Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Louis Stokes VA Medical Center Cleveland, Ohio

Report No. 04-02247-12 **November 3, 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 period July 19–23, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Louis Stokes VA Medical Center (referred to as the medical center), Cleveland, Ohio. 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 501 medical center employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 10.

Results of Review

The CAP review focused on 15 areas. As indicated below, the medical center complied with selected standards in the following six areas. The remaining nine areas resulted in recommendations or suggestions for improvement.

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

- Agent Cashier
- Community Nursing Home Contracts
- Environment of Care
- Government Purchase Card Program
- Part-Time Physician Timekeeping
- Quality Management

Based on our review, the following organizational strengths were identified:

- The Government Purchase Card Program was effectively managed.
- QM radiology initiatives improved the quality of care.

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

- Reduce delays in insurance billings and collections.
- Properly resolve controlled substances inspection discrepancies and strengthen other controls.
- Reduce excess supply inventories and strengthen inventory management controls.

- Strengthen equipment accountability controls.
- Properly document modifications to the bulk oxygen utility system contract.
- Remove expired sterile supplies and log off unattended computers.

Suggestions for improvement were made in the following areas:

- Ensure that service contracts are properly administered.
- Strengthen controls for automated information systems resources.
- Properly document moderate sedation treatments and specify sedation locations.

This report was prepared under the direction of Mr. David Sumrall, Director, Seattle Audit Operations Division, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

VISN 10 and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings, recommendations, and suggestions and provided acceptable improvement plans. (See Appendixes A and B, pages 14–24, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

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

Introduction

Medical Center Profile

Organization. The Louis Stokes VA Medical Center has two divisions, located in the Cleveland, Ohio, communities of Wade Park and Brecksville, and provides tertiary medical, surgical, psychiatric, and nursing home care services. Outpatient care is also provided at 12 community-based outpatient clinics (CBOCs) in Ohio, including Akron, Warren, and Youngstown. The medical center serves a population of about 82,000 veterans in Ohio, West Virginia, Pennsylvania, Kentucky, Michigan, and Indiana.

Programs. The Wade Park Campus is a 218-bed tertiary care facility, providing a full range of services in medicine, surgery, and neurology. The Brecksville Campus is a 420-bed geriatric facility that provides mental health inpatient services, and nursing home and domiciliary care. The medical center provides primary care and tertiary care in medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics. Special programs include Spinal Cord Injury, Compulsive Gambling, and Women Veterans Substance Abuse. In addition, the medical center has a program to provide services and conduct research on Functional Electrical Stimulation. The Veterans Health Administration (VHA) has designated this program as a Center of Excellence.

Affiliations and Research. The medical center is affiliated with Case Western Reserve University School of Medicine and School of Dentistry and supports 114 medical resident positions in 27 training programs. In Fiscal Year (FY) 2003, the medical center research program had 141 projects and a budget of $19.3 million. Important areas of research include cardiovascular disease, neurology, ocular motility, and infection control.

Resources. The medical center's FY 2004 medical care budget was $425.9 million, an 8.1 percent increase over FY 2003 funding of $394.1 million. FY 2003 staffing was 2,844.8 full-time equivalent employees (FTE), including 166.5 physician and 559.3 nursing FTE.

Workload. In FY 2003, the medical center treated 78,774 unique patients, an 8.4 percent increase from FY 2002. The FY 2003 inpatient average daily census was 559.3, and outpatient workload totaled 765,760 patient visits (an 11.8 percent increase from FY 2002).

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. 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 15 activities:

Agent Cashier	Medical Care Collections Fund
Bulk Oxygen Utility Systems	Moderate Sedation Practices
Community Nursing Home Contracts	Part-Time Physician Timekeeping
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Equipment Accountability	Service Contracts
Government Purchase Card Program	Supply Inventory Management
Information Technology Security	

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

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–13). 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 VA medical center management until corrective actions are completed.

During the review, we also presented fraud and integrity awareness briefings for 501 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

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 financial, logistical, and administrative requirements of the Government Purchase Card Program. During the 3-month period March–May 2004, 175 purchase cardholders made 12,410 purchases totaling $6 million. The purchases were reviewed by 80 approving officials. Cardholders had promptly completed transaction reconciliations, with 96 percent of transactions reconciled within 10 days and 98 percent reconciled within 17 days, which exceeded timeliness standards. Approving officials had completed all certifications within the 14-day standard. Our review of a sample of 40 transactions did not identify any improprieties, such as cardholders splitting purchases to circumvent their transaction dollar limits. Fiscal Service was effectively conducting 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.

