Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Portland VA Medical Center Portland, Oregon

Report No. 04-01128-201 **September 7, 2004**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of May 17–21, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Portland VA Medical Center (referred to as the medical center). The purpose of the review was to evaluate selected health care system 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 427 employees.

Results of Review

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

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

- Environment of Care
- Government Purchase Card Program
- Part-Time Physician Timekeeping
- Primary Care Clinics
- Quality Management Program

We identified the following organizational strengths:

- Patient record flags contribute to a safe health environment.
- Competency assessment process cited as a best practice by the Commission on Accreditation of Rehabilitation Facilities.
- The Government Purchase Card Program was effectively managed.

We identified nine areas that needed additional management attention. To improve operations we made the following recommendations:

- Strengthen equipment accountability controls.
- Reduce excess supply inventories and strengthen inventory controls.
- Provide bulletproof protection for pharmacy dispensing windows and keep the controlled substances outpatient vault door closed and locked when the pharmacy is closed.
- Properly procure controlled substances used in research and improve controlled substances inspections.

We made suggestions in the following areas:

- Improve training documentation for clinicians who provide moderate sedation.
- Ensure daily rates for community nursing home contracts do not exceed the VA benchmark.
- Improve clinical documentation needed for insurance bills and process bills more promptly.
- Strengthen controls for automated information systems (AIS).
- Improve procedures for certifying contractor invoices.

This report was prepared under the direction of Ms. Julie Watrous, Director, and Dr. Wilma Wong, CAP Coordinator, Los Angeles Regional Office of Healthcare Inspections.

VISN and 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 15–23, 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

Medical Center Profile

Organization. Based in Portland, Oregon, the medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in Bend, Salem, and Warrenton, Oregon; and Longview and Vancouver, Washington. The medical center is part of Veterans Integrated Service Network (VISN) 20 and serves a veteran population of about 290,000 in a primary service area that includes 19 counties in Oregon and 6 counties in Washington.

Programs. The medical center provides medical, surgical, mental health, geriatric, and advanced rehabilitation services. The medical center has 149 hospital beds and 72 nursing home beds and operates several regional referral and treatment programs, including the Liver and Renal Transplant Programs. The medical center also has sharing agreements with the Oregon Health & Sciences University.

Affiliations and Research. The medical center is affiliated with the Oregon Health & Sciences University and supports 126 medical resident positions. The medical center is also affiliated with several colleges to provide clinical training opportunities for nursing, pharmacy, and allied health students. In Fiscal Year (FY) 2003, the medical center research program had 92 projects and a budget of $28.8 million. Important areas of research include cancer and mental illness.

Resources. In FY 2002, medical center medical care expenditures totaled $241.6 million. The FY 2003 medical care budget was $275.6 million, 14 percent more than FY 2002 expenditures. FY 2003 staffing was 2,135 full-time equivalent employees (FTE), including 185 physician and 257 nursing FTE.

Workload. In FY 2003, the medical center treated 49,517 unique patients, a 14 percent increase from FY 2002. The inpatient care workload totaled 7,841 discharges, and the average daily census was 178. The outpatient workload was 481,184 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 services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, QM, benefits, 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 2003 and FY 2004 through April 2004 and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Community Nursing Home Contracts	Moderate Sedation
Controlled Substances Accountability	Part-Time Physician Timekeeping
Environment of Care	Pharmacy Security
Equipment Accountability	Primary Care Clinics
Government Purchase Card Program	Quality Management Program
Information Technology (IT) Security	Service Contracts
Medical Care Collections Fund (MCCF)	Supply Inventory Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5–14). For these activities, we made 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 facility managers until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees and 396 responded. We also interviewed 35 patients during the review. We discussed the interview and survey results with medical center managers.

During the review, we also presented 4 fraud and integrity awareness briefings for 427 employees. These briefings 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.

Results of Review

Organizational Strengths

Patient Record Flags Contribute to a Safe Health Environment. In 1986, the medical center began flagging electronic medical records to alert employees to patients whose behavior may pose a safety threat. Placing electronic flags on patients' medical records provides a discreet method to notify employees of any safety concerns related to patients who are seeking health care. The program's success resulted in national implementation with VHA Directive 2003-048, "National Patient Record Flags," issued August 28, 2003.

