely. However, there were three areas where management could strengthen controls. Purchase cardholders needed to discontinue making split purchases. Purchase cardholders with single purchase limits exceeding $2,500 needed training. In addition, warrants issued to purchase cardholders, whose single purchase limits exceeded $2,500, needed to specify the amounts of the warrants.

Split Purchases. Federal Acquisition Regulations (FAR) limit the use of Government purchase cards for purchases where the aggregate amount is $2,500 or less. Splitting purchases to circumvent the limitation is prohibited. Among a judgment sample of 41 purchase orders (POs) for medical supplies and services that occurred between October 2003 and January 2004, there were 20 POs totaling $38,112 that represented split purchases. These were POs to the same vendors, executed within a few minutes of each other. For example:

- On December 11, 2003, one purchase cardholder executed a transaction to buy medical supplies totaling $1,982. One minute later, the same cardholder executed another transaction to buy more medical supplies from the same vendor totaling $763.
- On January 12, 2004, another purchase cardholder executed a transaction to buy medical supplies totaling $2,233. Three minutes later, the same cardholder executed another transaction to buy more medical supplies from the same vendor totaling $2,437.

These purchases should have been made using required Government acquisition methods including using different vendors, rather than splitting the purchases into 20 separate POs.

Training. According to VA policy, purchase cardholders may be authorized to execute purchase card transactions that exceed the standard $2,500 limitation. However, these cardholders are required to receive 40 hours of specialized training in Federal and VA acquisition policies before being granted such authority. Nine Prosthetics Service employees[4] had authority to make Government purchase card purchases of prosthetic

[4] System Prosthetics Service employees were organizationally aligned under the Prosthetics Service at VA Medical Center Milwaukee, WI, but physically located at the System.

supplies of up to $25,000. However, VA's automated Training and Education Management Program tracking system contained no record that these employees had received the required training.

Warrants. VA policy allows Government purchase cards to be used for single purchases of up to $100,000, provided cardholders have been granted the appropriate warrants. One purchase cardholder had a single purchase limit of $100,000. However, the cardholder's warrant did not specifically reference the $100,000 limit. VISN 12 Great Lakes Acquisition Center (GLAC) employees located in Milwaukee, Wisconsin provided contracting support for the System. The VISN 12 GLAC Manager needed to issue the cardholder the appropriate warrant.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that: (a) the System Director establishes controls to prevent Government purchase cardholders from splitting purchases to circumvent single purchase limits; (b) Prosthetics Service employees receive required acquisition training and the training is documented; and (c) the VISN 12 GLAC Manager issues appropriate warrants to cardholders whose purchase limits exceed $2,500.

The VISN Director agreed with the findings and recommendations. Additional controls have been established to prevent Government purchase cardholders from splitting purchases. Prosthetics employees will receive acquisition training, and the training will be recorded in the electronic system. Warrants will be issued to cardholders whose purchase limits exceed $2,500, and an annual audit will be scheduled to validate warrants. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

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

Condition Needing Improvement. Senior managers needed to ensure that patient care areas were clean, maintained, and minimized infection control risk; sharp instruments were secured; and biohazardous wastes were properly stored and secured. Additionally, nurse managers needed to ensure that nursing employees promptly respond to emergency calls. VHA regulations require that the health care environment present minimal risk to patients, employees, and visitors, and that diligent infection control practices are employed to reduce the risk of hospital-acquired infections.

Cleanliness, Maintenance, and Infection Control. Patient rooms that were prepared for new admissions needed further cleaning and maintenance. For example, there was an accumulation of dust and debris along baseboards and in corners of the floors and soiled bases on rolling equipment items such as tray tables, intravenous poles, and blood pressure monitors. There were food particles, personal items, and patient care equipment left in bedside stands from previous patients' admissions. There was a broken bedside

stand drawer and holes in the walls that needed repair. Additionally, cracked and missing light covers needed to be replaced.

There was a pillow in a patient room that was tattered and needed replacing. Nurse managers told us that employees from various services who are responsible for making patient beds were required to inspect pillows and mattresses and report any damage so replacements could be obtained. Pillows and mattresses that are not intact may present infection control risks.

Environmental Management Service (EMS) Employees Needed to Improve Cleaning and Report Repairs. Employee survey comments indicated concerns about the cleanliness of high-use restrooms in Ambulatory Care at West Side. We inspected these restrooms and found that additional cleaning, re-stocking of paper products and soap, and repairs of dispensers were warranted. There were soiled floors, sinks, toilet stalls, and areas under urinals that required further cleaning. There were dirty paper towels on sinks and floors, trash receptacles that needed to be emptied, graffiti written on toilet stalls, and broken or missing dispensers. EMS managers reported that toilet paper and dispensers, soap and dispensers, and other items were frequently stolen from these restrooms. EMS managers also told us that housekeepers were directed to report items needing repair or replacement to their supervisor so that work orders could be generated.

