Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Beckley, West Virginia

Report No. 04-00540-208 **September 24, 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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Introduction

During the week of January 12-16, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Beckley Veterans Affairs Medical Center (referred to as the medical center), which is part of Veterans Integrated Service Network (VISN) 6. 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 194 employees.

Results of Review

This CAP review focused on 14 areas. As indicated below, there were no concerns identified in four of the areas. The remaining 10 areas resulted in recommendations or suggestions for improvement.

The medical center complied with selected standards in the following areas:

- Accrued Services Payable
- Pharmacy Security
- Purchase Card Charges
- Undelivered Orders

We identified 10 areas that needed additional management attention. To improve operations, the following recommendations were made:

- Improve accuracy of supply inventory reports and reduce stock levels.
- Enhance Medical Care Collections Fund billing procedures.
- Strengthen accountability over controlled substances.
- Aggressively pursue collection of accounts receivable.
- Improve information technology security to comply with policy.
- Refine the Root Cause Analysis (RCA) process and improve provider specific data analysis.
- Improve moderate sedation practices.
- Improve patient transportation services.

Suggestions for improvement were made in the following areas:

- Correct environment of care deficiencies.
- Fully document Price Negotiation Memoranda and Technical Representative letters.

This report was prepared under the direction of Mr. Nelson Miranda, Director, and Mr. Randall Snow, CAP Review Coordinator, Washington, D.C., Regional Office of Healthcare Inspections.

Medical Center Director Comments

The VISN Director and the medical center Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendices A and B, pages 14-24, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Facility Profile

Organization. Located in Beckley, West Virginia, the medical center is a tertiary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at a community-based outpatient clinic located in Braxton, West Virginia. The medical center is part of VISN 6 and serves a veteran population of approximately 36,000 in a primary service area that includes 11 counties in West Virginia and one county in Virginia.

Programs. The medical center provides medical, surgical, mental health, and geriatric care, and has 42 hospital beds (26 medical, 14 intermediate, and 2 surgical) and 50 nursing home beds.

Affiliations and Research. The medical center is affiliated with the following institutions: West Virginia School of Osteopathic Medicine, West Virginia University, Academy of Careers and Technology, Mountain State University, Bluefield State College, Norfolk State University, Radford University, and West Virginia University Institute of Technology.

Resources. The Fiscal Year (FY) 2002 budget was $45,101,287, the FY 2003 budget was $49,547,051, and for FY 2004 the budget is $51,760,205. Staffing for FY 2003 was 504 full-time equivalent employees (FTE). FY 2004 staffing is 532 FTE, including 23 physicians, 2 Nurse Practitioners, 84 Registered Nurses, 46 Licensed Practical Nurses, and 25 Nursing Assistants.

Workload. In FY 2003, the medical center treated 13,828 unique patients, a decrease from 14,654 in FY 2002. This decrease was due in part to the discontinuation of services provided to local federal agencies, such as flu shots and physical exams. The inpatient care workload totaled 1,323 discharges, the average daily census for the nursing home was 39, and the average daily census for the medical-surgical intermediate care unit was 22. The outpatient workload was 118,179 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful, or potentially harmful, practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FY 2002, 2003, and 2004 through January, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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

Accounts Receivable	Moderate Sedation Practices
Accrued Services Payable	Patient Transportation Services
Contract Administration	Pharmacy Security
Controlled Substances Accountability	Purchase Card Charges
Environment of Care	Quality Management
Information Technology Security	Supply Inventory Management
Medical Care Collections Fund	Undelivered Orders

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all medical center employees, 89 of whom responded. We also interviewed 17 inpatients and 16 outpatients during the review. The survey results were provided to medical center managers.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 194 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-13). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center managers until corrective actions are completed. For the activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Opportunities for Improvement

Supply Inventory Management – Inventory Accuracy Should be Improved and Some Supply Inventories Needed to be Reduced

Condition Needing Improvement. Acquisition and Materiel Management (A&MM) employees needed to make better use of automated controls to more effectively manage supply inventories and reduce excess inventories. Veterans Health Administration (VHA) policy mandates that facilities use the Generic Inventory Package (GIP) to manage inventories, and establishes a 30-day stock level goal. 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.

As of January 2004, inventory in the nine primary control points consisted of 1,811 items with an adjusted value of $448,687. To test the accuracy of the inventory balances and the reasonableness of inventory levels, we reviewed a sample of 85 items and found two issues.

