Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas

Report No. 04-01878-34 November 26, 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 VA North Texas Health Care System (the System). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 118 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 17.

Results of Review

This CAP review focused on 14 areas. There were no concerns identified in the following two areas.

- Information Technology (IT) Security
- Government Purchase Card Program

Based on our review of these two areas, the following organizational strengths were identified:

- IT resources were properly secured.
- Government purchase card transactions were appropriate.

The other 12 areas needed additional management attention. To improve operations, the following recommendations were made:

- Develop and implement a comprehensive QM program by collecting, summarizing, and analyzing relevant data.
- Maintain a clean and safe environment for patients, employees, and visitors.
- Strengthen inventory management controls over medical supplies.
- Ensure that controlled substances inventories and inspections are done.
- Increase Medical Care Collections Fund (MCCF) billings by improving documentation of resident supervision.
- Establish a process for monitoring moderate sedation event data from all services.
- Strengthen timekeeping controls for part-time physicians.
- Improve compliance with certain contracting requirements.
- Continue management initiatives to decrease patient waiting times.

Suggestions for improvement were made in the following areas:

- Perform equipment inventories within prescribed timeframes.
- Manage certain accounts receivable more aggressively and reconcile accounts receivable monthly.
- Pursue collection actions for duplicate payments made to contract nursing homes.

VISN 17 and System Director Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 24-43 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

This report was prepared under the direction of Mr. Michael Guier, Director, Dallas Audit Operations Division and Mr. Nicolas Torres, CAP Review Coordinator, Dallas Audit Operations Division.

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

Introduction

Health Care System Profile

Organization. The System includes the Dallas VA Medical Center (Dallas VAMC) and the Sam Rayburn Memorial Veterans Center, Bonham, Texas (Bonham VAMC). The Dallas VAMC is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. The Bonham VAMC provides inpatient and outpatient health care services on a more limited basis. Outpatient care is also provided at the Fort Worth Outpatient Clinic and 13 community-based outpatient clinics located throughout North Texas. The System, serves a veteran population of about 484,000 residing in 38 counties in North Texas and 3 counties in Oklahoma.

Programs. The System provides primary care, medical, surgical, mental health, and geriatric services. It also offers rehabilitation medicine, neurology, oncology, and dental services. As of April 1, 2004, the System had a total of 884 operating beds, including 304 acute care and 252 nursing home care beds.

Affiliations and Research. The System is affiliated with the University of Texas Southwestern Medical Center and supports 151 resident positions. It also has affiliations with numerous other institutions, including the Baylor College of Dentistry, Grayson County College, Texas Tech University, Texas Women's University, and the University of North Texas.

The System's medical research program included 270 active research projects in Fiscal Year (FY) 2004. Its research budget was about $3.1 million in FY 2003 and $2.4 million in FY 2004.

Resources. The System's medical care budget was $431.6 million in FY 2003 and $462.8 million in FY 2004. In FY 2004, the System had 3,342 full-time employee equivalents (FTE), which included 218 physician and 913 nursing FTE.

Workload. The System treated 94,628 unique patients in FY 2003. Inpatient workload totaled 14,003 discharges in FY 2003 and 6,898 discharges in FY 2004 (through March 31, 2004). The average daily patient census in FY 2004 (through March 31, 2004) was 219 for acute care and 222 for nursing home care. The outpatient workload totaled 831,932 visits in FY 2003 and 432,085 visits in FY 2004 (through March 31, 2004).

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, and financial and administrative management 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.

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
Controlled Substances
Duplicate Payments
Environment of Care
Equipment Accountability
Government Purchase Card Program
Information Technology Security
Medical Care Collections Fund
Medical Supply Inventory Management
Moderate Sedation
Patient Waiting Times
Quality Management
Service Contracts
Time and Attendance for Part-Time Physicians

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all System employees and 559 responded. We also interviewed 46 patients during the review. The survey results were shared with System managers.

We also presented six fraud and integrity awareness training sessions for System employees. A total of 118 employees attended the training, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered System operations for FY 2003 and FY 2004 through March 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. 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 System managers until corrective actions are completed.

Results of Review

Organizational Strengths

Information Technology Resources Were Properly Secured. System managers had established appropriate controls to protect IT resources from unauthorized access, disclosure, modification, destruction, or misuse.

- Physical security for computer rooms and equipment was adequate. The computer rooms were locked to prevent unauthorized entry, access was properly controlled and monitored, and the rooms contained appropriate hazard warning devices.
- The System was properly prepared for emergencies. Risk assessments, security plans, and contingency plans were current and complete. Information Resources Management Service (IRMS) personnel backed up IT system data on a regular basis and stored the backup media offsite. System managers had established an alternate processing site at the Bonham VAMC to provide required IT support in the event of an emergency at the main IT site at the Dallas VAMC.
- System personnel implemented appropriate IT system access controls. Background investigations were requested when required, and access privileges of separated employees were terminated in a timely manner. The use of strong passwords was required to gain access to the IT systems. In addition, System personnel had developed and implemented a commendable process for determining the scope of employees' access to the IT systems. The Information Security Officer, IRMS personnel, and Automated Data Processing Application Coordinators reviewed employees' position descriptions and other assigned responsibilities and granted employees access privileges to only those functions necessary to accomplish their specific assignments.
- All IT system users received annual computer security awareness training. The IT systems included a control that automatically locked out users who had not completed the required training.

Government Purchase Card Transactions Were Appropriate. We reviewed a judgment sample of 36 purchase card transactions totaling about $65,000 to identify split or duplicate purchases, purchases exceeding warrant authority, and purchases of goods or services unrelated to official VA business. We found no evidence that cardholders split or duplicated purchases, exceeded their warrant authority, or used Government purchase cards for unauthorized purposes. All of the purchases reviewed were properly justified and approved. Also, purchase card reconciliations were performed timely.

Opportunities for Improvement

Quality Management – Program Management and Important Review Processes Needed Improvement

Condition Needing Improvement. Senior System management did not meet Joint Commission on Accreditation of Healthcare Organizations (JCAHO) leadership standards to set expectations or to plan and manage performance improvement processes. The System did not have a QM program that complied with JCAHO standards and Veterans Health Administration (VHA) directives.

Our review showed that key QM processes were not conducted in all areas required by JCAHO. In those areas where QM processes were conducted, they were not integrated into an organization-wide program. There were deficiencies in the following potential high-risk processes: medication management, restraint use, operative and invasive procedures, resuscitation outcome, utilization management (UM), risk management, peer review, practitioner specific performance reviews, and mortality review. QM information was not consistently aggregated or analyzed to assess the quality of care provided, and plans were not considered and implemented to correct deficiencies that were identified. As a result, opportunities to improve patient care and performance were missed. The following conditions required management attention.

- The System's scores were consistently low compared to VHA national performance measures. The System scored the lowest within VISN 17 and, overall, ranked last among all VHA medical facilities with 80 percent of the measures below the fully satisfactory level. For example, a measure for medication, diet, and weight instructions for discharged patients with congestive heart failure was only 4 percent compliant. Although committees had discussed performance measures, they did not consistently make recommendations for improvement.
- The QM program was not planned, systematic, or coordinated on an organization-wide level. Senior System management did not follow their own performance improvement plan for the following required process measurements: outcomes related to resuscitation, operative and invasive procedure review, appropriateness of admissions, autopsy results, deaths, or VHA practice guidelines. There was no evidence that the patient safety information on medication errors, falls, or outcomes of root cause analyses was communicated to clinical service chiefs. Distribution of this information could help prevent adverse events. The Quality Council, the oversight committee for performance improvement (PI), did not have a process in place to review all program components. As a result, information was fragmented and QM managers were not performing essential functions required by JCAHO, VHA, and local policies.