Sharp Instruments Security and Biohazardous Waste Storage. There were used suture kits stored in an unlocked soiled utility storage room in a primary care clinic at West Side. Additionally, there was a bag of biohazardous waste sitting on the floor instead of being placed in an appropriate receptacle. There were also sharp instruments, such as scissors, tweezers, and forceps, in unlocked drawers in patient examination rooms in the primary care clinics at Lakeside.

Response to Emergency Calls. We tested the response time to the emergency call system in a communal patient restroom located on a medical unit. A nursing employee entered the restroom 2 minutes after the system was activated. Although System policies did not establish standard timeframes for response times, the nurse manager believed this 2-minute response time was unacceptable and could have compromised patient safety.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director requires that: (a) patient care areas are clean, repairs are made, and pillows and mattresses are regularly inspected; (b) EMS managers increase housekeeping coverage in high-use restrooms, and employees report damage to their managers; (c) sharp instruments are secured and biohazardous wastes are properly stored and secured; and (d) the System managers establish policy for response to emergency calls and test employee responses for compliance.

The VISN Director agreed with the findings and recommendations. Employees assigned to clean patient rooms received training, and supervisors are spot-checking rooms to

ensure that the rooms are thoroughly cleaned and the furniture is intact. Mattresses and pillows were inspected for replacement. Housekeeping employees have been instructed to report items in need of repair and to direct urgent repair needs to the Engineering Service Work Order Desk. Additional housekeeping resources and equipment have been committed to high-use areas. Staff will monitor security of sharp instruments and medical equipment, and nursing response to emergency call light systems will be monitored on a monthly basis. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened

Condition Needing Improvement. In FY 2003, the System spent $2.6 million on medical, prosthetic, and engineering supplies. VHA established goals for reducing supply inventories to 30-day levels and for using the Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage these inventories. GIP was used to manage medical supplies in Supply, Processing, and Distribution (SPD), and PIP was used to manage prosthetic supplies. Recorded inventory levels of both medical and prosthetic supplies were accurate. However, the System needed to fully implement GIP to manage engineering and janitorial supplies, reduce medical supply inventory levels, and conduct physical inventories.

Use of GIP for Engineering and Janitorial Supplies. System employees had not fully implemented GIP to manage engineering and janitorial supplies. System senior managers stated that the closure of inpatient beds at Lakeside in August 2003 and consolidation at West Side prevented earlier implementation of GIP for engineering and janitorial supplies. After August 2003, large quantities of both inventories were transferred to West Side and, as of the date of our review, employees had not completed the integration process.

Excess Medical Supply Inventory. As of April 7, 2004, SPD employees had 106 line items of medical supply stock on hand with a value of $33,169. Analysis of stock on hand showed that $14,499 of that stock was in excess of a 30-day supply level. Excess supply inventories tie up System funds that could be put to other uses.

Physical Inventory. VHA policy requires that a complete physical inventory of supplies be conducted annually. Engineering Service and EMS employees had not performed complete inventories of engineering and janitorial supplies during FY 2003 or FY 2004 through April 2004. Engineering Service and EMS supervisors stated that consolidation of Lakeside supply stocks into West Side supply stocks had taken priority over other aspects of inventory control.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director takes action to: (a) implement GIP to manage

engineering and janitorial supplies; (b) reduce medical supply inventory levels to a 30-day supply level; and (c) conduct annual physical inventories of engineering and janitorial supplies.

The VISN Director agreed with the findings and recommendations. Utilization of GIP is currently being implemented. EMS was scheduled for completion by June 30, 2004, and Engineering Service will be completed by August 31, 2004. Stock has been reduced to a 30-day or less level, and a physical inventory of supplies in Engineering Service and EMS will be conducted at least annually. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Controlled Substances – Resolving Discrepancies and Limiting Reappointments of Inspectors Would Strengthen Controls

Condition Needing Improvement. Accountability and security of controlled substances in Pharmacy Service were generally effective. Physical security was adequate, and the number of employees accessing storage vaults 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 conducted the required quarterly destruction of expired and unusable controlled substances. However, there were two areas where controls could be improved. Controlled substances inspectors needed to improve reporting procedures, and inspectors should not be reappointed immediately following expiration of their appointments.

