Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado

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VA Office of Inspector General
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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 June 21–25, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Eastern Colorado Health Care 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 333 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 19.

Results of Review

The CAP review covered 16 operational activities. As identified below, the system complied with selected standards in four areas. The remaining 12 areas resulted in recommendations or suggestions for improvement.

The system complied with selected standards in the following areas:

- Accounts Receivable
- Part-Time Physician Timekeeping
- Government Purchase Card Program
- Undelivered Orders

The following organizational strengths were identified:

- Pathology and Laboratory Medicine Service had a comprehensive performance improvement program.
- The Government Purchase Card Program was effectively managed.
- Unliquidated obligations were reviewed monthly and cancelled when not needed.

To improve operations, the following recommendations were made:

- Correct infection control, safety, and cleanliness deficiencies.
- Improve QM analysis, documentation, implementation, and reporting processes.
- Strengthen bulk oxygen utility internal controls.
- Improve documentation of clinical privileges for Moderate Sedation.
- Ensure community nursing home contracts are reasonably priced, documented, and invoices properly certified.

- Provide bulletproof protection for the pharmacy dispensing window.
- Update equipment records and properly perform equipment inventories.
- Strengthen controls for service contracts.
- Reduce excess supply inventories and strengthen inventory controls.

Suggestions for improvement were made in the following areas:

- Perform controlled substances inspections of all locations and document inventories.
- Process insurance bills promptly.
- Strengthen controls for automated information systems.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, and Ms. Marilyn Walls, CAP Review Coordinator, Dallas Regional Office of Healthcare Inspections.

Acting Under Secretary for Health, VISN 19, and System Director Comments

The Acting Under Secretary for Health, VISN 19 Director, and System Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendixes A, B, and C, pages 23–43, for the full text of the Acting Under Secretary's and Director's comments). We will follow up on the implementation of recommended improvement actions until they are completed.

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

Introduction

System Profile

Organization. The VA Eastern Colorado Health Care System is the result of the integration of two VA organizations, the VA Southern Colorado Health Care System and VA Medical Center (VAMC), Denver. System facilities include the 128-bed medical center in Denver and seven community based outpatient clinics (CBOCs) located in Aurora, Lakewood, Colorado Springs, Pueblo, La Junta, Lamar, and Alamosa, CO. There are two nursing homes (NH) with a total capacity of 100 patients. The Pueblo NH has 40 beds, and the Denver NH has 60 beds. The system is part of VISN 19 and serves approximately 45,000 unique veteran patients.

Programs. The system provides a full range of patient care services with state-of-the-art technology and serves as an educational and research center. The system provides medical, surgical, mental health, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics and extended care.

Affiliations and Research. The system is affiliated with the medical, pharmacy, and nursing schools of the University of Colorado Health Sciences Center. Residency programs are maintained in internal medicine and surgery and their subspecialties, as well as psychiatry, neurology, physical medicine and rehabilitation, anesthesia, pathology, radiology, and dentistry.

The system supports the training of over 120 residents annually. In addition, approximately 450 medical students rotate through the facility for their clinical experiences. The education department coordinates the rotation of over 370 nursing students from local schools. The system also provides training opportunities for paraprofessional and allied health students and is affiliated with 20 academic institutions.

The system has a large research and development program, which enhances clinician ability to provide state-of-the-art medical care. The Schizophrenia Research Center, one of three in the VA system, is the only research center in this discipline currently receiving funding from both VA and the National Institute of Health (NIH). The system is funded under the Research Enhancement Award Program to investigate prevention of cell death in neurodegenerative disorders, such as Alzheimer's Dementia and Parkinson's Syndrome. Other major areas of research include oncology, pulmonary medicine, cardiology, aging, and endocrinology.

During fiscal year (FY) 2003, there were 46 active VA-funded Principal Investigators and 51 active research projects supported by VA funds at the system. Counting all sources of public and private funding, 462 studies were active as of June 2004. The total research funding for FY 2003 from VA, NIH, and industry sources was approximately $11 million.

Resources. The FY 2003 medical care budget [including Medical Care Collections Fund (MCCF) collections, equipment, and multi-year medical care funds] was $205 million. FY 2003 staffing averaged 1,511 full-time equivalent employees (FTE), including 93.5 physicians and dentists and 377 nursing FTE.

Workload. During FY 2004 through May 26, the system treated 41,429 unique patients. The system provided 25,481 days of care in the hospital and 19,863 inpatient days of care in the nursing home care unit. As of June 2004, the inpatient average daily census was 111.3 and the nursing home average daily census was 86.7. The outpatient workload was 247,742 visits.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services (CARES)

On February 12, 2004, the CARES Commission issued a report to the Secretary of Veterans Affairs describing its recommendations for improvement or replacement of VA medical facilities. The Secretary published his decisions relative to the Commission's recommendations in May 2004. With regard to VA Eastern Colorado Health Care System, the Secretary decided that:

"VA will build a replacement VA medical center through a sharing agreement with DoD on the Fitzsimmons campus with some shared facilities with the University of Colorado. The Denver VAMC is old, has deficiencies in patient privacy, and has space deficiencies of 41,000 square feet in inpatient space and 201,000 square feet in outpatient space. To ensure effective implementation of this project, VA will develop a Master Plan for transition from the existing Denver VAMC to the new facility on the Fitzsimmons campus. The VA will develop plans for the size of the replacement nursing home using its long-term care and mental health strategic plans. While VA expects the transition to occur over several years, VA will complete the Master Plan by September 2004."