GIP stock value overstated. We conducted a physical inventory of the 85 items and found that for 56 items the counts did not agree with the balances shown in GIP. For the 85 items reviewed, the GIP-reported value was $74,296. However, the value of the actual stock balance was $46,281 (62 percent of the GIP-reported value). We estimate the entire adjusted inventory is overestimated by about $170,500 and should be valued at $278,200 ($448,687 x .62). This occurred because employees removed items from inventory but did not record those actions in GIP, or they reported zero inventory items when there were actually items on hand. While A&MM staff had completed physical inventories, they reported they had not documented the adjustments and corrected the balances in GIP.

Stock on hand exceeded 30-day standard. Usage data was not available for 38 of the 85 items; therefore, we were unable to calculate the days of stock on hand for those items. However, for 36 of the remaining 47 items reviewed, stock on hand exceeded 30 days of supply, with inventory levels ranging from 34 days to 2,800 days (over 7 years) of supply. For these 36 items, the value of stock exceeding 30 days was $20,412 or 73 percent of the total value of the 47 sampled items ($28,013). Applying the 73 percent of excess stock for the sampled items to the adjusted inventory value of supplies ($278,200), we estimated that the value of excess stock was about $203,090. According to A&MM management, the excess stock occurred because they had insufficient staff time to adjust all stock levels to meet the 30-day standard.

Recommended Improvement Action(s) 1. We recommended the VISN Director ensure that the medical center Director requires A&MM management to allocate sufficient staff time to correct GIP inventory reports and adjust supply stock levels to meet the 30-day standard.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries

Conditions Needing Improvement. The medical center increased Medical Care Collections Fund (MCCF) collections from $3.6 million in FY 2002 to $5.1 million in FY 2003, exceeding its FY 2003 collection goal of $4.9 million. Medical center managers could further improve MCCF program results by billing for fee-basis care and ensuring all professional fees for inpatient care are identified and billed. We found additional billing opportunities totaling $12,018.

Fee-basis Care. For FY 2003, medical center employees identified 583 fee-basis claims totaling $1.1 million. Of these, we determined that 44 payments totaling $27,883 could have been billed through MCCF for veterans with billable medical insurance. As of January 12, 2004, MCCF employees had not billed third party insurers for any of these payments because a reliable process had not been established to identify and bill for fee-basis care. Managers planned to identify billable fee-basis care payments for veterans with insurance for the last 12 months and retroactively bill those payments.

VA Care. We reviewed 10 outpatient visits and found that MCCF employees appropriately billed for care provided. However, we found missed billing opportunities related to inpatient care. We reviewed 14 inpatient discharges from September and October 2003 and determined MCCF employees appropriately issued 110 bills totaling $380,009 for these 14 discharges. We also identified 14 additional billing opportunities relating to seven of these inpatients for overlooked billable professional fees. MCCF employees issued 14 additional bills totaling $4,597 during our review.

Increased Collections. Billing for fee-basis care and ensuring all professional fees are billed will enhance revenue collections. We estimated that additional billings totaling $32,480 ($27,883 + $4,597) could have been issued. Based on the medical center's FY 2003 collection rate of 37 percent, MCCF employees could have increased collections by $12,018 ($32,480 x 37 percent).

Recommended Improvement Action(s) 2. We recommended the VISN Director ensure that the medical center Director establishes procedures and internal controls to:

(a) identify and bill fee-basis payments for veterans with insurance and (b) improve MCCF billing procedures by ensuring all professional fees are identified and billed.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Selected Controls and Destruction of Excess and Outdated Controlled Substances Needed Improvement.

Conditions Needing Improvement. The Chief of Pharmacy Service and the Controlled Substances Coordinator needed to strengthen controls to fully comply with VHA policy and help ensure accountability of controlled substances. The following deficiencies were identified.

Monthly Unannounced Controlled Substances Inspections. VHA policy requires that Controlled Substances Coordinators ensure that monthly inspections are completed in each area that stores controlled substances. Our review of the Monthly Unannounced Controlled Substances Inspection reports for the 12-month period ending October 2003 found that the following areas containing controlled substances were not documented as being inspected: the Pharmacy Vault for December 2002; the Pharmacy Cache Vault for May, June, and August 2003; Oncology for January and August 2003; and Ward 3B for June 2003. Controlled Substance Inspectors stated that the inspections were completed in all cases, except for the Pharmacy Cache Vault for May 2003; however, the inspections were not documented.

In July 2003, the medical center established a policy that monthly inspections be completed within one working day. In October 2003, the monthly inspection took two days to complete.

Training of Controlled Substances Inspectors. VHA policy requires that Controlled Substances Inspectors receive training on conducting the monthly inspections and this training be documented. During the 12-month period of our review, there were 10 inspectors, and while all 10 had received the required training, only three inspectors had the training documented.