Resolving and Reporting Controlled Substances Inspection Discrepancies. VHA policy requires that a controlled substances coordinator (CSC) review discrepancies noted by controlled substances inspectors, resolve discrepancies with the appropriate supervisors, and include that information in an inspection report to the System Director. There were two occurrences where controlled substances inspectors noted discrepancies that were not included in final inspection reports to the Director. In May 2003, System inspectors noted that unit records showed a controlled substance had been dispensed to a patient who was no longer on that unit. In November 2003, System inspectors identified a shortage of a second controlled substance on another unit. Although inspectors noted both discrepancies in their reports to the CSC, these reports did not explain how the discrepancies occurred, nor how they were resolved. The inspection reports did not indicate either the strength or dosage amounts of the missing controlled substances. In addition, there was no mention of either discrepancy in the final inspection reports to the System Director.

Appointment of Inspectors. VHA policy requires that controlled substances inspectors be appointed for terms not to exceed 3 years. We interviewed 9 of the System's 38 controlled substances inspectors. Three of the inspectors stated that they had been performing controlled substances inspections for more than 3 years, ranging from 5 to 21 years. All had been reappointed in 2002 for additional 3-year terms immediately after the

expiration of their terms. One of the advantages of limiting controlled substances inspectors to 3-year terms is to prevent opportunities for diversion of controlled substances through collusion between inspectors and those they inspect. Reappointment of an inspector to a consecutive term circumvents the 3-year appointment limitation.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the System Director takes action to: (a) ensure that the CSC resolves and reports identified controlled substances inspection discrepancies to the System Director; and (b) discontinue the practice of reappointing controlled substance inspectors immediately after expiration of their 3-year terms.

The VISN Director agreed with the findings and recommendations. All occurrences and resolutions of controlled substances discrepancies will be reported to the System Director, and consecutive terms for inspectors will not be permitted. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Agent Cashier – Accountability Needed To Be Transferred to an Alternate Cashier and Panic Alarms Installed and Repaired

Condition Needing Improvement. The amount of the Agent Cashier cash advance was appropriate. System employees properly conducted unannounced audits of the advance every 90 days. An OIG-requested unannounced audit of the Agent Cashier's advance identified a $5 overage that was appropriately deposited into the General Fund Receipt Account. However, accountability and responsibility for the Agent Cashier's cash advance needed to be transferred to an alternate cashier, and panic alarms needed to be installed.

Transfer of Accountability. There was no complete transfer of accountability and responsibility for the Agent Cashier's cash advance to an alternate cashier during calendar year 2003. VA regulations require that this be done once each calendar year for a period of at least 2 weeks. This requires an alternate cashier to take over complete operation of all Agent Casher functions. The transfer of accountability provides an independent check on the Agent Cashier and provides training and experience to the alternate cashier.

Panic Alarms. At the Crown Point CBOC, there was no panic alarm for cashiers to activate in the event of an emergency, and at West Side the Agent Cashier panic alarm did not function. At the time of our review, work was being done on the West Side alarm system that the Chief, Engineering Service said should resolve the problem. Through correspondence with facility managers, we confirmed that work had been completed and the Agent Cashier panic alarm at West Side was functional. However, the Crown Point Agent Cashier panic alarm was not included in this work.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the System Director takes action to: (a) transfer accountability and responsibility of the Agent Cashier's advance to an alternate cashier for a period of at least 2 weeks every calendar year; and (b) install a panic alarm at the Crown Point CBOC.

The VISN Director agreed with the findings and recommendations. Managers will ensure that accountability and responsibility of the Agent Cashier's advance is transferred to an alternate cashier for the required annual timeframe. Installation of a panic alarm at the Crown Point CBOC will be completed by July 30, 2004. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Contracting – Contract File Documentation and Administration Needed To Be Improved

Condition Needing Improvement. System employees monitored payments to vendors and reviewed invoices to ensure that vendors provided the specified services. Sales agreements were properly executed. However, VISN 12 GLAC contracting officers needed to improve contract file documentation and contract administration. In addition, System employees needed to keep VISN 12 GLAC employees informed of changes in contract administration conditions.

Contract File Documentation. FAR requires that contracting officers prepare price negotiation memorandums (PNMs), assess contractor performance, and conduct cost analyses for negotiated purchase contracts. FAR also requires that contracting officers review contracts before they are renewed to ensure that contractors performed adequately, that costs continued to be reasonable, and that contractors providing medical services maintained required liability insurance. Contracting files must document all these actions.