Competency Assessment Process Cited as a Best Practice by the Commission on Accreditation of Rehabilitation Facilities. The medical center has had a competency assessment process in place since 1998. The process integrates and documents the employee's professional advancement from the newly hired to the mature professional. Employee orientation, mandatory annual training, and new skills training are integrated into one document, which allows managers to easily review and assess training needs for each employee. Standardizing this process facilitates medical center requirements for patient care and safety. Employees reported that they find it easier to identify opportunities for improvement and career development pathways. The Commission on Accreditation of Rehabilitation Facilities cited this as a best practice in 2002.

The Government Purchase Card Program Was Effectively Managed. The medical center had established effective procedures and controls to ensure that purchases were appropriate and were meeting the requirements of the Government Purchase Card Program. During the period January–March 2004, 230 purchase cardholders made 10,725 purchases totaling $6.7 million. Cardholders had promptly completed transaction reconciliations, with 90 percent of transactions reconciled within 10 days, which exceeded timeliness standards. Approving officials had completed 100 percent of their certifications within the 14-day standard. Our review of a sample of 60 transactions did not identify any improprieties. The Financial Services Division effectively conducted monthly quality reviews of purchases. All cardholders who were authorized to make purchases in excess of $2,500 held appropriate procurement warrants. Purchase card accounts had been promptly cancelled for cardholders who had terminated employment.

Opportunities for Improvement

Equipment Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. Medical center management needed to improve procedures to ensure that nonexpendable equipment (items costing more than $5,000 with an expected useful life of more than 2 years) is properly safeguarded and accounted for. VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Material Management Service (A&MMS) staff were responsible for performing EIL counts and updating EIL records. As of May 17, 2004, the medical center had 270 active EILs listing 9,345 equipment items (value = $83.4 million). To assess equipment accountability, we reviewed a judgment sample of 30 items (combined value = $2.1 million) assigned to 20 EILs. We identified five deficiencies that required corrective action.

Inaccurate EILs. The EILs were inaccurate for 20 of the 30 sampled items (67 percent). Nine items (value = $1.8 million) could not be located during our review. One of the missing items was a linear accelerator (an oncology imaging device) valued at $1.6 million, which the medical center co-owned with OHSU. A&MMS staff told us that this item had probably been excessed by OHSU in 2001, but they had no documentation to support this. The other eight missing items (value = $170,000) consisted of medical equipment, such as microscopes and an electrocardiograph machine. For the remaining 11 items, the EILs did not reflect the current locations because the items had been moved within the service areas or transferred to other services.

Sensitive Equipment Items Not on EIL. Normally only items costing more than $5,000 are listed on EILs. However, if an item is classified as "sensitive" it must be listed on EILs regardless of its dollar value. Sensitive items are those subject to theft, loss, or conversion to personal use, such as computers. A&MMS had not classified 28 police weapons and approximately 2,750 computers as sensitive items and, as a result, did not include them on EILs as accountable inventory.

Physical Inventories Not Properly Performed. VA requires that annual or biannual equipment inventories be conducted by responsible officials (such as service chiefs) or their designees. These officials must certify that all equipment assigned to their areas is accounted for. We found four deficiencies pertaining to equipment inventories:

- A&MMS staff, not the responsible service chiefs, conducted the annual counts and certified the EILs.
- A&MMS staff and service chiefs or their designees had not performed required quarterly spot checks of completed EIL counts to ensure the accuracy of reported

information. A&MMS employees were not aware of VA policy requiring these spot checks.

- Some laptop computers had not been recorded on inventory lists since 1998. A&MMS assigned the responsibility for maintaining the EILs covering certain computers to the Technology and Information Management (TIM) Service. As of May 17, 2004, TIM could not account for at least 81 laptops (approximate value = $156,400) that were TIM's responsibility. This problem occurred because TIM did not maintain records identifying employees who had been assigned the laptops or their locations.

- Approximately 200 desktop computers listed as being still in use had not been inventoried since at least 1999.

Missing/Damaged Equipment Not Reported to VA Police. VA policy requires that supervisors notify local or VA police when VA equipment is lost, damaged, or destroyed. During the 12-month period April 2003–March 2004, 2 of 4 equipment losses reported to A&MMS were never reported to the VA police.