72-hour Inventories of Controlled Substances. VHA policy requires a perpetual inventory of all controlled substances that is verified by Pharmacy Service at a minimum of every 72 hours. Our review of the Main Pharmacy Vault found that during the 4-month period ending November 26, 2003, there were six occasions when 72 hours elapsed without an inventory being taken. For these six occasions, the elapsed time between inventories ranged from 96 to 120 hours. The 72-Hour Inventory is an important control in identifying discrepancies at an early stage.

Quarterly Destruction of Excess and Outdated Controlled Substances. VHA policy requires that excess or outdated controlled substances that are returned to the pharmacy be properly stored and destroyed under the control of Pharmacy Service employees. The inspecting official is to verify that drug destructions are completed at least quarterly and document the destructions on the monthly inspection report. Monthly inspection reports indicated excess and outdated controlled substances were not being destroyed quarterly. No excess or outdated controlled substances were destroyed from September 2002 through June 2003. This occurred because the company disposing of the controlled substances did not have the proper Drug Enforcement Agency documentation to dispose of the controlled substances. Destruction of excess and outdated controlled substances occurred in June and October 2003 and January 2004, but the quarterly destruction for July through September 2003 was not conducted.

Recommended Improvement Action(s) 3. We recommended the VISN Director ensure that the medical center Director requires that: (a) monthly unannounced controlled substances inspections are performed in all areas and within the same day, (b) training for controlled substances inspectors is documented, (c) all controlled substances inventories are verified at least every 72 hours, and (d) all excess and outdated controlled substances are destroyed quarterly.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Accounts Receivable – Aggressive Follow-Up is Needed for Improved Collections

Condition Needing Improvement. VA policy requires prompt and aggressive action to collect debts. Guidance provided by VHA's Chief Business Office suggests that follow-up telephone calls for unpaid bills begin 30 days after issuance to verify receipt and to determine the reason they remain unpaid. Also, VA policy requires that most debts over 180 days delinquent be referred to the Treasury Offset Program (TOP) for collection.

Collection debts remain unpaid. As of October 31, 2003, there were 14 active vendor, employee, and ex-employee accounts receivable totaling $28,534. Also, there were 92 vendor, employee, and ex-employee accounts receivable that had been cancelled or written off totaling $431,782. We reviewed a judgmental sample of 20 accounts receivable (nine active accounts totaling $28,048 and 11 cancelled or written off accounts totaling $61,484). The 11 cancelled or written off accounts were appropriately authorized. However, for the nine active accounts, staff did not make any follow-up telephone calls, and two accounts receivable totaling $8,724 were over 180 days delinquent but had not been referred to TOP.

Recommended Improvement Action(s) 4. We recommended the VISN Director ensure that the medical center Director aggressively pursues delinquent debts by: (a) conducting follow-up telephone calls after the bills remain unpaid for 30 days, and (b) referring cases to the TOP when appropriate.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Information Technology Security – Improvements are Needed to Comply with VA Policies

Conditions Needing Improvement. We reviewed medical center information technology security to determine if adequate controls were in place to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for the computer rooms was adequate and security plans were current and complete. The following security conditions needed improvement.

Security Awareness Training. Not all facility employees completed the Security Awareness Training Course for FY 2003, as required by VHA policy. During FY 2003, 403 of the facility's 492 employees completed the course. The Information Security Officer (ISO) agreed that all employees should have completed the class and stated all employees would complete the course for FY 2004.

Storage of Information Resource Management (IRM) Back-up Tapes. VHA Directive 6210 states that back-up tapes should not be stored in the same building where the computer room is located. Currently, the back-up tapes, which are in a vault in the warehouse, are in the same building as the computer room. The ISO and Chief, IRM Section, agreed and stated they would move the storage of the back-up tapes to another building.

Recommended Improvement Action(s) 5. We recommended the VISN Director ensure that the medical center Director requires that: (a) all employees complete the Security Awareness Training course for FY 2004, and (b) IRM employees move the back-up tapes to another building for storage.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

QM – Root Cause Analysis (RCA) Process Needed Refinement, and Provider Specific Data Analysis for Re-privileging Needed Improvement

Conditions Needing Improvement. The medical center had an active QM program to monitor and improve quality of care. The medical center utilized various methods to analyze QM data, detect trends, and take action to address identified issues. All nine RCAs conducted in the previous 12 months identified problems and corrective actions; however, follow-up and notification measures were inconsistent. In addition, Credentialing and Privileging (C&P) documentation and analysis of provider specific QM data in the re-privileging process were incomplete.