- Practitioner specific QM data, including peer reviews, were not used consistently in the process to renew privileges to practice medicine within the facility. VHA requires that the reprivileging process include an appraisal of professional performance from practitioner specific PI activities. Because information was not collected in required areas, information was not available to clinical service chiefs. The System initiated a comprehensive peer review program in March 2004. Prior to that time, there was no coordinated effort to review practice patterns, collect and trend data, and identify possibilities to improve patient care.
- QM managers did not collect, trend, or analyze mortality data. All System deaths needed to be analyzed for patterns or trends (unit, provider, and time of day).
- Clinical service chiefs did not adequately evaluate resuscitation outcomes as required by JCAHO. They only reported the number of events per month with immediate survival rates. This information needed to be trended by unit, provider, time of day, and patient response. Trending of this data could reveal potential problems and identify opportunities to improve patient care.
- The patient advocate collected and trended patient complaints monthly, but no one analyzed the data or reported it to a committee for recommendations or actions. Complaints indicated trends relating to performance measures that were low. For example, satisfaction with pharmacy waiting times was the lowest in VISN 17 according to national performance measures, and the data collected by the patient advocate noted this as a problem. However, services did not receive any information from the patient advocate. Although the services received data collected from patient correspondence to the System Director, this information was not trended and efforts between the two areas were not coordinated. This resulted in missed opportunities to improve care.
- Risk management/patient safety information was incomplete. Patient Safety Committee minutes noted that incident reports were not completed and received within the timeframe required by System policy. As a result, databases were incomplete. QM managers told us that not all patient injuries were recorded, and nurse managers did not receive reports relating to medication errors or falls. Adverse events related to moderate sedation were reported to clinical service chiefs, but there was no system in place to coordinate the reviews or trend and analyze the events.
- UM reviews had not been performed for over a year at the time of our review. Prior to that time, admission and continued stay appropriateness reviews were transferred from Nursing Service to QM Service. These reviews are required by JCAHO and VHA to increase the efficiency and appropriateness with which services are provided and resources are utilized. Patient care can be improved by sharing data on adverse events that may require admissions or extend the lengths of stay.
- Although various System personnel collected data concerning adverse drug, restraint and seclusion, and patient safety events, they did not consistently analyze these data

to identify trends, recommend corrective actions, or assign timeframes for the completion of those actions. For example, the Medical Records Committee monitored completion rates for signed patient histories and physicals. JCAHO requires a co-signature by an attending physician within 24 hours of admission. For a period of 18 months, this area was 10 to 25 percent below the minimum requirement and showed no improvement. The Medical Records Committee did not analyze the data by service or make recommendations for improvement. We were not provided documentation to show this information was reported to the medical staff.

The QM program was not comprehensive, did not provide oversight of patient care, and did not evaluate important clinical functions. System employees had not received the required education and training in basic QM principles prescribed by JCAHO standards. We concluded there was no evidence of a planned, collaborative effort to improve organizational performance.

Recommended Improvement Action 1. We recommended the VISN Director ensure the System Director initiates action to: (a) develop and implement a comprehensive QM program that will provide effective oversight of patient care and communicate results to System employees, (b) use QM data in the reprivileging process, (c) collect and trend PI data in all required areas (specifically, UM, peer reviews, safety reviews, mortality reviews, all patient complaints, and outcomes of resuscitation), (d) identify benchmarks and compare results, (e) analyze QM data for use in establishing recommendations, (f) determine corrective actions and designate accountability and timeframes, (g) develop criteria to evaluate effectiveness of corrective actions, (h) capture all patient incidents in a timely manner, and (i) provide PI education for employees.

The VISN and System Directors agreed with the finding and recommendations and reported that appropriate management actions have been initiated to develop and implement a comprehensive QM program. An external quality review conducted by QM staff from VISN 21, which was requested to evaluate the System's current QM program, identified opportunities for improvement and related action plans. Major management initiatives have been completed or proposed to improve oversight of patient care and enhance integration and coordination of QM and PI activities. A new QM Service Chief and External Peer Review Program (EPRP) nurse coordinator have been selected, and eight additional nurses have been hired for QM and Utilization Review (UR) functions. QM Service has been reorganized into two primary departments, Clinical QM and Safety/Consumer Affairs, with department chiefs assigned for a 90-day trial period. Also, a proposed revision to the current QM committee structure, which will be presented to the Quality Council in September 2004, should improve the process for monitoring, reporting, and communication of QM activities. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Condition Needing Improvement. System management did not maintain a consistently clean and safe environment of care (EOC) for patients at the Dallas VAMC. VHA directives and System policy require a safe and healthy environment for patients, employees, and visitors. To provide quality care, an effective EOC program should ensure:

- Facilities are clean and sanitary.
- Supplies are properly stored.
- Medication carts, medical supplies, sharp instruments, and other potentially hazardous materials are properly secured and inaccessible to patients.
- Medication refrigerators are properly maintained and temperatures are kept within the required range.
- Safe conditions are provided to reduce and control environmental hazards and risks.

Our review showed that the Bonham VAMC maintained a generally clean and safe EOC, although facility conditions could be further improved by:

- Maintaining appropriate refrigerator inspection logs in the canteen kitchen and conducting weekly inspections of the canteen eye wash stations.
- Moving boxes and other items off floors, cleaning storage and utility room floors, replacing damaged ceiling tiles, and performing other cosmetic repairs.

However, we concluded that the Dallas VAMC was not maintained to acceptable levels of cleanliness and safety. A pre-CAP survey done by VISN 17 staff in March 2003 documented many of the same EOC findings we identified. Specific findings are discussed below.

Patient Care Areas. Most patient rooms and bathrooms we inspected were unclean. Floors and walls had buildups of grime and the rooms had foul odors, suggesting that they had not been thoroughly cleaned over a significant period.

Intravenous (IV) pumps, poles, and patient stretchers were dirty. Storage rooms and utility closets were cluttered and had boxes on the floor. Additionally, most storage rooms had dirty floors. Sharps containers were unsecured on the floor in a patient room and at a nurse’s station. Various electrical devices were attached to an extension cord in a patient bathroom, creating an unsafe condition. Some stretchers were stained or had dried residue suggestive of body fluids (a patient stretcher with a large stain is shown in Picture 1 on the next page).

Picture 1 – Patient Stretcher

Ceiling tiles in patient rooms, hallways, and other areas were stained, damaged, or missing. Trash was found in ice machine overflow reservoirs in the hemodialysis and spinal cord injury units and the mental health ward. The medication refrigerator in the chemotherapy treatment room held both medications and staff food increasing the potential for cross contamination, as shown below in Picture 2.

Picture 2 – Medication Refrigerator

Clinic 7 had a large area that was missing about 70 floor tiles. On January 28, 2004, a work order was submitted to replace the tiles, and it showed the tiles were replaced on March 29, 2004. On April 8, 2004, a second work order to replace these tiles was submitted, and it showed they were replaced on May 17, 2004. However, the tiles were not replaced until May 20, 2004, after our inspection.

The lighting in both transitional care units was inadequate. Exposed electrical connections (uncovered bathroom heater switches) were found in patient bathrooms. Patient refrigerators needed cleaning, and there was no log to confirm temperature checks for one of the patient refrigerators. Two fire extinguishers did not have current inspections. The linen room shelves did not meet the requirement for storage (6 inches off the floor).

We observed opened bags of used medical disposables on the floor of an operating room suite during a procedure. The disposables should either have been stored in appropriate lidded containers or removed if left over from previous procedures. A surgical table covering was torn in many areas, which increased the risk of infection through contamination. Excess linen stored in plastic bags needed to be returned to the laundry. There were scattered hairline paint cracks in the ceiling throughout the surgical suite, and the satellite pharmacy wall had damaged sheet rock suggestive of neglect.

Units 4C, 6C, and 7B and the thoracic intensive care unit had unattended and unlocked medication carts. Drawers on medication carts on several other units were unlocked. Refrigerator inspections were not consistently performed on unit 6C and the coronary care units. On unit 8A, the medication refrigerator temperature was consistently below the required range, possibly altering the effectiveness of medications. The patient nourishment refrigerators in the spinal cord injury unit and same day surgery suite were dirty. Crash carts on unit 8A and the surgical intensive care unit were not inspected according to policy, and several crash carts were in disrepair and required tape to keep the doors closed. Unit 6C had no evacuation plan signage, and there was no patient representative signage in any patient care areas. An IV pole, soiled linen, a mop pail of dirty water, an oxygen tank, and a biohazard can were inappropriately stored in the radiology dressing area. Radiology equipment was covered with thick dust.

Public Areas, Air Vents, and Housekeeping Closets. Air vents throughout the Dallas VAMC needed cleaning. Carpets in the pharmacy pick-up area, canteen retail store, and audiology waiting area were stained. Vending machines, microwaves, and handrails in the outpatient clinic waiting areas were in need of cleaning. Most of the housekeeping closets needed cleaning and organizing, and housekeeping items needed to be moved off the floor. Housekeeping chemicals and supplies were unsecured in soiled utility rooms. Many public restrooms had stained floor tiles, dirty grout, and foul odors (Picture 3 on the next page shows the condition of the floor tiles in one of the public restrooms).