We reviewed files for 11 service contracts valued at $2.1 million. Files for four contracts did not contain all required documentation. For example:

- A contract file for echocardiography services, valued at $129,000, did not contain a record of public notification for the award of the contract. Although the contract was renewed twice, the contract file did not contain documentation that the contractor maintained liability insurance.
- A VA and Department of Defense sharing agreement, valued at $90,000, did not include records of cost analysis or a PNM.
- Files for two other contracts, with a combined value of $352,000, did not contain documentation that reviews of cost reasonableness and assessments of contractor performance were performed before the contracts were renewed.

Contract Administration. FAR requires that a contracting officer's technical representative (COTR) be appointed to work with the contracting officer to help ensure satisfactory performance by the contractor and that the appointment be documented in the contract file. Three of the 11 contract files did not contain documentation for the appointment of replacement COTRs. A VISN 12 GLAC contracting officer stated that the GLAC had not received notifications from System managers that the COTRs had been replaced.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that: (a) the VISN 12 GLAC contracting officers include required documents in contracting files and perform required reviews before exercising renewal options; and (b) the System Director ensures that VISN 12 GLAC employees are notified when COTRs are replaced.

The VISN Director agreed with the findings and recommendations. Processes have been established to ensure that VISN 12 contracting officers include required documents in contracting files and perform the required review before exercising renewal options; and VISN 12 employees are notified when COTRs are replaced. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Quality Management Program – Aspects of the Program Needed To Be Enhanced.

Condition Needing Improvement. The System's QM program, referred to as Performance Improvement (PI), was effective. Senior managers demonstrated support for PI by participating in PI activities and providing necessary resources to accomplish PI initiatives. However, there were aspects of the program that needed to be enhanced.

Clinical Privileges. VHA regulations require that physicians who practice medicine at VA medical facilities be privileged at least every 2 years. Clinical managers told us that the System had physicians who requested continued clinical privileges, but in the clinical managers' judgment, have not completed sufficient clinical time at the System to be adequately evaluated. This can happen, for example, when a physician specialist comes to the System to do a procedure that is infrequently performed. Clinical managers told us that when such a physician specialist was due to be re-privileged, the service chief requested a letter from their affiliated university hospitals verifying that the physician specialists were credentialed and privileged at those hospitals. However, System managers did not request information from the affiliated university hospitals detailing what privileges the physician specialists had been granted, and had no knowledge what these physician specialists were privileged to do at the affiliating hospitals. Clinical and senior managers agreed that this situation exposed the System to risk. Clinical managers agreed to request core and supplemental clinical privileges from affiliated hospitals before granting privileges to physician specialists who infrequently practice at the System.

Adverse Patient Events. VHA regulations require that patient events that cause injury be reported, reviewed, and assigned a safety assessment code (SAC)[5] score. A facility's Patient Safety Officer or appropriate PI employee usually assigns SAC scores and enters events and scores into a patient safety database. We found that adverse patient events were sometimes reviewed only by the Chief of Staff and were not always forwarded to the appropriate PI employee for SAC scoring and entering into the database. This condition made it difficult for PI managers to accurately identify trends in adverse patient events.

Informing Patients and Families of Adverse Events. VHA regulations require that facilities have processes to ensure that patients and families are promptly informed about adverse events. Additionally, VHA regulations require that there be documentation, for example in medical records, that patients and families have been informed about adverse events.

The System did not consistently inform families and patients about clinical facts associated with injuries related to adverse events. PI managers told us that the System was developing a policy that will ensure that patients and families are informed about adverse events and that notification of adverse events is appropriately documented in the medical records.

Process Owners. We reviewed meeting minutes from several committees (for example, the Medical Record Committee and the Quality Leadership Committee) and interviewed PI managers and employees. We found that PI employees were primarily responsible for ensuring that identified process deficiencies were corrected, and recommendations resulting from root-cause analyses were implemented and monitored for effectiveness. Accountability for process improvements should be placed with the individuals who can actually change or improve a process (the process owners). Additionally, process owners should report on the implementation and effectiveness of corrective actions to appropriate committees. Committee minutes need to accurately reflect progress toward implementation and the effectiveness of corrective actions, until deficiencies are resolved.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the System Director: (a) requires that clinical managers obtain the clinical privileges from affiliated university hospitals for physician specialists who practice infrequently at the System prior to granting the physicians' clinical privileges; (b) ensures that SAC scores are assigned to all adverse patient events and the events are entered into the patient safety database; (c) establishes processes to inform patients and families about

[5] SAC scores require an assessment of the severity of an injury, ranging from catastrophic to minor, and a probability rating (how often it occurs) ranging from frequent to remote. A severity category is paired with a probability category for either an actual event or a close call, and a score is determined: 3 = highest risk, 2 = intermediate risk, and 1 = lowest risk. A root-cause analysis is performed on those adverse events assigned a SAC score of 3.

injuries resulting from adverse events and that documentation reflects that this has occurred; and (d) ensures that process owners are accountable for implementing improvements and reporting the effectiveness of corrective actions to appropriate committees, and committee minutes reflect progress of corrective actions until deficiencies are resolved.