Notification of Adverse Events. All RCAs conducted over the past 12 months were reviewed. VHA policy requires healthcare providers to notify patients or surrogate decision makers of unanticipated outcomes or adverse events. There was no documentation maintained by the QM office that the patient or surrogate decision maker had been notified about the unanticipated outcome or adverse event. However, medical records showed five of the nine patients or surrogate decision makers had been notified. Nurse Managers were in the process of developing a new incident report form that included a data element to document notification to the patient or surrogate decision maker of adverse outcomes or unanticipated events.

Clinical Re-privileging. Re-privileging is the process of renewing the privileges of a licensed independent practitioner who currently holds privileges within the facility. VHA policy requires that part of this overall process include an appraisal of professional performance, judgment, and clinical/technical competencies and skills based in part on provider specific quality management/performance improvement (QM/PI) data.

We reviewed FY 2003 and the first quarter of FY 2004 minutes of the Professional Standards Board and C&P files of five physicians from four medical and surgical specialties. There was no documentation in the C&P files that clinical managers had evaluated provider specific QM/PI data (such as complication rates, utilization management, drug & blood usage, patient comments, benchmarking, etc.) While some clinical managers had developed forms to analyze various quality indicators unique to their medical specialty, these forms were not in use at the time of the inspection. Interviews with Service Line Administrative Officers revealed that provider specific drug data is not compiled for clinical managers to review. None of the files documented any benchmark comparison of provider specific performance data with internal or external comparative information.

Recommended Improvement Action(s) 6. We recommended the VISN Director ensure that the medical center Director requires that: (a) adverse event notification to patients or surrogate decision makers is completed in accordance with VHA Handbook 1050.1; (b) clinical managers collect and document provider specific QM/PI data for

consideration in the privileging renewal process; and (c) clinical managers evaluate provider specific QM/PI data against available comparative internal, local, VHA, VISN, or national benchmarks at the time of re-privileging.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Moderate Sedation – Documentation of Patient Evaluations and Qualifications of Clinicians Needed Improvement

Conditions Needing Improvement. Moderate sedation/analgesia is defined as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain an open airway, and spontaneous ventilation is adequate. The same anesthesia standards of care that apply in the Operating Room (OR) apply to areas outside of the OR.

VHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that facility managers provide the same standard of care for a patient receiving moderate sedation throughout a facility. All patients in all care settings should receive comparable and acceptable quality of sedation/analgesia care and anesthesiologists are required to help develop policies and procedures related to that care. VHA and JCAHO standards require that patients will have a pre-sedation assessment within 30 days of the procedure, which must include a review of medical, anesthesia, and medication histories, a history and physical exam (H&P), assignment of an American Society of Anesthesiologists classification (ASA), an anesthesia plan of care and a discharge plan.

Physicians performing invasive procedures for patients outside the OR need to document a re-evaluation of patients immediately before moderate sedation procedures and have the required training in the administration and monitoring of patients undergoing procedures utilizing moderate sedation. We identified the following conditions needing improvement.

Medical Records Review. We randomly selected medical records of 10 patients who underwent procedures under moderate sedation from October through December 2003. We found that history and physical exams and ASA classifications were performed on all 10 patients prior to the procedures. However, although the re-evaluation of the patients immediately before the procedures was documented by nurses monitoring the patients, there were no co-signatures by the physicians as prescribed by VA policy. Informed consents were obtained, patients were properly monitored during and after their procedures, and patients were discharged according to policy requirements.

Qualification of Clinicians. We reviewed the C&P records of five clinicians who performed procedures utilizing moderate sedation. We found that one of the five physicians was not properly privileged to perform procedures using moderate sedation.

Recommended Improvement Action(s) 7. We recommended the VISN Director ensure that the medical center Director requires that: (a) physicians document the re-evaluations of patients immediately before their procedures or co-sign the nurses' notes addressing the reevaluations, and (b) clinicians comply with VHA and JCAHO procedures for obtaining privileges to administer moderate sedation.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Patient Transportation Services – Internal Controls Needed Strengthening

Conditions Needing Improvement. We reviewed local policies and interviewed facility managers to evaluate the safety and effectiveness of the patient transportation program. We inspected three vans and interviewed drivers and patients. We found that managers need to ensure that: (a) yearly verification of employee driving records is performed and documentation of drivers training for employees is completed, (b) driver screening and training for current volunteer drivers be completed and a screening and training program established for future volunteer drivers, (c) inspected vans have internal cleaning, and (d) first aid kits have more supplies.

Employee Driver Screening and Training. VA policy requires that supervisors of Motor Vehicle Operators ensure that employee drivers receive physical examinations at least every 4 years, possess valid state drivers' licenses, and maintain safe driving records. The license and driving record should be checked annually, and a safe driving course is required yearly. We interviewed the facility manager, Engineering Division Manager and Chief, Human Resources, and reviewed training records, Official Personnel Folders, and health records of three of six employee drivers. We found that verification of driving records was not performed, and patient transportation training requirements were not met.