Need Local Policy and Procedures. The medical center did not have an equipment accountability policy that addressed issues such as equipment accounting requirements, loan of property, physical inventories, and equipment turn-ins. VA equipment accountability policies are too broad to be effectively implemented without a detailed local policy. The deficiencies discussed above may have been avoided if local policy had been published.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires the Chief of A&MMS to: (a) establish an accurate baseline equipment inventory by performing a one-time, 100 percent inventory of all EILs and ensure that records are updated to accurately reflect the status of all equipment; (b) ensure that all sensitive equipment items are properly classified and included on EILs; (c) perform periodic equipment inventories in accordance with VA policy; (d) report all missing or damaged equipment to the VA police; and (e) implement a detailed medical center equipment accountability policy.

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

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Conditions Needing Improvement. Our prior CAP review found that the medical center's stock levels for medical, prosthetic, and engineering inventories exceeded a 30-

day supply. We recommended reduction of the excess inventories and strengthening of inventory management controls (CAP review of VA Medical Center, Portland, Oregon, Report Number 00-01217-105, August 18, 2000). To determine if inventory management deficiencies had been corrected, we performed a follow-up review. The medical center still needed to reduce excess inventories of medical, prosthetic, and engineering supplies and make better use of automated controls to more effectively manage supply inventories.

In FY 2003, the medical center spent $18.7 million on medical, engineering, and prosthetic supplies. The Veterans Health Administration (VHA) Inventory Management Handbook establishes a 30-day supply goal and requires that medical centers use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventory counts.

Medical Supplies. Although A&MMS staff used GIP to manage medical supplies, the inventory exceeded the 30-day standard. As of May 2004, the medical supply inventory consisted of 6,743 items (value = $796,906). To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 supply items (value = $28,094). Eighteen of the 20 items had stock on hand that exceeded a 30-day supply. Based on GIP data and our sample review, we estimated that the value of the medical supply inventory exceeding current needs was $589,710 (74 percent of the total value). The excess stock remained a problem because staff still did not monitor supply usage or adjust GIP stock levels to meet the 30-day standard.

Prosthetic Supplies. The Prosthetics and Sensory Aids (P&SA) Service used VA's Prosthetics Inventory Package (PIP) automated system to control inventory. However, prosthetic inventory exceeded the 30-day standard. The P&SA Service maintained a supply inventory of 334 items (value = $114,978). To determine the reasonableness of inventory levels, we reviewed a judgment sample of 10 items (value = $6,291). All 10 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 107 to 1,100 days of supply. The estimated value of stock exceeding 30 days was $5,483, or 87 percent of the total value for the 10 items. Excess inventory continued to occur because P&SA staff were not properly adjusting stock levels to reflect actual usage rates. By applying the 87 percent estimate of excess stock for the sampled items to the entire stock, we determined that the value of excess stock was $100,031 (87 percent x $114,978 estimated actual PIP value of stock).

Engineering Supplies. The Facilities Management Service (FMS) used GIP to manage two general categories of engineering supplies. However, most engineering supplies were not controlled with GIP. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgment sample of 10 high-use engineering supply items (value = $12,832). Because most items were not in GIP, we

asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for 9 of the 10 items. Without sufficient inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded current needs. The Chief of A&MMS acknowledged the need to reduce the inventory and, during our review, developed a plan to fully use GIP to control engineering supplies.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) A&MMS staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) P&SA Service staff to adjust stock levels to reflect actual usage rates and reduce excess prosthetic inventory; and (c) FMS staff to reduce excess engineering supply inventory and work with A&MMS to implement plans to fully use GIP for engineering supplies.

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

Pharmacy Security – Bulletproof Protection Needed and Vault Door Should Be Kept Closed

Conditions Needing Improvement. The medical center needed to improve physical security in the pharmacy to ensure staff safety and to reduce the risk of loss or diversion of controlled substances. To evaluate pharmacy security, we reviewed security policies and access control records, inspected pharmacy storage areas, and interviewed VA Police and pharmacy staff. For most pharmacy areas, access controls were effective and physical security was adequate. However, we identified two deficiencies that needed correction:

- The six dispensing windows were not made of bulletproof glass as required by VA policy. In addition, the window walls were constructed of drywall, not concrete or similar material that would provide protection from firearms. The Chief of Pharmacy was aware of these deficiencies and acknowledged that pharmacy staff had expressed concern about their safety. He cited cost as the reason the deficiencies were not corrected. Medical center management should provide the funding needed to correct this security deficiency.