QM Radiology Initiatives Improve Quality of Care. The medical center had an effective QM program that included several initiatives to monitor and improve care for patients receiving radiology services. QM Service had established a flag in the computer system to alert physicians when their patients had abnormal radiology test results. Also, a computer program had been developed to track the time between the receipt of abnormal test results and the diagnosis and treatment of the patients. To further ensure that physicians received prompt notification, a hotline number had been established for radiologists to report abnormal test results to a QM nurse, who immediately forwarded the information to physicians. The QM nurse also ensured that follow-up treatments were scheduled within 30 days. In addition, QM Service and the VISN Patient Safety Council had developed procedures to identify patients with abnormal test results who were not returning to the medical center to receive follow-up treatments.

Opportunities for Improvement

Medical Care Collections Fund – Reduce Billing and Collection Delays

Conditions Needing Improvement. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain insured veterans. Although the MCCF staff were identifying veterans with insurance, they were not billing insurance companies promptly and were not aggressively following up on outstanding bills.

Third-Party Billing Delays. As of May 30, 2004, the medical center had 27,831 third-party unbilled outpatient episodes of care with a total value of about $5.9 million. For the first 6 months of FY 2004, billing delays ranged from 71 to 164 days. The average time to initiate a bill was 112 days, more than twice the VA benchmark of 50 days.

Collection Delays. As of May 30, 2004, the medical center had 33,738 third-party bills with a total value of about $9.5 million (excluding bills that had been referred to the VA Regional Counsel for collection). Of these, 18,471 with a value of $5.1 million (54 percent of the total value) were more than 90 days old.

To evaluate medical center collection efforts, we reviewed 50 bills (value = $229,435) that were more than 90 days old. Of the 50 bills, 24 had been appropriately cancelled or had been collected after we began our review of the sample. However, based on our review and discussions with the Chief of Claims Generation, 26 of the 50 bills (value = $98,929, or 43 percent of the total value of $229,435) required more aggressive collection efforts. The MCCF staff had sent initial collection letters but took an average of 50 days before making follow-up calls to insurers to determine why payments had not been made. VHA guidance requires staff to initiate follow-up calls within 30 days of the billing date. To aggressively pursue bills, multiple collection letters should be sent and follow-up calls should be made. Based on the results of our review, we estimated that the total value of bills more than 90 days old requiring more aggressive efforts was $2.2 million (43 percent x $5.1 million).

Need to Reissue Cancelled Bills. As part of our review, we examined the medical center's *Reasons Not Billable* report, which identifies bills that were cancelled and the reasons they were cancelled. The report showed that during the 6-month period October 2003–March 2004 MCCF staff cancelled 1,594 bills (value = $382,735) because of insufficient documentation of resident supervision and clinical services. At our request, MCCF staff began reviewing bills greater than $250 to determine how many could be reissued. Based on their review, 673 bills (value = $152,185) had collection potential. The Billing Supervisor agreed to analyze these claims and reissue bills as appropriate. During their review, the Billing Supervisor determined that MCCF staff had misclassified 1,170 of the bills as being cancelled due to insufficient documentation of resident

supervision. The bills had actually been cancelled for other reasons (such as non-billable, research-related care). The Billing Supervisor plans to provide MCCF staff refresher training in properly classifying cancelled bills.

Based on the medical center's FY 2004 third-party collection rate of 28 percent, we estimated that more aggressive collection efforts could increase collections by about $658,600 ($2.2 million in delinquent bills requiring more aggressive collection + $152,185 in cancelled bills with collection potential x 28 percent collection rate = $658,612).

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) insurance billings are done promptly, (b) bills are pursued more aggressively, and (c) the MCCF collection opportunities identified by our review are pursued aggressively.

The VISN and Medical Center Directors agreed and reported that a performance improvement initiative established procedures to promptly complete billings and to aggressively pursue accounts receivable. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Controlled Substances Accountability – Inspection Discrepancies Should Be Properly Resolved and Other Controls Strengthened

Conditions Needing Improvement. VHA policy requires that medical centers conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. Pharmacies are also required to maintain strong controls to prevent unauthorized access to controlled substances. Our review found that inspectors had received adequate training and were properly conducting inspections. Further, excess, outdated, and unusable drugs were destroyed quarterly, as required. However, we identified three deficiencies that required corrective action.

Resolution of Inspection Discrepancies Not Ensured. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period July 2003–June 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 concluded that the coordinator had not ensured that discrepancies found by the inspections were properly resolved.