Go to http://www1.va.gov/cares to see the complete text of the Secretary's decision.

Objectives and Scope of the CAP Review

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

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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 16 activities:

Accounts Receivable	Management of Moderate Sedation
Bulk Oxygen Utilities	Medical Care Collections Fund
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	Undelivered Orders

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of services and the quality of care. We made electronic survey questionnaires available to all system employees, and 196 responded. We also interviewed 32 patients during the review. The survey results were shared with system managers.

We also presented four fraud and integrity awareness briefings for system employees. These briefings, attended by 333 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered facility operations for FYs 2003 and 2004 through June 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 system management until corrective actions are completed.

Results of Review

Organizational Strengths

Pathology and Laboratory Medicine Service Had a Comprehensive Performance Improvement Program. The pathology and laboratory performance improvement program incorporated requirements of five regulatory agencies. Each major laboratory section had a mechanism to collect, analyze, and report data and to take corrective action. Some of this information is then tracked on a scorecard that the Chief, Pathology and Laboratory Medicine Service uses to assess the performance plan.

Several monitors were interdisciplinary and related to internal or external assessment. External assessment provides data on diagnostic accuracy and knowledge of the pathologists, while internal assessment deals with each section of the laboratory. Monitors are grouped into the following categories: pre-analytical, analytical, and post analytical. The program was unique because it included several monitors for utilization review and accuracy of coding for billing purposes.

The medical staff has agreed on standardized panels for diagnostic testing and receives computer alerts if tests are ordered outside the guidelines. This program has resulted in a decrease of laboratory tests, from 2.2 million in FY 1998 to 1.6 million in FY 2003, despite an increased patient workload.

The Government Purchase Card Program Was Effectively Managed. The system 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 February through April 2004, 138 purchase cardholders made 11,059 purchases totaling $6.4 million. The purchases were reviewed by 50 approving officials.

Cardholders promptly reconciled transactions, with 98 percent of transactions reconciled within 10 days and 99 percent reconciled within 17 days. Approving officials had substantially complied with timeliness standards, with 98 percent of certifications completed 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. The Business Office effectively conducted monthly and quarterly 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.

Unliquidated Obligations Were Reviewed Monthly and Cancelled when Not Needed. As of April 30, 2004, the system had 1,310 unliquidated obligations valued at $25.6 million. We reviewed a judgment sample of 50 obligations (30 undelivered orders valued at $12.6 million and 20 accrued services payable valued at $831,065). The Business Office was reviewing unliquidated obligations monthly, contacting system services to determine whether the obligations were still needed, and canceling obligations that were no longer needed.

Opportunities for Improvement

Environment of Care – Infection Control, Safety, and Cleanliness Deficiencies Needed To Be Corrected

Condition Needing Improvement. System management did not maintain a consistently infection free, safe, and clean environment of care (EOC). Veterans Health Administration (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:

- Infection control measures are monitored and maintained.
- Safety measures are in place.
- Facilities are clean and sanitary.

We determined that the Pueblo NH Care Unit was generally clean and well maintained; however, the Denver VAMC was not maintained to acceptable levels of infection control, safety, and cleanliness.

Infection Control

Aspergillosis. During our inspection, we learned that severely immunocompromised patients, including patients who had undergone recent bone marrow or solid organ transplants, were not being admitted to the system. The reason for this admissions suspension was the identification of a case of pulmonary aspergillosis[1] in a patient in May 2004, and a possible second case of pulmonary aspergillosis, also in May 2004, accompanied by the concern that the aspergillus mold could have originated from a site or source in the Denver VAMC. As of September 1, 2004, 19 immunocompromised patients had been diverted to other health care facilities.

The May 2004 case of aspergillosis followed on the heels of a cluster of aspergillosis cases that occurred in 2002, and possibly as early as August 2001. This 2001–2002 aspergillosis cluster was investigated extensively, including assistance by a contract industrial hygienist. It appeared that the 2001–2002 cluster was most probably nosocomial (hospital-acquired), with the aspergillus source being the Denver VAMC air circulation system. However, the possibility of the source being related to extensive air pollution in Denver during the summer of 2002 was also raised.

Because of the 2001–2002 aspergillosis cases, the system diverted or transferred severely immunocompromised patients to other medical centers. This "divert condition" was in

[1] "A disease condition caused by species of [the fungus] Aspergillus and marked by inflammatory granulomatous lesions in the skin, ear, orbit, nasal sinuses, [and] lungs." - Dorlands Illustrated Medical Dictionary. 27th Edition (W. B. Saunders Company, Philadelphia, 1988).

effect from June 20, 2002, through August 2003. In August 2003, after extensive cleanup and air sample testing, the system began readmitting immunocompromised patients and patients who had undergone recent bone marrow or solid organ transplantation.