- Although the outpatient pharmacy's gate to the controlled substances vault was kept locked at all times, the main door of the vault was not closed or locked when the pharmacy was closed in the evenings. This was a security issue because there was a large enough gap under the gate that a small person could fit through and gain access to the vault. In April 2004, the outpatient pharmacy converted from a 24-hour pharmacy to one that closes in the evenings. The Chief of Pharmacy agreed to keep the vault door closed and locked when the pharmacy is closed.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to require that: (a) the dispensing windows and window walls meet minimum security requirements, and (b) the outpatient controlled substances vault door is locked when the pharmacy is closed.

The VISN and Medical Center Directors concurred 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 – Procurement and Inspection Procedures Should Be Strengthened

Conditions Needing Improvement. Medical center management needed to address weaknesses in controlled substances procurement and inspection procedures. VHA policy requires medical centers to conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period April 2003–March 2004, interviewed the Controlled Substances Inspection Coordinator and Chief of Pharmacy, and observed unannounced inspections of selected areas where controlled substances were stored and dispensed. We identified several weaknesses in controlled substances accountability.

Controlled Substances Used in Research Were Improperly Procured and Monitored. VHA policy requires that controlled substances used in animal or human research be ordered through the Pharmacy Service, that VA Forms 10-2638 ("green sheets") be prepared as administration records for the drugs, and that the drugs be included in the monthly controlled substances inspections. We identified three deficiencies in the procurement and inspection of controlled substances for research:

- The six research laboratories ordered and received controlled substances directly from vendors instead of ordering through the Pharmacy Service. Further, the laboratories did not obtain or maintain green sheets for stored or dispensed controlled substances. The Chief of Pharmacy became aware of these deficiencies in about August 2003 but did not require these laboratories to order through the pharmacy and maintain green sheets until March 2004.

- Inspection records for the 12-month review period showed that 12 of the 72 (17 percent) inspections required for the laboratories were not performed. None of the laboratories was inspected during May 2003.

- Inspections did not always have the element of surprise. While the inspector attempted to perform an OIG-observed inspection, research staff refused to allow the inspection and instructed the inspector to return at a specified time. Although research staff had keys to the locked controlled substances, they insisted the

inspection be conducted with a particular member of the research staff who was not available at the time. The Controlled Substances Inspection Coordinator acknowledged this problem had occurred on a regular basis.

Inspection Procedures Not Consistent with VA Policy. We identified two weaknesses in the inspection procedures for other controlled substances:

- VHA policy requires inspectors to use a volumetric cylinder to measure all unsealed liquids in pharmacy stock. During the OIG-observed inspection, the inspector did not measure any liquids in unsealed bottles.

- VHA policy requires that unusable or expired drugs be removed from pharmacy stock during the monthly inspections. During the OIG-observed inspection, neither the inspectors nor the pharmacy staff reviewed drug expiration dates. We found expired drugs in one location.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director take action to require that: (a) all controlled substances be ordered through the pharmacy; (b) green sheets be maintained for all locations that store controlled substances; (c) all controlled substances storage locations undergo unannounced inspections every month; and (d) inspections are conducted in accordance with VHA policy.

The VISN and Medical Center Directors concurred 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 Training Was Incomplete

Condition Needing Improvement. We found incomplete documentation of required training for some clinicians who administer moderate sedation. To review the management of moderate sedation, we reviewed policies and procedures, patient medical records, and provider credentialing and training files. We also interviewed key employees and inspected treatment areas where moderate sedation is administered.

Provider Training. The medical center policy on moderate sedation states that all clinicians who administer moderate sedation should have completed basic life support (BLS) training as a requirement for clinical privileges. We found that only three out of five randomly selected clinicians who administered moderate sedation had evidence of current BLS training.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the medical center Director requires that all clinicians who provide moderate sedation have the required training, including current BLS training.

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

Community Nursing Home Contracts – Daily Rates Should Not Exceed the VA Benchmark

Condition Needing Improvement. Medical center contracting staff needed to ensure that the daily rates established in community nursing home (CNH) contracts did not exceed the VA benchmark of the Medicaid rate plus 18 percent. Rates exceeding this benchmark must be documented and justified. As of April 2004, the medical center had 39 locally-awarded CNH contracts (total FY 2003 cost = $3.8 million).

To evaluate the medical center's management of the CNH program, we reviewed five CNH contracts. For three of these contracts, medical center staff had negotiated and paid daily rates that exceeded the VA benchmark at the time the contracts had been established. Contract files did not have documentation justifying these rates. During our review, contracting staff identified an additional six contracts that had rates exceeding the VA benchmark. We estimate that the medical center could have saved $173,000 if the rates for these nine contracts had been negotiated in compliance with VA policy. In June 2004, the State of Oregon increased the Medicaid daily rate and made this increase retroactive to July 2003. Because of this, we determined that it is not cost effective to renegotiate these contracts. Contracting staff should ensure that future contracts are negotiated using the correct rates existing at the time of negotiation.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director requires that the contracting staff negotiate CNH contracts in compliance with VA policy.