Volunteer Drivers Screening and Training. VA policy requires that supervisors responsible for volunteer drivers ensure they receive physical examinations, possess valid state drivers' licenses, maintain safe driving records, and provide proof of automobile insurance. These components of volunteer driver screening should be performed at a minimum of every year.

We reviewed the files of three volunteer drivers and interviewed the Chief, Voluntary Service. Until December 2003, volunteer drivers had not been appropriately screened and no verification of driving record or automobile insurance had been performed.

Health examinations were done at the time of recruitment but not repeated, as required by policy.

We reviewed training records for three volunteer drivers who transport patients. Until December 2003, the Volunteer Services records did not indicate that safe driving training was accomplished annually, and the medical center had no program for screening and training new volunteer drivers.

Passenger Vans. VA Employee Safety Alert, dated June 11, 2003, states no more than 10 passengers are to ride in 15-passenger vans, nor will passengers or luggage be placed in the back seat or over the wheel well. The van scheduled to go to Richmond medical center on the day of our inspection was carrying 10 passengers; however, there were two passengers in the back seat. The driver stated that the passengers spread out so there would be more room and indicated he was not aware that passengers were not permitted in the back seat. The first aid kit in three vans consisted of Band-Aids, a 2x2 gauze pad, and one alcohol pad. We determined that the first aid kits needed more infection control supplies (e.g., gloves, waterproof barrier pads) than what was currently provided. Also, the interiors of three vans were dirty and had trash on the floors.

Recommended Improvement Action(s) 8. We recommended the VISN Director ensure that the medical center Director requires: (a) verification of driving records be completed according to VA policy for all employee drivers, (b) employee drivers receive annual safe driver training and documentation of training is maintained, (c) volunteers who transport patients receive initial screening and annual safe driver training, (d) a screening and training program be established for new volunteer drivers and documentation is maintained, (e) all vehicles be placed on a routine cleaning schedule and interiors checked daily, and (f) infection control supplies be included in all first aid kits.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

Contract Administration – Documentation of Contract Processing Needed Strengthening

Condition Needing Improvement. Medical center managers needed to ensure that contracting officers include documentation of all contract processing requirements in the contract file, in accordance with the Federal Acquisition Regulation (FAR) and VA policy. Contracting officers are required to establish files containing documentation of significant contract processing actions, such as the Price Negotiation Memorandum (PNM) and justification for other than full and open competition. The files should also contain written justification for exercising option years and Contracting Officer's Technical Representative (COTR) letters that delegate and describe duties and

responsibilities. We found deficiencies in 5 of 11 contracts reviewed. The total value of the 11 contracts was $3.2 million.

Documentation of Contract Actions. The FAR requires a PNM and a written justification for other than full and open competition. The file for the blood analyzer materials contract, valued at $34,200, did not include a PNM or justification for other than full and open competition. The FAR also requires a written justification to explain why exercising an option year for that contract was in the best interest of the Government. The artificial limbs contract and the health physics services for nuclear medicine and radiology contract, collectively valued at $484,000, also did not have written justifications for the option years.

Documentation of COTR. VA policy requires that a COTR be assigned in writing to monitor contract performance to ensure that services are provided in accordance with contract terms. Although an individual was fulfilling the performance monitoring duties of a COTR, the blood analyzer equipment contract, valued at $92,000, did not contain documentation that a COTR was assigned. Further, for the lithotripsy services contract, valued at $205,000, the assigned COTR was monitoring the medical outcome portion of the contract while an unassigned fee clerk was monitoring the billings.

Suggested Improvement Action(s) 1. We suggested that the VISN Director ensure that the medical center Director requires that contract files contain all documentation of the contracting process, including PNMs, option year justifications, and COTR letters, as required by the FAR and VA policy.

The VISN and Medical Center Directors concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Environment of Care – Minor Cleanliness, Security, and Repair Issues Needed to be Addressed.

Condition Needing Improvement. We inspected all clinical and administrative areas of the medical center and found the environment of care to be generally clean and safe. However, we found several minor problems such as: an unsecured prescription pad in the Primary Care Clinic, unsecured surgical carts, unlocked electrical panels, loose dividers in bathrooms, and conviction heaters with dusty vents. The Director concurred with our suggestion to correct these deficiencies and submitted an action plan to resolve the issues.

Suggested Improvement Action(s) 2. We suggested that the VISN Director should ensure that the medical center Director implements planned actions to correct environment of care deficiencies.