Over the 12-month period, inspectors reported an unusually high number of discrepancies. There were two types of discrepancies—apparent missing controlled substances (discrepancies between the amounts that were supposed to be on hand and the amounts inspectors actually found) and apparent missing accountability records known as "green sheets." Pharmacy technicians or nurses were responsible for resolving the discrepancies (determining if the controlled substances or green sheets were in fact

missing). According to the coordinator, these employees had reported the discrepancies as resolved. However, the coordinator had not followed up to verify that the discrepancies had actually been resolved or determined what steps had been taken to resolve the problems. Our review of inspection records found there was either no documentation of follow-up or that the documentation was inadequate. Because of the unusually high number of discrepancies, the lack of follow-up documentation, and other circumstances related to the discrepancies, we referred this matter to the OIG Office of Investigations for further review.

Lack of Element of Surprise. Inspections did not always have the element of surprise. In July 2003 and again in June 2004, employees at one clinic declined to let inspectors perform their unannounced reviews, telling them it was "not a good time" and to come back the following day. VHA policy requires that inspections be unannounced and have an element of surprise.

Security Deficiencies. Outpatient controlled substances were stored in a locked narcotics distribution unit in the pharmacy. However, the unit itself was not stored in a secured location, such as a vault, as required by VHA policy. In addition, controlled substances prescriptions awaiting outpatient pickup were placed in an unlocked cabinet in an area where all pharmacy staff routinely had access.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to require that: (a) procedures are implemented to ensure that all reported discrepancies are properly resolved and that controlled substances and green sheets are fully accounted for, (b) inspections maintain an element of surprise, and (c) controlled substances are stored in secure locations.

The VISN and Medical Center Directors agreed and reported that as of August 2004 improved procedures had been implemented for reconciling discrepancies, collecting and processing green sheets, and maintaining an element of surprise in inspections. In addition, outpatient controlled substances, including those awaiting outpatient pickup, will be stored in the outpatient pharmacy vault. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

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

Conditions Needing Improvement. The medical center 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 $18.2 million on medical, prosthetic, and engineering supplies. The 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. Supply, Processing, and Distribution (SPD) Section staff used GIP to manage the medical supply inventory. As of July 2004, the SPD inventory consisted of 2,125 items with a value of $240,606. To test the reasonableness of inventory levels, we reviewed a sample of 20 medical supply items. Eight of the 20 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 60 days to several years of supply. The excess stock in GIP occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-day standard. By analyzing GIP data and the results of our sample review, we estimated that the value of the medical supply inventory exceeding current needs was about $38,497, or 16 percent of the total value.

Prosthetic Supplies. Prosthetics and Sensory Aids (P&SA) Service had established a 30-day supply standard and used VA's Prosthetics Inventory Package (PIP) automated system to control inventory. We reviewed the quantities on hand and usage rates for 10 items (value = $6,291). Nine of the items had stock on hand at or below a 30-day supply. One item had a 120-day level, although the reorder point was set at a 30-day level. The Chief of P&SA Service was unable to account for purchases above the goal for this particular item. P&SA Service maintained a supply inventory of 331 items (value = $60,757). By analyzing PIP data and the results of our sample review, we estimated that the value of the prosthetic supply inventory exceeding current needs was $10,329, or 17 percent of the total value. The Chief of P&SA Service acknowledged that his staff needed to monitor and adjust usage rates and stock levels.

Engineering Supplies. Engineering Service was not using GIP to manage its engineering supplies. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for 10 engineering supply items (estimated value = $2,592). Because the service was not using GIP, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for seven items, with inventory levels for these items ranging from 60 to 309 days of supply. 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 Engineering Service acknowledged the need to reduce the inventory and to use GIP to control supplies.

Accuracy of GIP and PIP Data. In addition to testing the reasonableness of supply inventory levels, we tested the accuracy of GIP and PIP inventory records for medical and prosthetic supplies. Using the sample of 30 medical and prosthetic supply items that we used to review inventory levels, we compared the GIP and PIP quantities on hand with our actual counts. GIP and PIP inventory records were not accurate for 15 of the 30 items (12 overstated and 3 understated). For all 15 items, some transactions had been inaccurately or incompletely posted to inventory records. Inaccurate, incorrect, or

untimely postings to GIP and PIP will result in inaccurate inventory balances. If inventory balances are not kept current, GIP and PIP cannot accurately track item demand, which must be known in order to establish reasonable stock levels and reorder points.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires: (a) SPD Section staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) P&SA Service staff to monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetic supply inventory; (c) Engineering Service staff to reduce excess engineering supply inventory and to fully implement GIP for engineering supplies; and (d) inventory management staff keep GIP and PIP current by promptly and accurately posting inventory transactions.