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

Medical Care Collections Fund – Clinical Documentation Should Be Improved and Billing Delays Reduced

Conditions Needing Improvement. Under the MCCF program, VA may recover the cost of treating certain insured veterans from health insurance companies. Medical center management needed to ensure that clinical documentation is complete and timely and that fee basis bills are issued promptly.

Inadequate Clinical Documentation. During the 6-month period October 2003–March 2004, the MCCF staff had cancelled 365 bills (value = $83,166). We selected a judgment sample of 30 cancelled bills and reviewed the corresponding progress notes in the medical records. Two of the 30 bills did not have collection potential because of terms under the insurance plans. However, the remaining 28 bills were collectable but had been

cancelled because of insufficient clinical documentation or insufficient resident supervision documentation.

- Eighteen of the 28 bills (64 percent) valued at $13,000 had been cancelled because clinicians did not include the necessary clinical documentation, such as progress notes, in the medical records. For 6 of the 18 bills, adequate documentation was added after the bills had been cancelled. As a result of our review, MCCF staff reissued these six cancelled bills.

- About 59 percent (215 of 365) of the bills had been cancelled by MCCF staff because attending physicians did not sufficiently document resident supervision in the medical records. We reviewed 10 bills (value = $4,923) that had been cancelled because of insufficient resident supervision documentation. We determined that these claims are now billable under new VA guidelines that became effective March 2004. Attending physician names in the resident progress notes are now considered sufficient documentation for billing purposes. As a result of our review, MCCF staff reissued these 10 bills.

Billing Delays. Under the fee basis program, the medical center may authorize veterans to obtain health care at VA expense from non-VA providers. During the 5-month period October 2003–February 2004, the medical center paid more than 1,100 fee basis claims valued at $238,853. To evaluate insurance collection potential for these claims, we reviewed a judgment sample of 30 claims (value = $135,102). We concluded that 16 of the 30 claims (value = $57,364) were billable, but as of May 19, 2004, MCCF staff had not issued bills for these claims. The Billing Supervisor said that the billing delay was due in part to a personnel shortage. In addition, clerical staff in programs using fee basis care (Community Nursing Home, Community Outsourcing, etc.) were not routinely providing the MCCF billing staff with the information needed to prepare the bills. The Billing Supervisor agreed to analyze the 16 claims and issue bills as appropriate.

Better clinical documentation and timely billing procedures for fee basis care would have resulted in increased revenue collections. Based on the medical center's current collection rate of 32 percent, we estimate that MCCF staff could have increased collections by $24,092 [($13,000 + $4,923 + $57,364) x 32 percent]. Medical center managers responsible for MCCF (Acting Compliance Officer, MCCF Coordinator, and Billing Supervisor) agreed and, during our review, developed a MCCF-Billing Compliance Action Plan.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) medical records include adequate clinical documentation, (b) the MCCF collection opportunities identified by our review are pursued aggressively, and (c) insurance billings are done promptly.

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

Information Technology Security – Controls Need To Be Strengthened

Conditions Needing Improvement. We reviewed medical center AIS policies and procedures to determine if controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that adequate contingency plans had been developed, that on-site generators provided adequate emergency power for local area network computers, and that critical data were backed up on a regular basis. However, we identified several compliance issues that needed corrective action.

Inactive Accounts. Access to the medical center's main computer program had not been terminated for some inactive users. We reviewed 185 of a total of 250 user accounts for individuals who appeared to no longer need access. We determined that all 185 had access but were not shown as medical center employees in the VA payroll system as of April 2004. The Information Security Officer (ISO) determined the 185 users no longer needed access (former medical center employees, remote users, and contract employees). The ISO planned to review the remaining 65 user accounts to determine continued need.

Undocumented Change to Software Program. A medical center programmer altered a national software routine without documenting the change and did not test the change before implementation. The ISO and Chief Information Officer (CIO) agreed that all programming changes should be documented and tested.

Insufficient Temperature Control. VHA policy requires that computer rooms have adequate temperature controls to prevent conditions that could lead to system failure. Computer room temperature should be kept at mid-60 degrees Fahrenheit. During our inspection, the computer room's temperature was 80.4 degrees Fahrenheit.