The VISN and Medical Center Directors concurred with the findings and suggestions and submitted plans for improvement. The planned improvement actions are acceptable.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2004

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subject: **Response to Combined Assessment Program Review of the VA Medical Center Beckley, West Virginia—January 12-16, 2004.**

To: Nelson Miranda, Director, Washington, DC Region Office of Healthcare Inspections

1. I have reviewed and support the facility's responses to the report. Responses are included in the report as requested for your convenience.

2. If you have any questions or require a paper-copy of the report, please contact Mr. Gerard Husson, Director, VAMC Beckley, via MS Exchange or at (304) 256-5479.

(original signed by:)

Daniel F. Hoffmann, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 11, 2004

From: Director, Beckley VA Medical Center (517/00)

Subject: **Combined Assessment Program Review of the VA Medical Center Beckley, West Virginia**

To: Network Director, VISN 6

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommend the VISN Director ensures that the medical center Director requires A&MM management to allocate sufficient staff time to correct GIP inventory reports and adjust supply stock levels to meet the 30-day standard.

Concur **Target Completion Date:** 12/31/04*

*and/or in accordance with relevant regulations as of this date.

Response: In February 2004, two additional FTE were authorized for A&MM. The two new supply technicians began working in April and May of 2004.

As of June 30, 2004, the GIP inventory report entry requirement was completed. This process included assigning an item master file number to all recurring/repetitive supplies and entering this information into a primary inventory point in the generic inventory package (GIP), and a secondary inventory point. We are now working toward a goal of adjusting supply stock levels to meet the 30-day standard.

Recommended Improvement Action(s) 2. We recommend the VISN Director ensures that the medical center Director establishes procedures and internal controls to: (a) require fee-basis payments for veterans with insurance are identified and billed, and (b) improve MCCF billing procedures by ensuring all professional fees are identified and billed.

Concur **Target Completion Date:** August 2004

Response:

a. In April 2004, MCCF instituted the following procedure for the fee basis processing of coding/3rd party billing:

- ❖ Fee basis clerk will check to see if patient has insurance.
- ❖ If patient has insurance the fee basis clerk will attach medical documentation and forward to coding.
- ❖ Coding will verify that codes are correct or change the codes that documentation does not support. The packet will be returned to fee basis.
- ❖ The fee basis clerk will add the charges and forward to MCCF.
- ❖ MCCF will check to see if veteran is category c and add first party charges when applicable.
- ❖ MCCF will check to see if treatment is for a service connected condition.
- ❖ Packet will be forwarded to the Centralized Revenue Unit for billing.

b. MCCF is also reviewing inpatient billing periodically to ensure all billable encounters are being coded and billed. This procedure is now assigned to the validation clerks for a more formal monthly audit. Six inpatient records will be audited monthly beginning August 2004.

Recommended Improvement Action(s) 3. We recommend the VISN Director ensures that the medical center Director requires that: (a) monthly unannounced controlled substances inspections performed in all areas and within the same day, (b) training for controlled substances inspectors documented, (c) all controlled substances inventories are verified at least every 72 hours, and (d) all excess and outdated controlled are substances destroyed quarterly.

Concur **Target Completion Date:** July 2004

Response:

a. The unannounced monthly inspections of controlled substances are now performed by a team of two inspectors in order to complete inspections of all required areas within the same day. The number of trained inspectors was

increased to allow for the two-person team to insure completion of the inspection within the required timeframe.

b. Certification of completion of the web based controlled substance inspector training has been obtained for ALL currently assigned inspectors. Many of the current inspectors also have documentation of attendance of facility offered classroom-based training in the facility TEMPO education tracking system.

c. This has been a long-standing requirement, however, it is noted that adherence to this requirement has been lax by some of the assigned pharmacy personnel at times. As of February 1, 2004, all appropriate employees received reorientation on this requirement and are being held accountable for compliance.

d. The medical center did fail to have destruction of controlled substances accomplished on a quarterly basis, due to circumstances beyond our local control. Destruction of all excess and outdated controlled substances has been performed on January 7, 2004, and April 7, 2004. The "returned goods" company is scheduled to return on July 22, 2004. All excess and outdated controlled substances are to be turned over at this time. An electronic mail "tickler" has been created, by the supervisory pharmacist, to insure that the "returned goods" company is scheduled quarterly to come to the facility to take care of all expired and unusable medications, including controlled substances.

Recommended Improvement Action(s) 4. We recommend the VISN Director ensures that the medical center Director requires delinquent debts are pursued more aggressively by: (a) conducting follow-up telephone calls after the bills remain unpaid for 30 days, and (b) referring cases to the TOP when appropriate.