The VISN and Medical Center Directors agreed and reported that plans were being implemented to automate inventories and increase their accuracy. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Equipment Accountability – Inventories Should Be Properly Performed and Equipment Inventory Lists Updated

Conditions Needing Improvement. Medical center management needed to improve procedures to ensure that nonexpendable and sensitive equipment (items costing more than $5,000 with an expected useful life of more than 2 years or items subject to theft) 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 Materiel Management Service (A&MMS) staff are responsible for coordinating the EIL inventories, which includes notifying all services when inventories are due and following up on delinquent inventories. As of July 20, 2004, the medical center had 196 active EILs listing 7,014 equipment items (total value = $58.2 million). To determine if equipment was properly accounted for, we reviewed a judgment sample of 30 items (combined value = $3.0 million) assigned to 24 EILs. We identified two deficiencies that required corrective action.

Physical Inventories Not Properly Performed. VA policy 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 was accounted for. The medical center had not conducted inventories for 186 of 196 EILs (95 percent). The periods of inventory delinquency ranged from 18 months to 7 years. This problem occurred because the A&MMS staff did not consistently ask service chiefs to perform annual inventories, services did not submit completed inventories, or A&MMS staff did not follow up on delinquent inventories. In addition, for completed inventories, A&MMS staff and service chiefs or their designees had not performed

required quarterly spot checks to ensure the accuracy of reported information, and A&MMS staff had not followed up to resolve discrepancies.

Inaccurate EILs. The EILs were inaccurate for 11 of the 30 sampled items (37 percent). Four items (value = $21,317) could not be located during our review. One of the 4 missing items had been excessed, but not removed from the EIL, and had been erroneously certified as being on hand during the last inventory. For the remaining seven items (value = $369,825), the EILs did not reflect the current locations because the items had been moved within the service areas or transferred to other services.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires the Chief of A&MMS to: (a) perform a one-time, 100 percent inventory of all EILs, (b) perform periodic equipment inventories in accordance with VA policy, and (c) ensure that EILs are updated to reflect the accurate status of all equipment.

The VISN and Medical Center Directors agreed and reported that A&MMS plans to complete a 100 percent inventory of all EILs. Further, personnel would be hired and given the responsibility of ensuring that periodic equipment inventories are performed in compliance with VA policy and that EILs are accurate. The improvement actions are acceptable, and we will follow up on the completion of these planned actions.

Bulk Oxygen Utility System – Changes to Contract Requirements Not Properly Documented

Condition Needing Improvement A COTR did not document changes to the ordering and delivery requirements for a national contract for oxygen. The VA National Acquisition Center (NAC) had negotiated a contract for bulk oxygen utility systems with vendors nationwide. Each medical center participating in this contract designated a COTR to be responsible for local contract administration, such as providing specific delivery instructions to vendors. When changes are made to the original contract's ordering or delivery instructions, the NAC requires the COTR to document the changes in a mutual agreement with the vendor and to send a copy of this agreement to the NAC.

The COTR and vendor had discussed changes to the contract's original ordering and delivery instructions, such as requiring orders to be delivered up to 3 days early and after hours. The COTR did not document these changes, but instead relied on the vendor to honor this verbal agreement. To ensure that the oxygen supply is replenished when required, the COTR should document changes to the ordering and delivery instructions, have the vendor sign it, and forward a copy of this agreement to the NAC.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the COTR properly document

changes to the bulk oxygen utility system contract in a mutual agreement and send a copy to the NAC.

The VISN and Medical Center Directors agreed with the recommendation and reported that delivery changes had been documented in a mutual agreement and that the agreement had been forwarded to the NAC. The improvement action is acceptable, and we consider the issue resolved.

Environment of Care – Expired Sterile Supplies Should Be Removed and Unattended Computers Logged Off

Conditions Needing Improvement. VHA regulations require medical centers to ensure the safety of patients and the privacy of their information. To evaluate the environment of care, we inspected inpatient units, outpatient primary care and specialty clinic areas, and the medical center grounds. Although medical center staff maintained a generally clean and safe environment of care, they needed to remove expired sterile supplies and ensure that computers with private patient information were not left unattended.

Expired Supplies. SPD Section staff process and sterilize supply items, determine a shelf life or expiration date for each item, and distribute these items to the clinical areas. Clinical area staff are responsible for returning expired supplies to SPD for reprocessing. We inspected sterile supplies stored in the clinics and wards and found expired items in three areas. One of the items had expired in 2003. Expired supplies should be reprocessed as required to ensure sterility and reduce the risk of hospital-acquired infection.