Picture 3 – Public Restroom Floor

Canteen. In the canteen, we observed filthy dustpans and a grease holder stored on the floor in a food preparation area, gnats flying around trash cans, and rotting carrots in a refrigerator. Stoves, refrigerators, warming units, and dry storage areas were unclean. There was no soap at the employee hand-washing sink. Extension cords hanging from the ceiling presented a safety hazard. A clogged drain allowed dirty water to accumulate on the floor of the canteen, as shown below in Picture 4.

Picture 4 – Canteen Floor Drain

VISN and System managers were responsive to the findings and began corrective actions during the CAP review. However, in our opinion, the unclean conditions at the Dallas VAMC did not meet the standards of care expected of a VA medical facility and reflected neglect of some duration.

Recommended Improvement Action 2. We recommended the VISN Director require the System Director to ensure that: (a) patient care areas are kept clean, safe, and well organized; (b) medications are secured and refrigerator temperatures are logged as required; (c) crash carts are checked and maintained in a constant state of readiness; (d) evacuation plans and patient representative signage are accessible in all patient care areas; (e) public areas, air vents, and housekeeping closets are well maintained; and (f) the canteen drains are functioning properly and the area is clean and sanitary.

The VISN and System Directors agreed with the finding and recommendations and reported that immediate actions were initiated to correct the EOC deficiencies identified by the OIG team. The System Director reports that about 97 percent of the identified deficiencies have been corrected. Five additional FTE have been assigned to the Environmental Management Service (EMS), and EMS has been assigned responsibility for vending machines, patient refrigerators, and microwaves. Supervisory nurses are now monitoring compliance with the requirements to secure medications, log refrigerator temperatures, and maintain crash carts during their daily rounds. Patient representative signs and evacuation plans are being posted in patient care areas. Also, the EMS inspection program has been modified to better monitor the cleanliness of the facility by maintaining inspection schedules and logs that document the deficiencies found and actions taken to correct them. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Supply Inventory Management – Inventory Controls Should Be Strengthened and Stock Levels Should Be Reduced

Condition Needing Improvement. The System needed to maintain accurate inventory records and reduce stock levels of medical supplies. VHA policy requires that medical facilities use the automated Generic Inventory Package (GIP) to manage inventories and establishes a 30-day supply goal. Acquisition and Materiel Management Service (A&MMS), which operates the warehouse, and Nursing Service, which operates the Supply Processing and Distribution (SPD) activity, manage the System's medical supply inventory. At the time of our review, GIP data showed the System's medical supply inventory included 380 line items valued at $495,250 in the warehouse and 899 line items valued at $487,711 in the SPD activity.

Inaccurate Inventory Records. To assess the accuracy of GIP data, we inventoried a judgment sample of 33 line items, including 10 line items stored in the warehouse and 23 line items stored in the SPD activity. The recorded value of the line items in our sample was $178,756. For the 10 line items stored in the warehouse, the quantities recorded in

GIP were accurate. However, we found that quantities recorded in GIP were inaccurate for 20 of the 23 (87 percent) line items in the SPD activity, with 5 overages valued at $23,005 and 15 shortages valued at $71,623. A&MMS managers indicated that the untimely processing of receipts and distributions by SPD personnel contributed to the inaccurate inventory balances in GIP. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. GIP data indicated medical supply stock levels in the warehouse were higher than needed. The stock levels of 273 of the 380 (72 percent) line items stored in the warehouse exceeded the 30-day stock level. The total recorded value of warehouse medical supplies in excess of the 30-day level was about $194,000. We did not attempt to determine the number of SPD line items with stock levels exceeding 30-day supplies or estimate the value of excess stock in the SPD activity because GIP was unreliable. Reducing stock levels would reduce holding costs and make more funds available for other uses.

Recommended Improvement Action 3. We recommended the VISN Director ensure the System Director takes action to: (a) inventory medical supplies stored in the SPD activity and correct GIP inventory records as needed; (b) provide refresher training for SPD personnel, emphasizing the importance of promptly and accurately recording receipts and distributions; and (c) reduce stock levels of medical supplies to the 30-day goal.

The VISN and System Directors agreed with the finding and recommendations and reported that a comprehensive inventory of medical supplies stored in the SPD activity was conducted in July 2004, with related GIP records to be updated. SPD personnel received training on receipt and distribution policy in June 2004. Also, stock levels are being reduced by discontinuing use of the auto-generation process, receiving online notification of available stock levels, and ordering medical supplies based on actual inventory on hand. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances – Additional Improvements Were Needed to Ensure Accountability

Condition Needing Improvement. System managers needed to ensure that controlled substances inventories and monthly controlled substances inspections are done in accordance with VHA policy. VHA policy requires Pharmacy Service personnel to maintain a perpetual inventory of controlled substances and reconcile inventory records to the actual stock on hand at intervals of no more than 72 hours. In addition, each facility must establish a program of unannounced monthly controlled substances inspections performed by employees who are not involved in procuring, prescribing, dispensing, or administering medications. Controlled substances inspectors must be

appointed in writing for periods not to exceed 3 years and must receive annual training concerning their responsibilities.

Interviews with the Acting Chief, Pharmacy Service and the Controlled Substances Coordinator and reviews of controlled substances inspection reports for the period April 2003 through March 2004 disclosed that the System was not in compliance with VHA policy in 2003.

- Prior to November 2003, Pharmacy Service personnel did not perform controlled substances inventories for a period of about 8 months.
- Monthly controlled substances inspections were not done at the Bonham VAMC. Brief memoranda stating that inspections had been done and no deficiencies had been found were the only documentation of controlled substances inspections at the Dallas VAMC.
- Controlled substances inspectors were not appointed in writing and did not receive the required annual training.

Since the appointments of an Acting Chief, Pharmacy Service in November 2003 and a new Controlled Substances Coordinator in December 2003, accountability for controlled substances has improved. In November 2003, Pharmacy Service personnel at the Dallas VAMC began performing controlled substances inventories at intervals of no more than 72 hours in accordance with VHA policy. In January 2004, controlled substances inspectors were appointed in writing for 2-year periods and were provided training. Unannounced controlled substances inspections have been performed monthly since January 2004 and supporting documentation has been retained. Although significant improvements were made, we identified two additional opportunities for improvement.

- Bonham VAMC controlled substances inventory records for the period February 20, 2004, through May 20, 2004, showed controlled substances inventories were not performed frequently enough. The intervals between inventories at the Bonham VAMC ranged from 4 to 20 days. Inventories should be completed at the prescribed intervals to ensure that discrepancies are promptly identified and investigated.
- VHA policy requires that controlled substances inspectors receive written instructions for inspecting automated devices that dispense controlled substances. Also, when inspecting automated dispensing devices in outpatient clinic areas and inpatient units, a nurse assigned to the clinic or unit must accompany the controlled substances inspectors. The System's controlled substances inspectors had not received written instructions for inspecting automated dispensing devices and were not accompanied by nurses when inspecting devices in outpatient clinic areas and inpatient units.

Recommended Improvement Action 4. We recommended the VISN Director ensure the System Director takes action to: (a) perform controlled substances inventories at

intervals of no more than 72 hours, (b) continue to perform monthly unannounced controlled substances inspections and document the results, and (c) issue written instructions for inspecting automated devices that dispense controlled substances and require that controlled substances inspectors be accompanied by nurses when inspecting automated dispensing devices in outpatient clinic areas and inpatient units.

The VISN and System Directors agreed with the finding and recommendations and reported that, effective June 1, 2004, Pharmacy Service managers are required to initial 72-hour vault inspection reports to verify the related inventories are being performed. The Controlled Substances Coordinator reviews the vault inspection reports to ensure that inspections are completed timely and accurately. Since January 1, 2004, the monthly controlled substances inspection reports have been sent through QM staff and the Associate Director to the Director to ensure these inspections are completed each month and the inspection results are documented. Controlled substances inspectors were provided training and written instructions for inspecting automated devices that dispense controlled substances, and a nurse now accompanies each inspector during these inspections. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Collections Could Be Increased by Documenting Resident Supervision

Condition Needing Improvement. The System exceeded its MCCF collection goal each of the last 3 years, increasing overall collections from $9.6 million in FY 2001 to $23.1 million in FY 2003. However, our review showed that the System could further increase MCCF collections by ensuring that attending physicians[1] adequately document supervision of residents[2] in patients' medical records.