Access Not Logged Consistently. VHA policy requires that physical access to the computer room be logged and reviewed. The CIO had initiated plans to have a magnetic card reader system installed that would electronically log access. Until then, TIM staff and guests were using a manual log. However, the log was only used intermittently and therefore, did not provide adequate access control.

Annual AIS Security Training Not Tracked. VHA policy requires that all employees with computer access receive annual AIS security refresher training. The ISO acknowledged he had not ensured that all employees received the mandatory training. Because the ISO had not implemented controls for tracking employee compliance with the training requirement, we could not determine how many employees had not received the training.

Suggested Improvement Action 4. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) access be promptly terminated for all individuals who do not have a continued need for access; (b) all software program changes are adequately documented and tested; (c) the computer room temperature is properly controlled; (d) access to the computer room is logged and monitored, and (e) annual AIS refresher training is provided to all employees.

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

Service Contracts – Contractor Invoices Should Be Properly Certified

Condition Needing Improvement. Medical center management needed to ensure that only designated contracting officer's technical representatives (COTRs) certified contractor invoices. For each service contract, the contracting officer designates a COTR. The COTR is responsible for monitoring the contractor's performance and ensuring that services are provided in accordance with contract terms. This responsibility includes reviewing contractor invoices and certifying that the charges accurately reflect the work completed. According to medical center policy, COTRs may not delegate their authority to another person.

To determine if medical center contract administration procedures were effective, we reviewed 15 service contracts and 5 supply contracts (estimated combined annual costs = $14 million). For 15 of the 20 contracts, medical center staff other than the designated COTRs had certified the contract invoices and Financial Services Division staff had issued payments based on these certifications. One paid invoice had no certifying signature. These problems occurred because COTRs were not properly trained and because Financial Services Division staff did not verify that only designated COTRs had certified invoices before issuing payments to contractors.

Suggested Improvement Action 5. We suggested that the VISN Director ensure that the Medical Center Director takes action to provide refresher training to COTRs and Financial Services Division staff on responsibilities and procedures for properly certifying and paying invoices.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 8, 2004

From: Northwest Network Director (10N20)

Subject: Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon – Project Number: 2004-01128-HI-0128

To: Assistant Inspector General for Healthcare Inspections (54)

Thru: Director Management Review Service (10B5)

1. Enclosed please find the action plans for the areas of improvement that were recommended by the Office of Inspector General Combined Assessment Program. This response has been generated to address the survey team findings gathered during a site visit conducted on May 17-21, 2004, at the Portland Veterans Affairs Medical Center, Portland, Oregon.

2. Please refer any questions regarding this information to Susan Gilbert, Chief, Quality & Performance, at (503) 273-5267 or Nancy Schuh, Program Analyst, at (503) 220-8262, extension 55837.

(original signed by:)
LESLIE M. BURGER, MD, FACP

Enclosure:

Implementation Plan

Appendix B

Medical Center Director Comments

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

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

Equipment Accountability – Controls Should Be Strengthened

Concur with recommended improvement action: Concur

Since the OIG visit, the following actions and processes have been initiated or are currently being initiated:

a. A&MM is in the process of updating all records by conducting our annual inventory (100% of all EIL's). Target completion date: September 30, 2004.

b. A&MM is coordinating with TIMS and Police & Security to ensure all sensitive items are properly classified and included on EIL's. Target Completion Date: November 1, 2004.

c. A&MM will conduct periodic inventory counts throughout the fiscal year in accordance with VA policy. The first cycle will commence following the 100% inventory and sensitive property reviews. Target Completion Date: March 30, 2005.

d. A&MM and VA Police will collaborate on all missing or damaged equipment reports henceforth.

e. The development of a detailed medical center equipment policy is in progress. Target Completion Date: October 1, 2004.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Concur with recommended improvement action: Concur

a. A&MM staff will implement a monitoring process that will regularly and consistently monitor usage rates and adjust stock levels to reduce excess medical supply inventories. Target Date: Implemented June 1, 2004.

b. Prosthetics Service is scheduling 100% inventory reviews for each quarter beginning 4th Quarter Fiscal Year 2004. At the end of the first inventory cycle, the stock levels will be evaluated and adjusted to reflect estimated stock usage levels. The inventory and restocking level process will repeat each quarter until the Prosthetics inventory patch (#61) is installed in VistA and barcode inventory processes are implemented. The patch is schedule for release in FY05 for implementation but is dependent on appropriate staffing resources to achieve full ordering, stocking, and inventory management efficiencies. Target Date: October 1, 2004.

c. A&MM and FMS will work collaboratively to reduce excess Engineering supply inventory. A&MM is currently in the process of hiring staff to provide program support for identifying and entering items into GIP. Target Completion Date: March 30, 2005.