Unattended Computers. Federal law requires the safeguarding of confidential patient information. Our inspection of clinical areas found seven unattended computer terminals logged onto the medical center's computerized system. Two displayed confidential patient information. Employees should log off computers when leaving their work areas.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinical staff remove expired sterile supplies from clinical areas and return them to the SPD Section, and (b) employees log off unattended computers.

The VISN and Medical Center Directors agreed and reported that plans had been implemented to ensure that sterile supplies are checked on a daily basis. In addition, by December 2005, a program will be implemented to ensure that inactive computers are automatically locked. The improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Service Contracts – Payments on The Mortuary Services Contract Should Be Based on Contract Price

Condition Needing Improvement. To determine if contract negotiation and administration procedures were effective, we reviewed 10 service contracts (estimated combined annual costs = $12.0 million). These contract files were generally well organized and contained required documentation such as solicitations, price negotiation memorandums, and cost data. However, the COTR needed to ensure that payments for mortuary services were accurate.

In May 2004, the medical center awarded a contract to a vendor to provide mortuary services for indigent veterans who died at the medical center and whose remains were not claimed. The contract base price of mortuary services for each deceased veteran was $1,289. This price included the cost of providing burial clothing. As of July 2004, the medical center had paid only two invoices. Our review found that for both invoices, the medical center had been charged the $1,289 base price, plus $110 for clothing (total overpayment = $220). These charges were inappropriate because burial clothing costs were included in the base price.

The COTR had not identified these inappropriate charges because she did not review the paid invoices. In VISN 10, vendors send all invoices to the Austin Automation Center for payment. For invoices under $2,500, the center automatically issues payments without requiring COTRs to certify that the charges are accurate. However, COTRs are still responsible for obtaining and reviewing the invoices and ensuring that charges are correct.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the Medical Center Director requires the COTR to: (a) properly review all mortuary services invoices and ensure charges are correct, and (b) pursue recovery of the $220 overpayment.

The VISN and Medical Center Directors agreed and reported that the COTR had been instructed to review the mortuary services invoices to ensure charges are correct. In addition, steps had already been taken to pursue recovery of the overpayment.

Automated Information Systems Security – Controls Need To Be Strengthened

Conditions Needing Improvement. We reviewed medical center automated information systems (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 an adequate security risk assessment had been developed, on-site generators provided adequate emergency power for Local Area Network (LAN)

computers, and critical information was backed up on a regular basis. However, we identified four compliance issues that needed corrective action.

Inactive Accounts Not Terminated. Veterans Health Information Systems and Technology Architecture (VistA) access had not been terminated for some inactive users. We reviewed a sample of 30 access accounts for users who had VistA access but who were not shown as current medical center employees in the VA payroll system as of June 29, 2004. For 18 of the 30 users (60 percent), the access accounts were for valid users, such as students, consultants, and employees of other VA facilities. However, access for 12 users (40 percent) should have been terminated because they no longer worked at the medical center.

Contingency Plan Training Not Conducted. Medical centers are required to implement contingency plans designed to reduce the impact of disruptions in services, provide critical interim processing support, and resume normal operations as soon as possible. VA policy requires that all employees receive training in their contingency plan related duties. This training had not been provided to service level staff or CBOC employees.

Access Not Logged Consistently. VHA policy requires that all physical access to the computer room be logged and monitored. Access to the medical center's computer room was only logged intermittently in a manual log and, therefore, did not provide adequate access control.

Annual AIS Security Training Not Tracked. VHA policy requires that all individuals with computer system access receive annual security awareness refresher training. Although the Information Security Officer (ISO) tracked compliance for medical center employees, she had not ensured that residents or non-VA employees, such as contractors, received the mandatory training. Because the ISO had not implemented controls for tracking compliance for these types of users, we could not determine how many residents or non-VA employees had not received the training.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) VistA access be promptly terminated for all individuals who do not have a continued need for access, (b) all personnel receive training in their contingency plan related duties, (c) access to the computer room is logged and monitored, and (d) annual refresher training is provided to all computer system users.

The VISN and Medical Center Directors agreed and reported that a plan was developed to ensure that the Information Resources Management Service (IRMS) is notified of employees no longer needing VistA access. Medical center and CBOC personnel will receive contingency plan training. All IRMS employees have been instructed to sign-in on the manual log. In addition, plans will be implemented to ensure refresher training is provided to residents and non-VA employees.

Moderate Sedation Management – Treatments Should Be Properly Documented and Policy Should Specify Sedation Locations

Conditions Needing Improvement. All medical centers should establish policies, procedures, and guidelines regarding the administration and monitoring of moderate sedation. Moderate sedation is the use of medication to minimally lower the patient's level of consciousness while the patient undergoes a medical procedure, such as a biopsy. To evaluate moderate sedation procedures, we reviewed local policy, interviewed clinical staff, and reviewed patient treatment records. We found two deficiencies.