VHA and System policies require that insurance carriers be billed for care provided by residents. As a prerequisite to billing, medical records must show that resident care was properly supervised by attending physicians. This supervision should be documented in progress notes entered into the medical records by the attending physicians or be reflected in progress notes prepared by the residents. The *Reasons Not Billable Report* covering the period October 1, 2003, through March 31, 2004, showed that MCCF staff canceled 1,552 potential billings totaling about $509,000 because the related care was provided by residents. We selected a judgment sample of 20 of the 1,552 potential billings, and found that 10 potential billings totaling $27,387 were canceled because the patients' medical records did not contain documentation of the attending physicians' supervision of residents. If clinicians had complied with the documentation requirements prescribed by VHA, MCCF staff could have potentially collected $12,050 for the 10

[1] An attending physician is a staff physician responsible for the patient care provided by residents.
[2] A resident is an individual who is engaged in a graduate training program in medicine, dentistry, podiatry, or optometry, and who participates in patient care under the direction of attending physicians.

encounters based on the System's current collection rate from health insurance carriers of about 44 percent ($27,387 x 44 percent).

Recommended Improvement Action 5. We recommended the VISN Director ensure the System Director requires that: (a) attending physicians properly supervise resident care, and (b) attending physicians and residents receive additional training concerning documentation of resident supervision.

The VISN and System Directors agreed with the finding and recommendations and reported that MCCF, Medical Records Committee, and EPRP staff are currently monitoring the supervision of resident care by attending physicians. Non-compliance is reported through the responsible service chief to the Chief of Staff. The Compliance Officer will provide additional monitoring of resident supervision. Refresher training on resident supervision was provided to the appropriate medical staff by July 1, 2004. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Moderate Sedation – The System Should Collect and Trend Event Data from All Services to Ensure Compliance with Prescribed Standards for Care

Condition Needing Improvement. Senior System management needed to establish procedures for QM reviews of moderate sedation (conscious sedation) event data from all services and ensure compliance with JCAHO standards and System policy.

JCAHO requires that medical facilities provide consistent high quality moderate sedation care throughout the facility and establish standards of care. To assess the quality of moderate sedation care, we evaluated System policy and procedures, sampled 10 patient medical records and 5 health care provider credentialing and training records, inspected selected treatment areas, interviewed key employees, and evaluated moderate sedation quality improvement processes.

We determined that the System had established appropriate policy for performing procedures involving moderate sedation, properly credentialing and training staff for moderate sedation, and ensuring availability of appropriate equipment. However, procedures were not established to trend and critically analyze results of moderate sedation across all services that performed moderate sedation. As a result, the System could not ensure that moderate sedation was consistently provided in accordance with JCAHO standards and System policy.

Recommended Improvement Action 6. We recommended the VISN Director require the System Director to ensure moderate sedation event reports are collected from all services, aggregated, and critically analyzed to monitor performance and identify quality improvement opportunities.

The VISN and System Directors agreed with the finding and recommendation and reported that the moderate sedation workgroup has been reactivated to establish a process for collecting, trending, analyzing, and monitoring moderate sedation data from all services. The workgroup will meet monthly to develop mechanisms for better collection, trending, and analyses of moderate sedation data. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Time and Attendance for Part-Time Physicians – Timekeeping Controls Needed To Be Strengthened

Condition Needing Improvement. The System needed to strengthen controls over timekeeping for part-time physicians. All of the System's 34 part-time physicians had designated at least 25 percent of their work hours as core hours in accordance with VHA policy, and an unannounced roll call of 16 part-time physicians we conducted on May 17, 2004, showed that all 16 were performing VA duties when scheduled or had submitted leave requests. However, we identified five timekeeping issues that required management attention.

Completion of Subsidiary Time Sheets. VHA policy states that part-time physicians will record their hours of duty and leave each week on subsidiary time sheets (VA Form 4-5631a, *Subsidiary Time and Attendance Report for Part-Time Physicians*) and sign the time sheets. We interviewed 6 of the 8 timekeepers who were responsible for the time and attendance records of the System's part-time physicians. One of the timekeepers, who was responsible for the records of 16 part-time physicians in Medical Service, inappropriately recorded each physician's hours worked on the subsidiary time sheets before giving the time sheets to the physicians for signature.

Accuracy of Leave Charges. To verify that leave shown on subsidiary time sheets was properly recorded, we compared subsidiary time sheets with corresponding data in the Enhanced Time and Attendance (ETA) System for a judgment sample of 10 part-time physicians. Our review covered 30 part-time physician pay periods (from January 25, 2004, through May 15, 2004) and a total of 878 work hours. We found that three Medical Service physicians who had recorded leave on their subsidiary time sheets had not submitted leave requests and had not been charged for a total of 35.5 hours of annual leave they had used. We informed the responsible timekeeper of the discrepancies, and she took action to correct the specific deficiencies identified.

Timekeeper Desk Audits. VA policy requires semiannual desk audits of all timekeepers. Human Resources Management Service (HRMS) personnel conducted desk audits of part-time physicians' timekeepers in May 2003, and noted that two Medical Service physicians had not entered leave requests into the ETA System. HRMS personnel did not follow up on the deficiencies identified and, as of May 20, 2004, they had not done any subsequent desk audits. If HRMS personnel had conducted semiannual desk audits as required, they might have noticed that part-time physicians were not recording the hours

they worked on their subsidiary time sheets, and that not entering leave requests in the ETA System was a recurring problem.

Timekeeper Training. VA policy requires that all timekeepers receive annual refresher training. However, reviews of the training records for the eight part-time physician timekeepers indicated the most recent refresher training was provided in November 2002. HRMS personnel provided additional refresher training for 4 of the 8 timekeepers during the week of our onsite review.

Written Agreements. VHA policy requires service chiefs, product line managers, and other supervisors to maintain current written agreements with all part-time physicians describing VA's expectations and the part-time physicians' responsibilities. At the time of our review, four part-time physicians did not have the written agreements.

Recommended Improvement Action 7. We recommended the VISN Director ensure the System Director takes action to: (a) ensure that part-time physicians record their hours worked and leave taken on subsidiary time sheets, (b) remind Medical Service physicians to submit leave requests when appropriate, (c) conduct semiannual desk audits of all timekeepers and follow up on the deficiencies identified, (d) provide annual refresher training for all timekeepers, and (e) ensure service chiefs and other supervisors maintain current written agreements with all part-time physicians describing VA's expectations and the part-time physicians' responsibilities.

The VISN and System Directors reported that part-time physicians are now recording the hours they work on the subsidiary time sheets, and on May 28, 2004, Medical Service physicians received training concerning submission of leave requests. Semiannual desk audits will be scheduled in October and April, with the next audits to be completed by October 29, 2004. Timekeepers received training in May 2004 and will receive additional training in October 2004 and every year thereafter. The required written agreements with part-time physicians were completed by June 12, 2004, and timekeepers will maintain copies of the agreements. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts – Pre-Award Audits and Reviews Should Be Requested When Required, Supervisors Should Receive Guidance Concerning Conflicts of Interest, and Contract Files Should Include Required Documents

Condition Needing Improvement. To evaluate System contracting activities, we reviewed a judgment sample of 14 service contracts valued at about $8.7 million. Contracting officers used noncompetitive acquisition procedures for 10 of the contracts and competitive bidding procedures for 4 contracts. Our review showed that contracting officers had appropriate warrant authority, contract files were generally well organized,

and billing and payment procedures were adequate. However, we identified three issues requiring management attention.

Pre-Award Audits and Legal and Technical Reviews. VHA policy requires pre-award audits of all noncompetitive contracts with estimated values of $500,000 or more. In addition, legal and technical reviews are required for all noncompetitive contracts valued at $500,000 or more and all competitive contracts valued at $1.5 million or more. Our judgment sample included two contracts requiring pre-award audits and three contracts requiring legal and technical reviews, but none of the required audits and reviews had been done.

Guidance Concerning Conflicts of Interest. VHA policy requires that each physician supervisor or manager receive a copy of VHA Handbook 1660.3, which provides guidance for avoiding conflicts of interest, and acknowledge its receipt in writing to indicate they understand and agree to abide by the guidance. We reviewed the Official Personnel Folders of 10 physician supervisors and managers and found that 2 had not signed the required acknowledgments.

Contract Documentation. Although contract files generally included appropriate documentation, 3 of the 14 files reviewed did not contain required documents.