Pharmacy Security – Bulletproof Protection Needed and Vault Door Should Be Kept Closed

Concur with recommended improvement action: Concur

a. In order to meet the minimum security requirements for the Outpatient Pharmacy glass dispensing windows and window walls, Pharmacy Service, Facilities Management Service, and Police Service have met to review the architectural plans for the Outpatient Pharmacy Remodel to ensure that these design elements offer the required life/safety protection for Pharmacy staff. Target Date: January 2005.

b. The security issue regarding the Outpatient Pharmacy Vault has been corrected. The vault combination has been changed and the vault gate and the main door are

now closed and locked at close of business. Target Completed Date: June 2004.

Controlled Substances Accountability – Procurement and Inspection Procedures Should Be Strengthened

Concur with recommended improvement action: Concur

a. All animal and human controlled substances are now being ordered through the Pharmacy. Research and Development and Pharmacy Services have developed policies and procedures to ensure that this occurs. Target Date: Implemented March 17, 2004.

b. Implementation of a green sheet system for all controlled substances in Research began in March 2004 and was completed by April 2004. All controlled substances on hand were reweighed and issued a green sheet for the remaining balance. All new orders for controlled substances receive a green sheet. Target Date: Implemented April 2004.

c. Research and Development has given a spreadsheet to the CSI coordinator showing the location of all safes holding controlled substances. A primary and secondary contact person at each location is also listed. If the inspector is unable to contact a person in the lab at the time of the inspection, or if the contact person is engaged in an experiment that can't be interrupted, the inspector is to contact the Research Service office. The Research Service office will maintain, in a locked file cabinet, a copy of a key to each safe, or the combination. A research service staff member will escort the inspector back to the room containing the safe in question, unlock the door with a master key, and open each safe for the inspector to conduct the check of the inventory. If multiple investigators use the same safe, the contact person will allow inspections of the inventory for all investigators. Target Date: August 1, 2004.

d. Volumetric cylinders are now being used to measure all unsealed liquids in Pharmacy stock during the

Controlled Substance Inspection of the Pharmacy vaults. For the safes in individual laboratories, inventories will be quantitated in metric system units using a scientific balance. Accudose dispensing units for controlled substances are now being checked for expired drugs monthly during the ward inspection process and being turned into pharmacy for destruction. Target Date: Implemented June 2004.

Moderate Sedation – Documentation of Training Was Incomplete

Concur with recommended improvement action: Concur

a. All files were audited for all providers with moderate sedation privileges. Those with no record of current BLS were noted. Their Service Chiefs were notified and Education Division notified in order to set up an immediate series of classes. Audit completed June 30, 2004. The Medical Staff office will now link the requirement for current BLS with the request for reprivileging for moderate sedation privileges. This will prevent lapses in the future. Target Date: July 10, 2004.

Community Nursing Home Contracts – Daily Rates Should Not Exceed the VA Benchmark

Concur with suggested improvement actions: Concur

The Contracting Officer has a completed a 100% review of pricing on all 39 Nursing Home contracts. An error was found in a previously used formula to determine rates in nine older contracts, which resulted in some prices exceeding the VA benchmark. Each of the nine contracts have been reviewed and evaluated, and those contract prices not currently in compliance are being renegotiated to within VA guidelines. A contract review process has been implemented to insure each new CNH contract or contract renewal option is priced in compliance with the VA benchmark. Target Date: October 1, 2004.

Medical Care Collections Fund – Clinical Documentation Should Be Improved and Billing Delays Reduced

Concur with suggested improvement actions: Concur

A Compliance Committee has been formed and will coordinate the following corrective actions:

a. Improvement of medical records documentation:

1. The Graduate Medical Education Committee will coordinate education for the medical staff related to the new requirements for supervision of residents.

2. The Graduate Medical Education Committee and the Compliance Officer will develop criteria for reviewing documentation of outpatient resident supervision.