Incomplete Documentation. We reviewed a sample of 10 patient treatment records. On two sedation procedure forms, clinical staff had not documented whether supplemental oxygen had been administered. In addition, one discharge criteria assessment had not been completely filled out as required.

Locations Not Specified In Policy. The medical center moderate sedation policy did not specify, as required, the clinical locations where moderate sedation was authorized to be administered.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) patient treatment records contain all required documentation, and (b) medical center policy specifies clinical locations where moderate sedation may be administered.

The VISN and Medical Center Director agreed and reported moderate sedation treatment records will be reviewed and monitored for documentation compliance, and that the medical center policy had been revised to include the moderate sedation locations.

Appendix A

VISN 10 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 16, 2004

From: Network Director
VA Healthcare System of Ohio (10N10)

Subject: Combined Assessment Program (CAP) Review of the Louis Stokes VA Medical Center Cleveland, Ohio

To: Director, Seattle Audit Operations Division (52SE)

I have reviewed the Comments and Implementation Plan prepared by the Louis Stokes VA Medical Center for the above CAP Review.

I concur with their comments and the Plan for action.

(original signed by:)

Clyde L. Parkis

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 13, 2004

From: Medical Center Director

Subject: Louis Stokes VA Medical Center Cleveland, OH

To: Director, Seattle Audit Operations Division (52SE)

1. Please see the VAMC response to the Combined Assessment Program Review of the Louis Stokes Medical Center Cleveland, Ohio.

2. If you have any questions or need additional information, please contact Grace A. Rotter, RN, Quality Manager at (216) 231-3456.

(original signed by:)
WILLIAM D. MONTAGUE

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

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Medical Care Collections Fund – Reduce Billing and Collection Delays

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) insurance billings are done promptly, (b) bills are pursued more aggressively, and (c) the MCCF collection opportunities identified by our review are pursued aggressively.

Concur **Target Completion Date: Completed**

(a) The medical center is in compliance with the National Performance Measure 5c Days to Bill as it is calculated by averaging the total First Party Days to Bill plus Total Third Party Days to Bill plus Total Misc. Days to Bill divided by the Total number of bills. The medical center has established a performance improvement initiative to decrease the third party days to bill. We have added an additional billing contract and implemented code me/bill me software within the Quadra Med product.

Target Completion Date: Completed

(b) Have added a second Accounts Receivable vendor to help reduce old receivables.

Target Completion Date: Completed

(c) The identified episodes of care have been reviewed and were re-billed when the billing requirements were met.

Target Completion Date: Completed

2. Controlled Substances Accountability – Inspection Discrepancies Should Be Properly Resolved and Other Controls Strengthened

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to require that: (a) procedures are implemented to ensure that all reported discrepancies are properly resolved and that controlled substances and green sheets are fully accounted for, (b) inspections maintain an element of surprise, and (c) controlled substances are stored in secure locations.

Concur Target Completion Date October 1, 2004

(a) Pharmacy Service revised the procedures for reconciling discrepancies and for collecting and processing green sheets. Pharmacy Service has revised procedures to ensure all discrepancies are properly and expediently resolved. The new process includes timely retrieval of completed green sheets from narcotic dispensing sites, prompt review by Pharmacy and electronic documentation of green sheet upon return to Pharmacy. If an inspection report indicates that a green sheet is missing from the ward, Pharmacy will locate and attach a photocopy of the green sheet to the inspection report. The resolved inspection report will be signed and returned to the Controlled Substance Coordinator with the photocopy of the green sheet.

Target Completion Date August 15, 2004

(b) Procedures for conducting monthly controlled substance inspections have been revised to require the Inspector to immediately contact the Controlled Substance Coordinator if a situation arises whereas the inspection site defers the Inspector. Inspectors are required to conduct all assigned inspections on a random and unannounced basis to ensure the element of surprise.

Target Completion Date: August 15, 2004

(c) Controlled substances in the Outpatient Pharmacy are to be moved into a secure room on or before October 1, 2004. A Class V safe has been ordered and placed in the room. Electronic locks have been placed on the door (for tracking entry as well as controlling access). A "pass through window" is being constructed to allow controlled substance prescriptions to be checked by a pharmacist from outside the room. Engineering has drafted plans for the pass through window and construction should begin soon. As soon as the pass through window is completed, all controlled substance in the in the outpatient pharmacy will be moved into the safe in the room for storage and dispensing. The spring on the cage door in the inpatient pharmacy has been strengthened to assure that the door fully closes.