- The files for two noncompetitive contracts did not contain justifications for noncompetitive acquisitions or price negotiation memoranda.
- The file for one competitive contract did not include a written designation of the Contracting Officer's Technical Representative (COTR) and a description of the COTR's authority.

Recommended Improvement Action 8. We recommended the VISN Director ensure the System Director takes action to: (a) request pre-award audits and legal and technical reviews when required, (b) provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt, and (c) include all required documentation in contract files.

The VISN and System Directors reported that contracting officers were provided training on contract technical review requirements in August 2004. Appropriate staff members were given a copy of VHA Handbook 1660.3 and required to sign the prescribed acknowledgment form, and HRMS personnel are in the process of reviewing the personnel folders of these staff members to ensure compliance. In June 2004, procurement technicians began checking the contract files to ensure required documents are maintained in the files. In a subsequent discussion with the System Director, he stated contracting officers will ensure that pre-award audits are requested when required in the future. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Patient Waiting Times – Further Reductions Were Needed

Condition Needing Improvement. Although waiting times for clinic appointments generally decreased in the last year, the System did not meet VHA's goal of scheduling patient appointments within 30 days of the appointment dates desired by either the patients or clinicians. The VHA goal is the same for new and established patients. We reviewed waiting times for six clinics (audiology, cardiology, combined primary care, eye care, podiatry, and urology) for the 12-month period ending March 31, 2004. For 5 of the 6 clinics, average waiting times for both new and established patients exceeded the 30-day goal. For new patients, the average waiting times for these five clinics ranged from a low of 42 days in the eye care clinic to a high of 83 days in the podiatry clinic. For established patients, the average waiting times for these five clinics ranged from a low of 36 days in the eye care clinic to a high of 90 days in the podiatry clinic.

Even though 5 of the 6 clinics reviewed did not meet the 30-day goal for scheduling appointments, the System was making progress in reducing waiting times. For example, a comparison of average waiting times for the first 6 months and the last 6 months of the review period showed that the cardiology clinic reduced average waiting times for established patients from 65 days in the first 6 months to 53 days in the last 6 months. Average waiting times for new patients in the cardiology clinic were reduced from 46 days in the first 6 months to 44 days in the last 6 months.

System managers closely monitored waiting times and implemented several initiatives to reduce them. Initiatives included hiring additional clinic staff, increasing the number of residents from affiliated institutions, increasing clinic operating hours, and contracting out some of the clinic workload.

Recommended Improvement Action 9. We recommended the VISN Director ensure the System Director continues to monitor waiting times and implements initiatives to achieve the goal of scheduling patient appointments within 30 days of the desired appointment dates.

The VISN and System Directors reported that various management initiatives were ongoing to decrease patient waiting times. These initiatives include developing contracts for medical services when demand exceeds local capacity, hiring qualified clinical providers, and increasing clinic operating hours as additional staff resources become available. To reduce patient waiting times for the podiatry clinic, two podiatry assistants were hired on May 26, 2004, and the podiatry clinic started offering Saturday appointments effective July 31, 2004. Other clinics also started offering appointments and certain services on Saturdays, in addition to contracting for some of their services, to reduce patient waiting times. To improve the process for scheduling patient appointments, training was provided to all schedulers on August 6, 2004. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Equipment Inventories Should Be Scheduled at Required Intervals and Completed Timely

Condition Needing Improvement. System personnel needed to schedule equipment inventories in accordance with VHA policy and complete equipment inventories timely. The System had 112 active Equipment Inventory Listings (EILs) with total acquisition costs of about $125.6 million.

Scheduling of Inventories. VHA policy requires that equipment inventories be completed at intervals ranging from 6 months to 2 years depending upon the accuracy of the prior inventories. However, A&MMS, which was responsible for notifying designated personnel when equipment inventories were due, did not track the accuracy of prior inventories. Instead, A&MMS personnel scheduled inventories for all EILs at 12-month intervals.

Timely Completion of Inventories. System personnel did not complete equipment inventories timely. VHA policy requires that inventories be completed within 10 or 20 days after notice is received that an inventory is due depending on the total number of items included on the EIL. We reviewed the equipment inventory schedule for the period April 1, 2003, through March 31, 2004, and found that inventories for 48 EILs, with acquisition costs totaling $81.8 million, were completed up to 13 months after the due dates. There was no evidence that System personnel had completed inventories for five other EILs with acquisition costs totaling $9.8 million, even though the inventories were up to 13 months past due at the time of our review.

Suggested Improvement Action 1. We suggested the VISN Director ensure the System Director requires that: (a) A&MMS personnel track the accuracy of equipment inventories and schedule equipment inventories at required intervals, and (b) System personnel complete equipment inventories timely.

The VISN and System Directors agreed with the finding and suggestions and reported that A&MMS personnel will track the accuracy of equipment inventories to ensure they are scheduled within the prescribed timeframes. As of June 1, 2004, A&MMS personnel started using appropriate software to verify the accuracy of inventories and to determine whether the inventories are done at the required intervals. On September 30, 2004, A&MMS personnel were to begin submitting monthly reports to the Director on delinquent equipment inventories. The improvement plans are acceptable.

Accounts Receivable – Controls Needed To Be Strengthened

Condition Needing Improvement. Fiscal Service personnel needed to manage certain accounts receivable more aggressively and reconcile accounts receivable monthly.

Management of Accounts Receivable. To evaluate management of accounts receivable, we reviewed a judgment sample of 30 accounts receivable owed by vendors, employees, and other Federal agencies as of March 31, 2004. The accounts receivable in our sample totaled $12.5 million. Fiscal Service personnel took appropriate and timely action on 23 of the accounts receivable in our sample, aggressively pursuing collection, canceling, or writing off the debts when appropriate. However, seven of the accounts receivable should have been managed more aggressively. Six of the 7 accounts receivable were owed by other Federal agencies, and these receivables could have been closed sooner if Fiscal Service personnel had requested inter-agency fund transfers promptly or initiated close-out actions immediately after the funds were transferred. The other account receivable was improperly coded as a Federal receivable although it involved a debt owed by a patient. The coding error could have been identified and corrected sooner if Fiscal Service personnel had performed follow-up reviews of outstanding accounts receivable in a timely manner.

Reconciliation of Accounts Receivable. VA policy requires Fiscal Service personnel to reconcile outstanding accounts receivable to the general ledger each month. However, as of the date of our review in May 2004, Fiscal Service personnel had not done the required reconciliation since December 2003.

Suggested Improvement Action 2. We suggested the VISN Director ensure the System Director takes action to: (a) promptly request inter-agency fund transfers and initiate actions to close accounts receivable when the funds are transferred, and (b) reconcile accounts receivable to the general ledger each month.

The VISN and System Directors agreed with the finding and suggestions and reported that a systems analyst was hired for Fiscal Service on August 22, 2004. The systems analyst will be responsible for ensuring that all inter-agency fund transfers are requested in a timely manner and the related accounts receivable are closed when the funds are transferred. In addition, the analyst will reconcile accounts receivable to the general ledger monthly. The improvement plans are acceptable.

Duplicate Payments – Payments Needed To Be Recouped

Condition Needing Improvement. During our review of the MCCF program, we became aware of 18 duplicate fee basis payments that were made to contract nursing homes in November 2003 and February 2004. Eight contract nursing homes were overpaid about $58,000 because two batch payments that were supposed to be canceled were inadvertently processed in the Financial Management System. In both cases, Fiscal Service personnel used the wrong code when attempting to cancel the payments. Prior to our review, Fiscal Service personnel had issued bills of collection to recoup 12 duplicate payments totaling about $37,500 and a nursing home had voluntarily returned a duplicate payment of about $2,200. As a result of our review, Fiscal Service personnel issued bills

of collection for the five remaining duplicate payments totaling about $18,300 and received refresher training on the codes used to cancel payments.

Suggested Improvement Action 3. We suggested the VISN Director ensure the System Director requires that Fiscal Service personnel aggressively pursue recoupment of the duplicate payments made to contract nursing homes.

The VISN and System Directors agreed with the finding and suggestion and reported that bills of collection have been issued to all vendors receiving the duplicate payments. Collection letters mandated by the Treasury Offset Program will be issued during the period September through November 2004. If the vendors do not respond to these collection letters, the overpayments will be recouped in December 2004 using procedures prescribed under the Treasury Offset Program. The improvement plan is acceptable.