3. Each Division will perform quarterly record reviews and report documentation compliance to the medical staff through the Medical Records Committee, Graduate Medical Education Committee and Medical Staff Council beginning 1st Quarter Fiscal Year 2005.

4. Medical records that are incomplete after 30 days will be reported to the Chief of Staff immediately.

5. The Financial Services Division will provide feedback to the Medical Records Committee, Q&P Service, and Division Directors about medical records that are returned by 3rd party payers for lack of appropriate documentation immediately.

Target Date: October 1, 2004.

b. The Billing Supervisor is charged with investigating methods and making recommendations to track non-billable episodes of care related to missing documentation, incomplete documentation, and/or supervision of residents

to pursue every opportunity for MCCF collections. Target Date: October 1, 2004.

c. The MCCF Coordinator will monitor billing timeliness and provide feedback to the Division Directors if delays are related to missing documentation, incomplete medical records, and/or supervision of residents. Target Date: October 1, 2004.

Information Technology Security – Controls Need To Be Strengthened

Concur with suggested improvement actions: Concur

a. Inactive Accounts: TIMS is building a new program that will include data from the paid employee and new persons file. The program will do the following:

1. If a user's account has had no activity for 90 days, that user's account will be placed in a "disused" status.

2. If a users account has had no activity for 180 days, that user's account will be "terminated."

3. If a user has separated for the following reasons: retired, transferred, graduated, terminated, etc. they will be "terminated" immediately.

4. The reasons for any account modification will be automatically entered in the appropriate file.

5. The network user administrator will also be sent a copy of the recent terminations so those terminated will also no longer have Network access.

6. A mail group with the appropriate staff (i.e./e, Help Desk, CAC's), will also receive this information.

This process is now being done manually until the new automated computer program is up and running. This

program is to be operating by the end of July 2004. TIMS will document this procedure in a SOP. Target Date: October 1, 2004.

a. Undocumented Changes to Software Program: All software program changes are adequately documented and tested. Target Date: July 1, 2004.

b. Insufficient Temperature Control: Facility Management Service (FMS) is pursuing purchasing and installing a fan to improve air temperature in computer room. Target Date: August 1, 2004.

c. Access Not Logged Consistently: Exception list on sign in/out sheet will be removed. Sign will be placed on the entry to computer room stating all persons must sign in and out of the computer room. The goal is to have the proximity card reader fixed so that access to the computer room will be monitored electronically. A work order has been submitted. Target Date: October 1, 2004.

d. Annual AIS Training Not Tracked: To ensure that all users complete their mandatory AIS refresher training, the Education Division will provide a quarterly report from Tempo with training completion data by service to the ISO. The ISO will send this report to the SBU managers quarterly, starting with the 3rd Quarter FY04 report. This report will also be presented to the Cyber and Information Security Advisory Committee (CISAC) and will be reported to Executive Management Team (EMT) in quarterly and annual reports. The ISO will also keep copies of these reports for external reviews. Target Date: September 1, 2004.

Service Contracts – Contractor Invoices Should Be Properly Certified

Concur with suggested improvement actions: Concur

a. The Portland VA Medical Center (PVAMC) policy outlining COTR responsibilities was not clear in specifying the type of contract requiring COTR certification of invoices.

b. Although local COTR procedures were ambiguous regarding COTR certification of invoices, the medical center always maintained compliance with appropriation and finance requirements. Our processes have been verified to be compliant with VHA, MP, and IG Comptroller General Decisions. Financial Services Division staff are processing invoices per VHA regulations.

c. Process improvement actions implemented or in process of implementation are:

    1. Local COTR procedures and instructions have been clarified, revised, and distributed.

    2. All COTR's have been contacted and notified of the revisions.

    3. Revised COTR training documents and materials are in place for all future training sessions.

    4. Local policy development involving financial and contractual issues will be collaborative.

Target Date: Implemented May 20, 2004.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds	Questioned Costs
2	Better use of funds by reducing excess medical & prosthetic supply inventories.	$689,741	$0
N/A	Better use of funds by including adequate clinical documentation in the medical records and ensuring insurance billings are done promptly.	$24,092	$0
	Total	$713,833	$0

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Director, Los Angeles Office of Healthcare Inspections (310) 268-3005
Acknowledgments	Gary Abe Daisy Arugay Kevin Day James Eckrich Gary Humble Barry Johnson Judy Lawhead Barbara Moss Vishala Sridhar Myra Taylor Orlando Velasquez Sherry Ware Wilma K. Wong

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