Target Completion Date: October 1, 2004

3. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Recommended Improvement Actions 3. We recommend that the VISN Director ensure that the Medical Center Director requires: (a) SPD staff to monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) P&SA staff to monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetic supply inventory; (c) Engineering staff to reduce excess engineering supply inventory and to implement full usage of GIP for engineering supplies; and (d) inventory management staff keep GIP and PIP current by promptly and accurately posting inventory transactions.

Concur Target Completion Date: September 30, 2004

(a) SPD section is monitoring GIP levels and usage as an ongoing inventory management tool in reducing and accurately reporting medical supply inventory. Physical inventory conducted to correct discrepancies with GIP information and on hand levels. Bar code labels changed to reflect accurate levels maintained in primary. Conduct daily

reviews of inventory transactions; ensure transactions are being posted promptly and accurately.

Target Completion Date: Completed.

(b) P&SA provides ongoing oversight into PIP levels. Prior to and since the CAP survey, P&SA have worked to keep PIP levels below the recommended percentage. We have taken steps to reduce overages in our inventory and are currently within acceptable limits per VACO determinations. A new position has been approved for an Inventory Specialist to ensure correct inventory levels are maintained, through weekly inventory checks. Use of bar code labels/equipment to be implemented FY05.

Target Completion Date: Completed.

(c) During August 9 – 13, 2004, Engineering Service completed a comprehensive, wall-to-wall inventory survey. AMMS received approximately 7000 line items from Engineering Service. These items are to be entering into GIP or excess as required.

Target Completion Date: September 30, 2004

(d) SPD is conducting daily reviews of inventory transactions and ensuring information is posted in GIP. Inventory Management has began creating a database in GIP for Engineering Service; we have currently established two (2) Primary Inventory Points and ten (10) Secondary Inventory Points. Through research of procurement history and Internet service we have accurately entered approximately 1600 items in our database.

Target Completion Date: September 30, 2004

4. Equipment Accountability – Inventories Should Be Properly Performed and Equipment Inventory Lists Updated

Recommended Improvement Actions 4. We recommend that the VISN Director ensure that the Medical Center

Director requires the Chief of A&MMS to: (a) perform a one-time, 100 percent inventory of all EILs, (b) perform periodic equipment inventories in accordance with VA policy, and (c) ensure that EILs are updated to reflect the accurate status of all equipment.

Concur Target Completion Date: September 30, 2004

(a) A&MMS is rewriting the local policy to reflect national standard of VA Policy 7127. We have established an inventory schedule to complete all EIL CMR's in a timely manner. EILs were sent out to all CMR officials for signature and changes and to ensure completion. All CMRs are routed through the Medical Center Director's Office to the Chief, A&MMS.

Target Completion Date: September 30, 2004

(b) Personnel changes are being made and a new position, NX Technician, is being created. This candidate in this position will be responsible for conducting biennial inventories and accountability of equipment. The frequency of the inventories is based on VA Policy and local inventory schedules. This schedule will consist of:

1. Date of inventory

2. Title of responsible CMR official

3. Date of notification of responsible official

4. The date of completion of all adjustment made by AMMS

Target Completion Date: September 30, 2004.

(c) To ensure inventory accuracy, NX Tech will conduct quarterly inventory spot checks according to VA regulation. These quarterly inventory spot checks will help ensure accurate information on all equipment on EIL.

Target Completion Date: September 30, 2004.

5. Bulk Oxygen Utility System – Changes to Contract Requirements Not Properly Documented

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires that the COTR properly document changes to the bulk oxygen utility system contract in a mutual agreement and send a copy to the NAC.

Concur Target Completion Date: September 30, 2004

The mutually agreed to changes between the COTR and the contractor to the delivery time frames of the contract have been documented. The COTR forwarded a request to NAC for a signed mutual agreement modification between AGA Gas and the NAC. A signed copy of the fully executed modification has been initiated by the NAC. It will be returned to the COTR when signed by AGA Gas.

Target Completion Date: September 30, 2004

6. Environment of Care – Expired Sterile Supplies Should Be Removed and Unattended Computers Logged Off

Recommended Improvement Actions 6. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) clinical staff remove expired sterile supplies from clinical areas and return them to SPD and (b) employees log off unattended computers.