Appendix A

VA North Texas Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2004

From: Director, VA Heart of Texas Health Care Network, VISN 17 (10N17)

Subject: **CAP Review of VA North Texas Health Care System Dallas, Texas**

To: Director, Dallas Audit Operations Division

Network 17 appreciates the OIG's review and recommendations concerning the VA North Texas Health Care System (VANTHCS). Each action plan has been designed to completely address all issues identified within the recommendations. The VISN office is taking both the recommendations and the corrective actions very seriously. We will continue our bi-monthly face-to-face meetings with the VANTHCS leadership. Active VISN participation, in all areas of improvement, will continue until all recommendations are completely satisfied in a timely manner. We welcome the OIG to return to VANTHCS to review the improvements.

Thomas J. Stranova

Network Director

VA North Texas Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2004

From: Director, VA North Texas Health Care System (549/00)

Subject: **CAP Review of VA North Texas Health Care System Dallas, Texas**

To: Director, Dallas Audit Operations Division

The VA North Texas Health Care System Director's comments for the subject CAP review are listed in the appendix after each specific recommended or suggested improvement action.

VA North Texas Health Care System Director Comments

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's report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director initiates action to: (a) develop and implement a comprehensive QM program that will provide effective oversight of patient care and communicate results to System employees, (b) use QM data in the reprivileging process, (c) collect and trend PI data in all required areas (specifically, UM, peer reviews, safety reviews, mortality reviews, all patient complaints, and outcomes of resuscitation), (d) identify benchmarks and compare results, (e) analyze QM data for use in establishing recommendations, (f) determine corrective actions and designate accountability and timeframes, (g) develop criteria to evaluate effectiveness of corrective actions, (h) capture all patient incidents in a timely manner, and (i) provide PI education for employees.

Concur **Target Completion Date:** Dec. 2004

Action 1A. Develop and Implement a Comprehensive QM program that will provide effective oversight of patient care and communicate results to system employees:

1. Initiate external quality review team to assess and evaluate current Quality Management Program at VANTHCS.

Status: Complete. External review conducted by QM staff from VISN 21, opportunities for improvement identified, actions incorporated into this plan.

2. Reorganize existing QM program to provide effective oversight and enhance integration and coordination of QM and Performance Improvement (PI) activities.

VA North Texas Health Care System Director Comments

Status: Complete. The QM Service has been reorganized into two primary departments: Clinical QM and Safety/Consumer Affairs with Chiefs assigned to each for a ninety day trial.

3. Allocate adequate resources to conduct, support and facilitate QM activities at VANTHCS.

Status: Complete. A new Chief of Clinical QM Service has been selected and is on board; 4 new QM nurses and 4 new UR nurses are now on-board. New EPRP nurse coordinator on board.

4. Review and modify existing committee structure to enhance, define and ensure effective monitoring, reporting and communication of QM activites.

Status: Work in progress. Committee structure has been revised and will be presented to Quality Council in Sept. 2004.

5. Enhance and ensure communication of QM & PI activities at all levels of the organization by:

a. Developing a computerized data repository of QM & PI reports, accessible by all VANTHCS employees.

Status: Work in progress. Hard copy reports are being developed for incorporation into the computer via intranet.

b. Disseminate Functional Committee minutes via intranet.

Status: Pending. Tentative start date Oct. 1, 2004

c. Utilize annual management briefings to communicate service level PI activities and accomplishments with top management and other services.

Status: Work in progress. In the past, services have communicated PI activities to top management via management briefings. In Sept. 2004, all Services Chiefs will be participating and sharing their accomplishments at a day and half retreat.

VA North Texas Health Care System Director Comments

d. Conduct annual Performance Improvement Fair for services to display their best PI initiative for the past year to employees, patients and visitors.

Status: Ongoing. VANTHCS has conducted PI Fairs the past 2 years with great success and will continue to utilize this forum in the future to showcase and communicate best PI accomplishments.

e. Incorporate PI outcomes/accomplishments into VANTHCS Annual Report.

Status: Pending. VANTHCS Annual Report for FY04 will include accomplishments linked to our strategic goals and performance improvement activities.

Action 1B. Use QM data in the reprivileging process:

1. Modify the provider profile utilized in the reprivileging process to include QM data (e.g. Committee Attendance, Level II & III Peer Reviews, Blood Transfusion data, etc.).

Status: Work in progress. The form has been modified to include QM data profiled by provider and was used by the Professional Standards Board in Aug. 2004 in the reprivileging process. The form will continue to be revised as Physician Profiling data becomes available. A physician has been assigned to QM to facilitate reprivileging.

Action 1C. Collect and trend PI data in all areas (specifically UM, Peer Reviews, Safety Reviews, Mortality Reviews, all Patient Complaints and Outcome s of Resuscitation:

1. Utilization Management:

a. Hire 4 UR nurses to conduct admission and continued stay reviews of inpatient care.

Status: Completed. 4 UR nurses are on board. Admission and continued reviews are to begin in Sept. 2004.

b. Conduct formal training in InterQual criteria and standards.

VA North Texas Health Care System Director Comments

Status: Work in progress. InterQual training has been scheduled for Sept. 15-17 2004 to include UR nurses, QM staff and other VANTHCS staff.

c. Trend and analyze UM statistical indicators pertinent to resource utilization, staff productivity, inpatient and outpatient efficiency, etc.

Status: Work in progress. UM indicators have been trended for years without integration into our QM program. These indicators will be reported to the appropriate committee for analysis, action and integration into QM.

d. Conduct appropriateness and necessity reviews of outpatient services and programs.

Status: Work in progress. An appropriateness review was recently conducted on the utilization of the Emergency Department. The review will be reported to the Quality Council for evaluation and action.

2. Peer Review:

a. Conduct peer reviews for all level 2 & 3s.

Status: Complete. New Peer Review Committee conducted its first meeting June 2004. New policy written and all level 2&3s data will be collected, tracked and trended.

3. Safety Reviews:

a. Findings of Root Cause Analyses will be presented to the Director and Chief of Staff within 45 days from start of RCA process.

Status: Ongoing. In Aug. 2004, RCAs are being presented to Director and Chief of Staff within 45 days of the process.

b. Maintain and enter SPOT data in a timely manner.

VA North Texas Health Care System Director Comments

Status: Work in progress. A position has been approved and selected to keep SPOT data current, projected EOD Sept. 7, 2004. In the interim, other QM staff will update and enter SPOT data.

4. Reactivate Moderate Sedation Workgroup to collect, trend and analyze moderate sedation data for adverse events.

Status: Work in progress. Workgroup was reactivated in Sept. 2004, data is being collected and trended.

5. Monitor medication usage data to identify adverse events.

Status: Work in progress. Pharmacy Service is identifying medication usage data to track and trend by the Medication Use/Nutrition Committee.

6. Monitor, trend and analyze Mortality Data.

Status: Work in progress. VANTHCS has obtained and revised a mortality review spreadsheet from STVHCS, data is being collected and will be reported to the Patient Care Committee.

7. Monitor, trend and analyze Patient Complaints and Patient Satisfaction.

Status: Work in progress. VANTHCS has trended written complaints and will include verbal issues. Data will be presented to Quality Council for review and action.

8. Monitor, trend and analyze Resuscitation Outcomes.

Status: Work in progress. Computerized data collection tool is being developed that will generate graphs for trending and analysis. Data for 2003-2004 has been collected and presented to Critical Care Workgroup, including survival rate, code locations & time.

Action 1D. Identify benchmarks and compare results:

VA North Texas Health Care System Director Comments

1. Utilization of benchmark, standards and criteria for activities will include: JCAHO & CARF standards; VHA Performance Measure Goals; ORYX Data; InterQual & other external criteria and standards; VHA Program standards (e.g. NSQIP).

Status: Complete (ongoing)

Action 1E. Analyze QM data for use in establishing recommendations:

1. Utilize functional committees to review system-wide performance and develop recommendations; individual services will analyze service-specific data and make recommendations; create workgroups to address specific data, as needed.

Status: Work in progress. Committee structure has been revised for presentation at Sept. 2004 Quality Council.

Action 1F. Determine corrective actions and designate accountability and time frames:

1. Utilize Plan, Do, Check, Act for all major PI activities requiring further follow-up.

Status: Work in progress. JCAHO's Plan, Do, Check, Act will be incorporated into QM/PI activities.