Concur **Target Completion Date:** Completed

Response: The following action plan is currently being implemented:

- A staff accountant was hired on June 1, 2004.
- Subsidiary accounts receivable records are being established by accounts receivable type, such as current employees, ex-employees, vendors, etc.

- Staff accountant is responsible for the recommended follow-up of unpaid bills by conducting follow-up telephone calls, referring unresolved issues to Fiscal Officer for action, and at the request of the Fiscal Officer, submitting cases to TOP.
- In addition, the agent cashier will maintain a copy of all employee accounts receivable to ensure that employees clearing station will pay their debt.

Recommended Improvement Action(s) 5. We recommend the VISN Director ensures that the medical center Director requires that: (a) all employees complete the Security Awareness Training course for FY 2004, and (b) IRM employees move the back-up tapes to another building for storage.

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

Response:

a. Beckley VAMC is continuously working to improve security awareness training. In order to meet/exceed this recommendation the medical center has done the following:

- Appointed a full-time ISO.
- ISO provides continuing education for employees and introduces new employees to the medical center's security policies and procedures during initial orientation.
- ISO is the central point of contact for employee security questions or concerns.

As of July 16, 2004, 80% of the employees have completed the Security Awareness Training. The ISO will continue to monitor and track the medical center's compliance with the training requirement for all employees.

b. On July 9, 2004, the IRM back-up tapes were moved to another building for storage.

Recommended Improvement Action(s) 6. We recommend the VISN Director ensures that the medical center Director requires that: (a) adverse event notification to patients or surrogate decision makers is provided in accordance with VHA Handbook 1051.1, January 20, 2002, Section 8. Informing Patients About Adverse Events, (b) clinical managers collect and document provider specific

QM/PI data for consideration in the privileging renewal process, and (c) clinical managers evaluate provider specific QM/PI data against available comparative internal, local, VHA, VISN, or national benchmarks at the time of reprivileging.

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

Response:

a. In order to provide more consistent and timely follow-up to RCA recommended actions and outcome measures, the following procedure was implemented in October 2003:

- All required actions and outcome measures are communicated in writing to the staff responsible for the actions at the leadership briefing meeting. This meeting ensures communication of the RCA findings and approved actions by top management to the responsible service lines.
- Actions and outcome measures, and the names of responsible staff are communicated in writing to the quality management program support assistant, who schedules the reporting of those actions to the Quality Management Committee. Reporting occurs every 3 months to the QM Committee by the service lines. As part of the service lines required performance improvement monitoring and data analysis, all RCA actions are reported at this time. The reporting calendar for the QM Committee of all indicators and RCA follow-up requirements are provided within the attachment (Attachment – QM Performance Calendar). This calendar has ensured that all required areas are consistently reported and follow-up has occurred as required.
- The QM Committee reviews and documents in the minutes, the reported data and analysis of RCA outcome measures submitted by the service lines and programs.
- These reports are entered into the electronic National Patient Safety Database by the patient safety coordinator with notation of the effectiveness of the measures.

After consultation with the Director of the National Center for Patient Safety, Dr. James Baigan, and Ray Hampton, District Council, documentation of disclosure in the RCA review and the medical record is not appropriate. The medical center does agree that in keeping with the philosophy of VHA

policy, evidence of disclosure of adverse events will be kept on file in the QM office. To further clarify the disclosure process for the physicians, the following procedure has been developed and included in medical center memorandum (MCM) No. 11Q-9, Patient Safety Improvement, Attachment E.

b. The Interim Chief of Staff has discussed this issue with the service line chiefs and medical directors. They are to collect and document provider specific QM/PI data for each practitioner on a monthly basis. Clinical practice review forms are currently being utilized by the service lines to analyze various quality indicators unique to the specific service line practitioners. Monthly reviews will allow for timely intervention by the clinical managers towards corrective action that will immediately improve the quality of care provided. On a quarterly basis, these provider specific reviews are forwarded to the Chief of Staff for his review and to ensure compliance. At re-privileging time, the service line chiefs will ensure that the monthly/quarterly reviews are compiled into one report for a 2-year practice period, which will be review for reappraisal. This enhanced document will provide more specific identifications of problem areas, corrective action taken, and demonstrate the practitioner's ability to perform requested clinical privileges and subsequent appointment.

c. Guidance forthcoming from Kathryn W. Enchelmayer, Director for Credentialing and Privileging, Veterans Health Administration, to ascertain legality and attainment of this recommendation.