Concur Target Completion Date: December 31, 2005

(a) SPD staff checks all supply rooms on a daily basis. Storage areas not stocked and checked by SPD is the responsibility of clinical staff to check on a monthly basis for outdated sterile supplies. In addition, the Environment of Care team inspects the Unit/Ward/Clinic sterile supplies rooms to ensure that there are no outdated sterile supplies in any of the storage areas. Clinical staff is also instructed to check the expiration date of all sterile supplies prior to use.

Target Completion Date: Completed

(b) The Environment of Care Team now includes computer security in the inspection checklist. The Team notifies the responsible Service Chief of all unsecured computers. Service Chiefs were informed to issue verbal counseling for the first offense of unsecured computer. Progressive disciplinary action is taken for additional offenses. The facility is changing its PC Imaging process to include software modifications that will automatically lock a computer based on a predetermined time (minutes) of inactivity. IRM will also implement the VA National Smart Card technology to automatically lock computers when the user is no longer in direct contact with the computer.

Target Completion Date: December 31, 2005

7. Service Contracts – Payments on The Mortuary Services Contract Should Be Based on Contract Price

Suggested Improvement Actions 1. We suggest that the VISN Director ensure that the Medical Center Director requires the COTR to: (a) properly review all mortuary services invoices and ensure charges are correct and (b) pursue recovery of the $220 overpayment.

Concur Target Completion Date: Completed

(a) A modification to the mortuary services contract was done to require the contractor to submit invoices to the COTR in PCAS, in addition to the invoice copy that is sent to Austin Finance Center. The COTR has been instructed on properly reviewing invoice charges and ensuring changes are correct.

Target Completion Date: Completed

(b) Letters of collection for the $220 overpayment have been issued through VAMC Cleveland Fiscal Service to the responsible funeral home.

Target Completion Date: Completed

8. Automated Information Systems Security – Controls Need To Be Strengthened

Suggested Improvement Actions 2. We suggest that the VISN Director ensure that the Medical Center Director requires that: (a) VistA access be promptly terminated for all individuals who do not have a continued need for access, (b) all personnel receive training in their contingency plan related duties, (c) access to the computer room is logged and monitored, and (d) annual refresher training is provided to all computer system users.

Concur Target Date: September 30, 2004

(a) The ISO will continue current processes of running the National Disuser Routine and the weekly separations report. It is expected that better software can be developed to allow for identification of all staff that leave employment/contract status. IRM and HRMS have developd a plan to ensure that IRM is notified promptly and accurately of employee/contractor/student separation.

Target Completion Date: Completed

(b) Contingency Templates have been created and will be sent to all CBOC Directors and Service ADPACs for completion. Once completed and reviewed by the Medical Center ISO, each Service will be responsible for training users on contingency plan procedures. The Medical Center ISO will record contingency testing on a quarterly basis in conjunction with quarterly downtimes. When a downtime is not sufficient testing, separate testing will be accomplished and recorded on the same basis.

Target Completion Date: September 30, 2004

(c) All IRMS staff has been instructed to log into the computer room logbook. The ISO will conduct periodic audits of this log. A longer-term solution is already being planned to procure a physical access system, which will log all authorized traffic. This was initiated prior to the CAP survey.

Target Completion Date: Completed.

(d) A program is being created in VistA for the students and Residents. Contractors and volunteers will be taking National training. A review will be done quarterly to assess compliance with training requirements. The VistA program will be completed by September 30, 2004.

Target Completion Date: September 30, 2004

9. Moderate Sedation Management – Treatment Should Be Properly Documented and Policy Should Specify Sedation Locations

Suggested Improvement Actions 3. We suggest that the VISN Director ensure that the Medical Center Director requires that: (a) patient treatment records contain all required documentation and (b) medical center policy specifies clinical locations where moderate sedation may be administered.

Concur Target Completion Date: Completed

(a) All moderate sedation-monitoring records are reviewed for compliance with assessment criteria and entered into a database. This process has been in place for over 5 years. Documentation compliance is trended and reported to the Moderate Sedation Committee. All deficiencies are reported to the responsible Service/Section Chief for prompt action.

Target Completion Date: Completed.

(b) The medical center policy has been revised to include the moderate sedation locations.

Target Completion Date: Completed

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds through more aggressive collection of delinquent bills and reissuing cancelled bills.	$658,612
3	Better use of funds by reducing excess medical and prosthetic supply inventories.	48,826
	Total	$707,438

OIG Contact and Staff Acknowledgments

OIG Contact	David Sumrall (206) 220-6654
Acknowledgments	Myra Taylor Randall Snow Richard Horansky Kevin Day Randy Alley Sheila Cooley Gary Humble Gavin McClaren Barbara Moss Tom Phillips Michelle Porter Orlando Velasquez Sherry Ware

Appendix E

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