2. Report monitoring activities monthly or as deemed appropriate to assigned committee(s).

Status: Work in progress. Charters are being developed for Functional Committees identifying monitoring activities to be tracked, trended and analyzed along with timeframes for reporting.

Action 1G. Develop critera to evaluate effectiveness of corrective actions:

VA North Texas Health Care System Director Comments

1. QM/PI activities will include criteria from the sources identified above and apply Plan, Do, Check, Act to evaluate effectiveness of corrective actions.

Status: Ongoing.

Action 1H. Capture all patient incidents in a timely manner:

1. Revise the adverse event log and include Safety Assessment Code(SAC) score for each.

Status: Complete.

2. Review and revise the current process for completing and reporting incidents and adverse/sentinel events.

Status: Work in progress. Revising Patient Safety PC 9.

3. Monthly reminders will be sent to all services to forward all incident report forms to Patient Safety Manager.

Status: Work in progress. Developing a memo to be sent to each service chief monthly, as a reminder to submit all incident reports.

4. Patient Safety Manager will be included as member of Quality Council.

Status: Completed. Patient Safety Manager is a member of Quality Council.

Action 1I. Provide PI education for employees:

1. Formal classes on data management will be arranged with Cedar Valley College.

Status: Work in progress. Classes are being set-up to train VANTHCS staff.

2. InterQual will provide on-site training to QM and other VANTHCS staff.

Status: Work in progress. Training scheduled for Sept. 15-17 2004.

VA North Texas Health Care System Director Comments

2. Tracer visits will be conducted by Chief of Staff and QM staff to educate and prepare staff for external reviews and audits.

Status: Work in progress. Chief of Staff and QM staff conducted their first tracer visit on Aug. 25, 2004. These will continue at the rate of 2-4 per month.

Recommended Improvement Action 2. We recommend the VISN Director require the System Director to ensure that: (a) patient care areas are kept clean, safe, and well organized, (b) medications are secured and refrigerator temperatures are logged as required, (c) crash carts are checked and maintained in a constant state of readiness, (d) evacuation plans and patient representative signage are accessible in all patient care areas, (e) public areas, air vents, and housekeeping closets are well maintained, and (f) the canteen drains are functioning properly and the area is clean and sanitary.

Concur **Target Completion Date:** Sept. 2004

Action 2A. Patient care areas are kept clean, safe and well organized:

1. Staff was immediately assigned to correct identified areas; many resolved prior to the OIG/CAP leaving; Additional 5 FTEE assigned to EMS for rolling stock, etc; Inspection schedule sent weekly to Nursing Service.

Status: Work in progress. 97% of EOC deficiencies have been corrected; 3% are waiting to proceed through the project process; Completed: 5 new staff on board to address rolling stock. Vending machines, patient refrigerators and microwaves are now assigned to EMS; Weekly inspection schedules are being sent to Nursing Service.

Action 2B. Medications are secured and refrigerator temperatures are logged as required:

1. Maintain and monitor refrigerator logs in designated areas.

VA North Texas Health Care System Director Comments

Status: Work in progress. Compliance confirmed with Supervisory Nursing rounds (ongoing).

Action 2C: Crash carts are checked and maintained in a constant state of readiness:

1. Crashcarts checked and maintained according to policy.

Status: Work in progress. Compliance confirmed with Supervisory Nursing rounds. Nurse managers perform daily rounds and monthly team rounds are conducted. Nursing staff awareness and involvement heightened. 100% monthly audit report to Environment of Care Committee.

Action 2D. Evacuation plans and patient representative signage are accessible in all patient care areas:

1. Patient Representative signage in all patient areas; Evacuation Plan signage in patient area (6C) will be posted.

Status: Work in progress. Patient Rep signs being posted week Aug. 30, 2004 with completion date by Sept. 3, 2004; Evacuation Plans are now posted in all patient care areas - complete.

Action 2E. Public areas, air vents and housekeeping closets are well maintained:

1. Maintain and monitor public bathrooms; Modify existing EMS Inspection program to monitor environmental areas.

Status: Logs are posted and signed by the employee and checked by the supervisor on an hourly basis-Completed - Aug. 26, 2004; Ongoing: Once a week a schedule is sent to housekeeping supervisors and Nursing Service. The inspecting supervisor conducts the inspection; results are given to area supervisor and the Office of the Chief; inspected area has 2 weeks to correct any cited deficiencies; then inspecting supervisor returns to verify deficiencies have been corrected; Verification is sent back to Office of the Chief-Completed - Aug. 26, 2004; Ongoing function.

Action 2F. The canteen drains are functioning properly and the area is clean and sanitary:

VA North Texas Health Care System Director Comments

1. On going monitoring of Canteen area.

Status: Ongoing. Canteen is on the Inspection Program, see above for detail. Canteen drain line has been repaired.

Recommended Improvement Action 3. We recommend the VISN Director ensure the System Director takes action to: (a) inventory medical supplies stored in the SPD activity and correct GIP inventory records as needed, (b) provide refresher training for SPD personnel, emphasizing the importance of promptly and accurately recording receipts and distributions, and (c) reduce stock levels of medical supplies to the 30-day goal.

Concur **Target Completion Date:** Jan. 2005

Action 3A. Inventory medical supplies stored in SPD activity and correct GIP inventory records as needed:

1. Conduct complete inventory of SPD and enter/correct GIP records.

Status: Work in progress. Comprehensive inventory completed July 2004; Projected completion GIP inventory record update Oct. 1, 2004.

Action 3B. Provide refresher training for SPD personnel, emphasizing the importance of promptly and accurately recording receipts and distributions:

1. Train all personnel in receiving and distribution of policy and procedure. Cross-train Surgical Support staff.

Status: Completed: Training completed in June 2004. Post training turnover rate for August 2004 was 14.30 verses an April turnover rate of 35.05.

Action 3C: Reduce stock levels of medical supplies to the 30-day goal.

1. Discontinue Auto-Generation process; Order based on actual inventory; and reduce long term stock.

Status: Work in progress. Now receiving online notification of available stock levels.

VA North Texas Health Care System Director Comments

Recommended Improvement Action 4. We recommend the VISN Director ensure the System Director takes action to: (a) perform controlled substances inventories at intervals of no more than 72 hours, (b) continue to perform monthly unannounced controlled substances inspections and document the results, and (c) issue written instructions for inspecting automated devices that dispense controlled substances and require that controlled substances inspectors be accompanied by nurses when inspecting automated dispensing devices in outpatient clinic areas and inpatient units.

Concur **Target Completion Date:** Completed July 2004

Action 4A. Perform control substances inventories at intervals of no more than 72 hours:

1. Implement 72-hour controlled substance inspections.

Status: Completed. As of June 1, 2004 Pharmacy Program Managers initial on the bottom of the 72 hour vault inspection reports. The Control Substance Inspector Coordinator checks to ensure 72 hour inspections are completed timely and accurately.

Action 4B. Continue to perform monthly unannounced control substances inspections and document the results:

1. All monthly controlled substance inspections will be conducted timely.

Status: Completed. As of Jan. 1, 2004 monthly reports sent thru QM and AD to the Director.

Action 4C. Issue written instructions for inspecting automated devices that dispense controlled substances and require that controlled substances inspectors be accompanied by nurses when inspecting automated dispensing devices in outpatient clinic areas and inpatient units.

VA North Texas Health Care System Director Comments

1. Controlled Substance Inspectors have received training and written instructions regarding inspections. Each inspector is accompanied by a nurse.

Status: Completed. July 1, 2004 Training is conducted through an online program. Each inspector must pass to be issued a certificate. The Controlled Substance Inspection Coordinator has records of inspectors training.

Recommended Improvement Action 5. We recommend the VISN Director ensure the System Director requires that: (a) attending physicians properly supervise resident care, and (b) attending physicians and residents receive additional training concerning documentation of resident supervision.

Concur **Target Completion Date:** July 2004

Action 5A. Attending physicians properly supervise resident care:

1. Monitor documentation of resident supervision by attending physicians.

Status: Ongoing. Sept. 15, 2004; Current monitoring is being conducted by MCCF, Medical Records Committee and EPRP. Non-compliance is reported thru the Service Chief to the COS. An additional monitoring process will be conducted by the Compliance Officer on resident supervision documentation.

Action 5B. Attending physicians and residents receive additional training concerning documentation of resident supervision.

1. Conduct medical staff training of resident supervision documentation.

Status: Completed. As of July 1, 2004 refresher training was given to staff. VHA Resident Supervision Handbook has been made available to attending physicians and each service has reviewed the guidelines with them.