The VISN Director agreed with the findings and recommendations. Clinical managers will request that affiliated university hospitals verify competence for active providers' privileges and provide assurance that the providers have met volume and quality standards. SAC scores are being assigned to all adverse patient events, and the events are entered into the patient safety database. Managers have established processes for informing patients and families about injuries resulting from adverse events. Process owners are accountable for implementing corrective actions and reporting the effectiveness of the actions to appropriate committees until deficiencies are resolved. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

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

Condition Needing Improvement. Hines VAH Fiscal Service employees maintained PFOP accounts for the System. PFOP clerks, who worked at the Hines VAH in Medical Administration Service, documented patients' competency status and maintained signature cards. Hines VAH Fiscal Service employees performed monthly and semi-annual reconciliations of the accounts and posted withdrawals and deposits timely. As of April 1, 2004, there were 193 active accounts totaling $13,200. However, controls over PFOP accounts needed to be strengthened.

Competency Status. VHA policy requires that a patient's competency status be annotated in the PFOP accounting record. The purpose is to allow PFOP clerks to determine whether a patient's account is restricted or unrestricted.[6] The competency status listed on 9 of the 193 PFOP accounts was "unknown" and another account did not indicate status. The competency status of these patients needed to be entered into the PFOP accounting record.

Signature Cards. VA policy requires that patients with funds in PFOP accounts have signature cards on file with the PFOP clerks. Cards for patients with active accounts are to be filed alphabetically, and cards for patients with inactive accounts are to be filed by calendar year in a separate file. The PFOP clerks maintained a single signature card file for both active and inactive accounts rather than two separate files.

[6] 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.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the System Director takes action to: (a) document patients' competency status in PFOP accounting records; and (b) maintain signature cards according to VA policy.

The VISN Director agreed with the findings and recommendations. Processes have been established to ensure that the patients' competency status is verified and that signature cards are maintained. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2004

From: VISN 12 Director

Subject: **VA Chicago Health Care System Chicago, Illinois**

To: Assistant Inspector General For Healthcare (54)

1. In response to the Draft Report of the Combined Assessment Program Review of the VA Chicago Health Care System, attached please find comments, corrective action plans and completion dates for each Recommendation, as provided by the Medical Center Director.

2. I have reviewed and concur with the attached response.

(original signed by:)

Joan E. Cummings, M.D.

Attachments

VISN 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 Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the System Director requires that: (a) clinical managers ensure that the medical records of patients who receive moderate sedation include all pertinent documentation; (b) patients' vital signs be monitored during transports to post-procedure recovery areas; and (c) all employees involved in the care of patients who receive moderate sedation maintain CPR certification.

Concur **Target Completion Date:** 8/31/04

(a) Service Chiefs will be responsible for sampling and reviewing records of all providers under their management that use moderate sedation and will provide appropriate feedback when deficiencies exist to the Chief of Staff. Quantitative provider-specific information about completeness of medical records will be maintained by the Service Chief and used for credentialing and privileging of providers. Medical Record Committee will monitor completeness of medical record for patients undergoing procedures and will provide aggregate data to the Medical Executive Council at least quarterly. A retrospective and concurrent medical record review of moderate sedation for 39 patients was conducted with 100% compliance of all pertinent documentation on June 21, 2004.

(b) Endoscopy patients, at the Lakeside Campus, who received moderate sedation during the procedures are transported from the GI Lab on the 9th floor to the Same Day Surgery recovery area on the 3rd floor, with portable cardiac, pulse oximetry and vital signs monitoring unit and are continuously monitored by an RN during the transport. After a procedure, the patient stays in the procedure room and is monitored until he is stable and fully alert. Post sedation and post procedure recovery documentation is initiated. The patient is then helped to a wheelchair and connected to a portable monitoring unit that is fastened to the wheelchair. He/she is further observed and monitored closely while in the wheelchair. This may take 15-20 minutes of monitoring immediately after the procedure to the time the patient is transported to the Same Day Surgery Area. The post sedation & post recovery documentation is continued and completed by Same Day Surgery nurses. As per (a), the medical record review and tracer methodology were used to verify that this practice has been implemented.