Recommended Improvement Action(s) 7. We recommend the VISN Director ensures that the medical center Director requires: (a) physicians document the reevaluations of patients immediately before their procedures, or co-sign the nurses' notes addressing the reevaluations, and (b) compliance with VHA and JCAHO policies and procedures related to the qualifications of clinicians who administer moderate sedation.

Concur **Target Completion Date:** Completed

Response:

a. Immediately following the OIG team inspection, a documentation template was developed and implemented for the Operating Room to assure compliancy with documentation of reevaluation of patients immediately prior to their procedures. This template contains a section for preassessment by the physician immediately prior to the procedure, and a section for the physician signature. There is a separate section for the RN documentation and signature.

b. At the time of the OIG inspection, the medical center had one physician who was administering conscious sedation but had never formally requested privileges and received approval in which to administer conscious sedation, although he met the requirements. This was corrected immediately following the OIG visit. Privileges were requested by this physician and approved. The medical center currently has two physicians who perform procedures under conscious sedation, and these physicians maintain current privileges. Copies of these privileges are sent to the Operating Room and ICU Clinical Coordinators for information and to assure compliance regarding privileging requirements. A copy is also maintained in the physician-privileging folder in the Acute Care office, and the Administrative Officer is responsible for assuring the correct timeframes are met in relation to privileging and submitting information to the Professional Standards Board.

All full time ER physicians are being credentialed to perform procedures. All RN nurses in the ER have been trained. A template has been created for use in the ER for conscious sedation.

Recommended Improvement Action(s) 8. We recommend the VISN Director ensures that the medical center Director requires: (a) verification of driving records be completed according to VA policy for all employee drivers, (b) employee drivers receive annual safe driver training and documentation of training is maintained, (c) volunteers who transport patients receive initial screening and annual safe driver training, (d) a screening and training program be established for new volunteer drivers and documentation is maintained, (e) all vehicles be placed on a routine cleaning

schedule and interiors checked daily, and (f) infection control supplies be stocked in all vans.

Concur **Target Completion Date:** Completed

Response:

a. On March 4, 2004, request for license and background check forms were completed by all employee drivers and were verified and approved by Lt. Michael Schausten, Supervisory Police Officer, VA Medical Center, Beckley, WV.

b. On January 10, 2004, Defensive Driving Techniques training and infection control for drivers training was provided to employee drivers. Training documentation is located in the safety office.

c. All new volunteer drivers are required to undergo a health screening by Employee Health prior to being permitted to drive. Of the current 23 volunteer drivers, health screening is pending on seven. As Employee Health is able to schedule health screenings, these will be updated. As of today, four potential volunteer drivers are waiting health screenings with one being scheduled today. On January 10, 2004, Defensive Driving Techniques training and infection control for drivers training was provided to volunteer drivers who transport patients. This training was provided again on June 10, 2004, to volunteer drivers who were not trained in January 2004. Documentation of this training is located in the Voluntary Service Office. Initial screening, consisting of a complete physical performed by a M.D. or P.A., lab work, and visual acuity testing is completed on each volunteer driver prior to his/her performing these duties. Records are located in the Employee Health Section.

d. Screening and training programs have been established for new volunteer drivers and documentation is maintained by Voluntary Service.

e. On the date of the inspection, all vehicles were placed on a routine cleaning schedule with interiors to be checked daily.

f. Infection control supplies were ordered and, upon receipt, March 2004, were stocked in all vans utilized to transport patients.

g. On the date of the initial inspection, the back seat of the 15-passenger van was removed. There are no 15-passenger vans currently being used by our DAV program.

OIG Suggestion(s)

Suggested Improvement Action(s) 1. We suggest that VISN Director ensures that the medical center Director requires that contract files contain all documentation of the contracting process including PNMs, option year justifications, and COTR letters as required by the FAR and VA policy.

Concur **Target Completion Date:** Completed

Response: A review has been completed and a process is now in place at the VISN.

Suggested Improvement Action(s) 2. We suggest that the VISN Director should ensure that the medical center Director implements planned actions to correct environment of care deficiencies.

Concur **Target Completion Date:** Completed

Response: All environment of care deficiencies noted by the surveyors during their walk-thru and noted on the spreadsheet provided to the Facilities Management Service Line Chief were completed within timelines discussed with the inspector.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Reducing excess supply inventories	$203,076
2	Increasing MCCF collections	12,018
	Total	$215,094

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director, Washington, D.C., Regional Office of Healthcare Inspections (202) 565-8181
Acknowledgments	William Withrow, Director, Kansas Office of Audit Robert C. Zabel, Audit Team Leader Randall G. Snow, OHI Team Leader Dennis A Capps James L. Garrison Ken Myers Henry J. Mendala Rayda Nadal Michelle Porter Oscar L. Williams

Appendix E

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