VA North Texas Health Care System Director Comments

Recommended Improvement Action 6. We recommend the VISN Director require the System Director to ensure moderate sedation event reports are collected from all services, aggregated, and critically analyzed to monitor performance and identify quality improvement opportunities.

Concur **Target Completion Date:** Sept. 2004

Action 6. Monthly Moderate Sedation Workgroup reactivated to establish a process for better collection, trending, analyzes and monitoring of data from all services.

Status: Work in progress. Next meeting Sept. 2, 2004; Workgroup is developing mechanisms for better collection, trending and analyzes.

Recommended Improvement Action 7. We recommend the VISN Director ensure the System Director takes action to: (a) ensure that part-time physicians record their hours worked and leave taken on subsidiary time sheets, (b) remind Medical Service physicians to submit leave requests when appropriate, (c) conduct semiannual desk audits of all timekeepers and follow up on the deficiencies identified, (d) provide annual refresher training for all timekeepers, and (e) ensure service chiefs and other supervisors maintain current written agreements with all part-time physicians describing VA's expectations and the part-time physicians' responsibilities.

Concur **Target Completion Date:** Oct. 2004

Action 7A. Ensure that part time physicians record their hours worked and leave taken on subsidiary time sheets:

1. Strengthen timekeeping controls for part-time physicians.

Status: Completed. May 28, 2004 Timekeepers received additional training. Physicians now record hours worked on the subsidiary time cards.

Action 7B. Remind medical service physicians to submit leave request when appropriate:

1. Re-educate Medical Service physicians how and when to appropriately submit leave requests.

VA North Texas Health Care System Director Comments

Status: Completed. Training was conducted May 28, 2004.

Action 7C. Conduct semi-annual desk audits of all time keepers and follow up on the deficiencies identified:

1. Implement timekeeper semiannual desk audits and follow-up on any deficiencies.

Status: Ongoing. Established a schedule for Semiannual desk audits for October and April; next audit of all timekeepers will be conducted NLT October 29, 2004; any noted deficiencies will be addressed within 30 days.

Action 7D. Provide annual refresher training for all time keepers:

1. Provide annual training for all timekeepers.

Status: Ongoing. Timekeepers were trained May 20, 2004 to include the eight cited timekeeper and annual refresher training will be conduct the last week in October and posted in their training record and every year there after.

Action 7E. Ensure service chiefs and other supervisors maintain current written agreements with all part time physicians describing VA's expectations and the part time physicians responsibility:

1. Maintain written agreements with part-time physicians.

Status: Completed. June 12, 2004; All service timekeepers maintain a file of written agreements.

Recommended Improvement Action 8. We recommend the VISN Director ensure the System Director takes action to: (a) request pre-award audits and legal and technical reviews when required, (b) provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt, and (c) include all required documentation in contract files.

Concur **Target Completion Date:** Sept. 2004

Action 8A. Request pre-reward audits, legal and technical reviews when required:

VA North Texas Health Care System Director Comments

1. Legal/technical review requirements to be met prior to contract award.

Status: Completed. August 2004; providing continued training of Contracting Officers on complying contract information for technical reviews.

Action 8B. Provide each physician supervisor or manager a copy of VHA Handbook 1660.3 and obtain written acknowledgment of its receipt:

1. Provide appropriate staff with handbook and obtain written acknowledgement.

Status: Work in progress. Sept. 15, 2004; Written acknowledgement form has been obtained and filed in personnel file; HR is reviewing folders to ensure compliance.

Action 8C. Include all required documentation in contract files:

1. Improve compliance with certain contracting requirements.

Status: Completed. June 2004; Procurement Technicians have begun checking contract files for proper documentation.

Recommended Improvement Action 9. We recommended the VISN Director ensure the System Director continues to monitor waiting times and implement initiatives to achieve the goal of scheduling patient appointments within 30 days of the desired appointment dates.

Concur **Target Completion Date:** Jan. 2005

Action 9A. Continue management initiatives to decrease patient waiting times and implementation of Advance Clinic Access (ACA).

Status: Continue to develop contracts for services that exceed local capacity. Continue hiring qualified clinical providers. Increase clinic hours as staff support increases.

VA North Texas Health Care System Director Comments

To assist with compliance with wait times in podiatry funding was approved for two podiatry assistants who started May 26, 2004. Additionally a Saturday podiatry clinic was started July 31, 2004 to increase the capacity to see patients in podiatry. The allergy clinic is now at 43.3 days, which is a significant drop from 315 days due to additional allergist who was hired, in addition to Saturday allergy clinics, which started on Saturday August 21, 2004.

Saturday Dermatology Clinics in Dallas and Bonham. Next available is now 1 week. Saturday GI Lab for colonoscopy. Contract with University of North Texas for colonoscopies. Wait times continue to be excessive. We are working on contracting with a GI group in Sherman and one in North Texas to alleviate this. Eye Clinics have initiated outside contracts. Urology Clinics have implemented extended clinic hours.

ACA in the Ambulatory Care (AC) service was implemented in Bonham July 2004, followed by ACA in the Fort Worth Clinic August 2004. ACA rollout in AC is set to occur at the Dallas site September 27, 2004. Using the VHA Directive on Panel size in order to implement ACA, AC received 8 additional FTEE to increase our capacity and to work down the waiting times for our ambulatory care patients.

Action 9B.

1. Identify the gaps in training and improper use of scheduling package.

Status: Completed. As of Aug. 6, 2004 MAS provided training to all VANTHCS schedulers on scheduling appointments and consults. Developed and distributed a quick reference guide on scheduling.

VA North Texas Health Care System Director Comments

OIG Suggestions

Suggested Improvement Action 1. We suggest the VISN Director ensure the System Director requires that: (a) A&MMS personnel track the accuracy of equipment inventories and schedule equipment inventories at required intervals, and (b) System personnel complete equipment inventories timely.

Concur **Target Completion Date:** Sept. 2004

Action 1A. A&MMS personnel track the accuracy of equipment inventories and schedule equipment inventories at required intervals:

1. Perform equipment inventories within prescribed timeframe.

Status: Completed. June 1, 2004 AEMS/MERS software is used to verify the accuracy of inventory. A&MMS will assure inventory is done at required intervals.

Action 1B. System personnel complete equipment inventories timely:

1. Perform equipment inventories within prescribed timeframe.

Status: Pending. Sept. 30, 2004: A&MMS will begin submitting monthly delinquent equipment inventory reports to the Director.

Suggested Improvement Action 2. We suggest the VISN Director ensure the System Director takes action to: (a) promptly request inter-agency fund transfers and initiate actions to close accounts receivable when the funds are transferred, and (b) reconcile accounts receivable to the general ledger each month.

Concur **Target Completion Date:** Dec. 2004

VA North Texas Health Care System Director Comments

Action 2A. Promptly request inter-agency fund transfers and initiated actions to close accounts receivable when the funds are transferred:

1. Manage certain Accounts Receivable (AR) more aggressively.

Status: Work in progress. Effective Aug. 22, 2004, a Systems and Procedures Analyst was hired in Fiscal Service to request inter-agency fund transfer and close AR when funds transferred.

Action 2B. Reconcile accounts receivable to the general ledger each month:

1. Reconcile Accounts Receivable monthly.

Status: Work in progress. Effective Aug. 22, 2004, a Systems and Procedures Analyst was hired to reconcile accounts receivable monthly.

Suggested Improvement Action 3. We suggest the VISN Director ensure the System Director requires that Fiscal Service personnel aggressively pursue recoupment of the duplicate payments made to contract nursing homes.

Concur **Target Completion Date:** Dec. 2004

Action 3. Pursue collection actions for duplicate payments made to contracting nursing homes.

Status: Work in progress. Dec. 31, 2004; Bills of collections have been issued to all vendors. Treasury Offset Program (TOP) collection letters will follow in September-November. If no response from vendor to collection letters, TOP will pursue/recover funds in December.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation or Suggestion	Explanation of Benefits	Better Use of Funds
Recommendation 3c	Reducing stock levels will reduce holding costs and make funds available for other uses.	$194,000
Recommendation 5	Improving documentation of resident supervision will increase MCCF billings and collections.	12,050
Suggestion 3	Pursuing bills of collection for duplicate payments made to contract nursing homes will recoup funds.	18,300
	Total	$224,350

Appendix D

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Appendix E

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