(c) Physician providers who are privileged for procedures that require moderate sedation will need to demonstrate basic life support certification in order to be privileged/re-privileged for the moderate sedation procedure. In addition a database is being established by the Chief of Anesthesia, with the assistance of Education Service, to track all providers who have moderate sedation privileges and to verify CPR certification.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that: (a) the System Director revises clearance procedures to include Hines VAH Fiscal Service as a clearance point for employees who are terminated, transferred, or separated; (b) Hines VAH Fiscal Service employees reconcile employee accounts receivable; (c) Hines VAH Fiscal Service employees use required collection methods; and (d) Hines VAH Fiscal Service employees follow up on decisions regarding requests of waiver for suspended employee accounts receivable.

Concur **Target Completion Date:** 9/30/04

(a) The policy for Employee Clearance from Hospital Indebtedness currently includes as a final step the Agent Cashier. The policy is being revised to expand the actions that must be taken by the cashier when an employee clears. The cashier should review the A/R package to determine whether the employee has an active debt due to the VA. However, not all employee debt can be located within the A/R Package. FEHB and PCS debts are created by the FSC while the VCS allows for advance purchasing with payroll offset. As a result, the Payroll Section will need to determine whether employees have debt related to FEHB or the VCS. The Accounting Section would verify whether debt is in place for PCS.

(b) The Assistant Fiscal Officer will work with the Supervisory Accountant to insure that employee debt at JBVAMC is properly reconciled. This will require that the A/R Tables in FMS be reconciled to the General Ledger as well as the A/R Package within VISTA. This will then identify those debts created by the FSC that do not reside within A/R. Three months ago, we began a new reconciliation process specifically for FEHB. As a result of this new process, we have begun to clear several FEHB debts. Fiscal Service will now expand that process to cover all employee debt. The final document will than be shared with all relevant parties to aid in identifying potential collections during the clearance process. This will be performed in conjunction with the aforementioned reconciliation between FMS, the General Ledger, and A/R.

(c) The Assistant Fiscal Officer for JBVAMC will coordinate with the Supervisory Accountant, Payroll Supervisor, and Operations Supervisor to ensure that all appropriate collection measures are followed. This will require following the appropriate due process measures and referral measures.

(d) Employee debt should be suspended if it has been referred to the Committee for Waivers and Compromise. The debt identified as currently suspended will be unsuspended and collection pursued as we are not aware of any cases currently under review by the Committee.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that: (a) the System Director establishes controls to prevent Government purchase cardholders from splitting purchases to circumvent single purchase limits; (b) prosthetics employees receive required acquisition training and the training is documented; and (c) the VISN 12 GLAC Manager issues appropriate warrants to cardholders whose purchase limits exceed $2,500.

Concur **Target Completion Date:** 09/30/04

(a) Split purchasing has been a prohibited practice for several years. This issue has been, and will continue to be, emphasized during the training sessions. We will also enhance the purchase card audit process to include an opportunity to provide brief refresher training. The Purchase Card Coordinators and the VISN Head of Contracting Authority will monitor the splitting of orders. The VISN CFO will brief the VISN 12 Executive Leadership Council. The VISN CFO will review VISN Policy memorandum #10N12-02-14 to determine whether a revision is necessary.

(b) The VISN 12 Prosthetics Service Line Manager ensures that the required acquisition training will be accomplished for the JBVAMC prosthetics staff and that it is recorded in the TEMPO system. This training will be provided in conjunction with the VISN Head of Contracting Authority.

(c) The VISN 12 Great Lakes Acquisition Center Manager, in the capacity as Head of Contracting Authority, will issue appropriate warrants to cardholders whose single purchase limits exceed $2,500. The Acquistion Center will conduct an annual audit each fiscal year to validate appropriate warrants to cardholders whose single purchase limit exceeds $2,500.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the System Director requires that: (a) patient care areas are clean, repairs are made, and pillows and mattresses are regularly inspected; (b) EMS managers increase housekeeping coverage in high-use restrooms, and employees report damage to their managers; (c) sharp instruments are secured and biohazardous wastes are properly stored and secured; and (d) the System managers establish policy for response to emergency calls and test employee responses for compliance.

Concur **Target Completion Date:** 9/30/04

(a) All mattresses and pillows were reviewed for replacment. Twenty-six pillows and 5 mattresses were replaced due to wear and tear. All staff assigned to discharge cleaning have received additional training on proper procedures for discharge cleaning. Supervisors are also spot-checking rooms after being cleaned to ensure bedside furniture is in working condition and thoroughly cleaned. A reminder checklist is also being used to remind housekeeping staff of each room item that requires cleaning and replenishment of supplies. All housekeeping personnel have been instructed to report to their supervisor any observations of items in need of repair. Staff has been informed of the importance of reporting any urgent repairs to the Engineering Service Work Order Desk.

(b) Restrooms in the atrium outpatient clinics have all been repainted and repairs completed. Pictures are being added for visual appeal and new waste receptacles are currently on order and scheduled for delivery mid August 2004. A full-time housekeeper is being hired to provide cleaning services solely for these high traffic restrooms. This is currently under recruitment and we anticipate having this position filled by late July 2004. In addition, four new KIVAC hands-free restroom cleaning systems have been purchased and are being used to clean restrooms throughtout our facilities. The high traffic atrium outpatient clinics are being cleaned with this system on a weekly basis. Retraining for all housekeeping staff regarding patient and public restroom cleaning was completed during April 2004.

(c) Clinical Managers for outpatient clinic areas will assign staff to monitor areas for used sharps and to make sure that medical equipment is secured.

(d) Nursing Service safety representatives will check the emergency call light system for their units and the employees' response to the emergency call light system, on a monthly basis. This information will be documented on the monthly unit safety round sheet.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the System Director takes action to: (a) implement GIP to manage engineering and janitorial supplies; (b) reduce medical supply inventory levels to a 30-day supply level; and (c) conduct annual physical inventories of engineering and janitorial supplies.

Concur **Target Completion Date:** 8/31/04

(a) Utilization of the GIP inventory management system is currently being implemented at the Jesse Brown VAMC to comply with requirement contained in VHA Handbook 1761.2 and guidance issued on May 13, 2004 from the Deputy Under Secretary for Health for Operations and Management. The implementation effort for Environmental Management Service (including janitorial supplies) is scheduled for completion June 30, 2004. The implementation effort for the Engineering program area is scheduled for completion August 31, 2004. However, implementation requirements in the Engineering program are being completed in a modified version, which has been approved by the VHA Office of Clinical Logistics.

Specifically, due to the fact that the current CARES construction has created a need to continuously relocate the Engineering Program over the next 2-3 year period, the requirement to utilize bar code labels has been deferred until Engineering is located in permanent space.

(b) The number of line items managed by the SPD program area has consistently been at approximately 250 items for the past several months. Additionally, for the past few months, Jesse Brown VAMC has maintained an average stock level of 30 days or less stock on hand, with no excess funding involved. These figures are based upon data contained in the SPD GIP stock status system. We agree that holding inventory investment to a minimum is one of the primary focal points of sound inventory management practices. Enhanced utilization of the GIP system is expected to provide the monitoring and reporting tools needed to consistently realize acceptable turnover and stock on hand rates. It should be noted that a memorandum dated May 20, 2004 from the Acting Chief, VHA Office of Clinical Logistics, sent to the Deputy Under Secretary for Health for Operations and Management and The Acting Deputy Under Secretary for Health, indicates that network performance measures associated with turnover and stock on hand were in the process of being reviewed and possibly revised pending a six to twelve month review of national stock status reports once mandated program areas have fully implemented GIP use at their respective facilities. This memorandum was generated as a direct result of the memorandum from the Deputy Under Secretary for Health for Operations and Management, dated May 13, 2004 regarding the mandatory utilization of GIP.

(c) Current VHA policy relative to physical inventory of supplies is contained in VA Handbook 7127/1, Part 4, sections 5301-2 and 5302. However, the requirement for an annual physical inventory, relates only to warehouse stock (supply fund) maintained in a perpetual inventory account. However, in keeping with sound inventory management practices, we agree that a physical inventory of supplies in the Engineering and EMS (including janitorial) will be conducted at least annually.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the System Director takes action to: (a) ensure that the CSC resolves and reports identified controlled substances inspection discrepancies to the System Director; and (b) discontinue the practice of reappointing controlled substance inspectors to immediate additional 3-year terms.

Concur **Target Completion Date:** 7/31/04

(a) All occurences of discrepancies will be identified and reported to the Medical Director, along with any resolution of the discrepancy.

(b) The recruitment procedures for the selection of Narcotics Inspectors at the Jesse Brown VA Medical Center has been changed. The limit of term for any inspector is 3 years. Consecutive terms for inspectors will not be permitted and current inspectors cannot be renominiated.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the System Director takes action to: (a) transfer accountability and responsibility of the Agent Cashier's advance to an alternate cashier for a period of at least 2 weeks every calendar year; and (b) install a panic alarm at the Crown Point CBOC.

Concur **Target Completion Date:** 7/31/04

(a) The annual requirement to turn over the advance at W/S was not accomplished. We identified this discrepancy within our internal Quality Assurance Review. The Assistant Fiscal Officer in conjunction with the Operations Supervisor will ensure that all advances are appropriately turned over in the required annual timeframe.

(b) The Chief of Police and Security, as well as the Chief of Engineering Service, will ensure that a panic alarm is installed by July 30, 2004.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that: (a) the VISN 12 GLAC contracting officers include required documents in contracting files and perform required reviews before exercising renewal options; and (b) the System Director ensures that VISN 12 GLAC employees are notified when COTRs are replaced.

Concur **Target Completion Date:** 9/30/04

(a) An interim supervisory 'pre-award' Quality Assurance(QA) review is mandatory for sole source procurements exceeding $1,000,000 and awarding to other than the lowest priced offer or/bidder when the procurement exceeds $100,000. Specifically, the Contracting Officer Supervisor will be approving/disapproving Contracting Officers Price Negotiation Memorandum prior to award. A QA team was formed to include; GLAC Management Assistant, Program Analyst and Small Purchase Center Supervisor. The QA team will conduct contract reviews on all mandatory procurements subject to an interim supervisory review as well as contracts selected for a quarterly random review. QA review findings will be incorporated into a GLAC performance measure and reported quarterly to the VISN 12 Finance Council.

(b) The Jesse Brown VAMC has developed a new Medical Center Policy outlining inter-service transfer and a clearing of station procedures that must be accomplished by all employees transferring between services or leaving the facility. This process requires the departing service to check with the GLAC to determine whether the employee is a COTR as part of the "clearing" process for the individual before he or she can move to the new service or terminate employment. If the answer is yes, the service will be responsible to inform the GLAC of whom will be assuming the COTR duties.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the System Director (a) requires that clinical managers obtain the clinical privileges from affiliated university hospitals for physician specialists who practice infrequently at the System prior to granting the physicians' clinical privileges; (b) ensures that SAC scores are assigned to all adverse patient events and the events are entered into the patient safety database; (c) establishes processes to inform patients and families about injuries resulting from adverse events and that documentation reflects that this has occurred; and (d) ensures that process owners are accountable for implementing improvements and reporting the effectiveness of corrective actions to appropriate committees, and committee minutes reflect progress of corrective actions until deficiencies are resolved.

Concur **Target Completion Date:** 9/30/04

(a) At the time of privileging or re-privileging of provider staff who have concomitant privileges at an affiliated medical school hospital, medical center will send the list of VA requested privileges to the credentialing and privileging official at the affiliated hospital. The medical center is requesting of the affiliated hospital verification of competence for active privileges and assurance that the provider has met their volume and quality standards.

(b) SAC scores are being assigned to all adverse events and the events are entered into the patient safety data base including the NCPS, as appropriate for aggregate reviews

(c) Jesse Brown VA Medical Center has established a process for informing patients and families about injuries resulting from adverse events and the documentation that the event has occurred. The final draft of the memorandum, "Disclosure of Adverse Events" is pending clinical concurrence and final signature.

(d) Process owners are now accountable for implementing improvements and reporting the effectiveness of corrective actions until deficiencies are resolved. Process owners will attend designated meetings and present their action plans as assigned by Senior Leadership.

Recommended Improvement Action 10. We recommend that the VISN Director ensure that: the System Director takes action to (a) document patients' competency status in PFOP accounting records; and (b) maintain signature cards according to VA policy.

Concur **Target Completion Date:** 6/30/04

(a) The PFOP clerk has responsibility for documentation of patients' competency in the PFOP records. The clerk utilizes data obtained from the Patient Administration Screen that is updated with every admission. A mechanism has been put into place to ensure that if competency is not properly reflected on the accounting record, the PFOP clerk will verify the patient's appropriate status prior to proceeding.

(b) The PFOP clerk has separated active from inactive accounts. The signature cards for inactive accounts are being filed by calendar year in accordance with VA policy.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds	Questioned Costs
2 (a), (b), and (c)	Improving clearance procedures, reconciling employee accounts receivable, and using required collection procedures would help collect employee debts.		$146,867
5 (b)	Reducing medical supplies would make funds available for other uses.	$14,499	
	Total	$14,499	$146,867

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	John Brooks Paula Chapman Larry Chinn Kenneth Dennis William Gerow Theresa Golson Terrye Hall Freddie Howell, Jr. Raymond Jurkiewicz Dana Martin Katherine Owens Cherie Palmer Jennifer Roberts Leslie Rogers William Wells Ora Young

Appendix D

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