The source for the May 2004 aspergillosis case(s) has not yet been determined. A leading hypothesis is that it is related to a water main break in the Denver VAMC subbasement. Another possibility includes spore release from the nearby demolition of three buildings. Also, community-acquired infection remains a possibility.

The system is again taking extensive actions to identify the source of the aspergillus, including environmental culturing, air sampling, and planned airflow studies.

Environment of Care Review

Surgical Suite. Multiple large holes were observed in the walls of the Surgery Post Anesthesia Care Unit (PACU) adjacent to the operating rooms (picture 1). Drywall and paint were chipping off the walls in the operating rooms. There was a large area of chipped drywall in an operating room where the surgical instrumentation cart was stored.

Picture 1 – Surgery PACU

In the Surgery Intensive Care Unit (SICU), pull cords fashioned from gauze strips were attached to the electrical light switches above inpatient beds. The cords were dirty and appeared to have dried body fluids on them. Staff reported that the gauze strips were not changed between patients.

Linen. The contracted consolidated laundry service did not comply with VHA requirements that there be a physical separation between soiled and clean processing areas. Employees reported finding soiled linen in the clean linen bags. We found bags of dirty linen on hallway floors in the SICU and the psychiatry units. Dirty linen transport carts were being used to deliver clean linen. Plastic, paper, and medical supplies were found on the floor of the linen chute, indicating it was being used for refuse and had not been cleaned.

Housekeeping employees were setting up operating room linens in a corridor outside the operating room suite, stacking linen on window ledges and draping linen on contaminated linen carts (picture 2). Operating room linens were being handled multiple times, increasing the possibility of cross contamination. Clean linens were stacked on the floor next to the clean linen cart in the PACU.

Picture 2 – Surgery Suite Linen Set-Up

Endoscopy Nurse Manager Office. The nurse manager's office was used for storing dirty linen and as a staff break area (picture 3). A cart containing staff food items was also in this room. The front door was tied open with plastic tubing attached to the bedpan washer. The back door was propped open with a cardboard box to increase airflow into the room. There was on open vent between the dirty utility room and a procedure room where biopsies were performed.

Picture 3 – Endoscopy Nurse Manager Office

Cystoscopy Clinic. The cystoscopy clinic area had unacceptable patient privacy and infection control (picture 4). Up to 20 patients were processed in a group setting. Patient consents and pre-procedure instructions were obtained without privacy. Patients disrobed in a public bathroom, walked down two public corridors wearing only gowns, and carried their belongings and urine samples back to the waiting room. Patients' belongings were then placed in bags on the floor, and urine samples were placed on an end table. We observed unsecured medical records on a waiting room table.

Picture 4 – Cystoscopy Waiting Room

Chemotherapy Treatment Clinic. The chemotherapy clinic consisted of two small exam rooms located outside the emergency room. The space was so small that patients receiving chemotherapy were arm-to-arm, resulting in patient privacy, infection control, and safety deficiencies. Because the space was fragmented between two rooms, nursing staff could not observe all the patients. One treatment room door was propped open with paperback books, and patients receiving chemotherapy could be observed by public traffic in the hallway. There was a rusted drain cover over the main sink, and there was a large stain on the floor around the trashcan.

Safety

A medication cart on 5 South (medical-surgical unit) was broken and did not lock. Despite multiple work orders, the cart lock remained broken. On the Same Day Surgery Unit, an unattended housekeeping cart blocked the door to the crash cart room, preventing quick access to the crash cart. The crash cart had not been checked according to policy.

During our visit, the dialysis unit was unlocked on a non-clinic day. The supply storage areas were unlocked, including the medical supply room, the biohazard utility closet, and supply carts. Staff reported that the dialysis unit should have been locked on a non-clinic day.

Access to the Emergency Room entrance was blocked with pallets and office supplies. Staff reported the supplies had been delivered weeks before our visit.

A medical resident staff space contained numerous uninspected kitchen appliances, including a bread maker, a crock-pot, and a microwave oven. None had been inspected for electrical safety as required by facility policy.

There was no eye wash station available for employee safety in the main kitchen. A food tray line belt could not be used because an overhead vent needed repair. Ceiling tiles needed cleaning in the kitchen, dry storage area, and hallway. Dishwasher temperatures were not recorded for most cycles from June 1 to June 23, 2004. During a 2003 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey, the facility was cited for rinse cycle temperatures below the standard. We noted one final rinse cycle that was below the required temperature.

A contract engineering project had not been completed, leaving holes completely through walls in several areas of the hospital for at least 4 weeks and exposing the building and patients to pests and weather. During our inspection, the holes were covered with plastic and duct tape, but the tape did not hold during a rainstorm, and significant amounts of water pooled on the first and second stairwell landings. A major ceiling leak was noted on the 8th floor landing.

In the prosthetics repair room, flammable chemicals were found on the floor, not in the flammable storage unit. Employees stated there had been a recent fire near the flammable storage unit that they did not report to the safety officer.

Cleanliness

We found inadequate cleanliness throughout the facility. Fifty-four percent of the employees responding to our employee survey reported they did not believe the facility was clean. Facilities Management Service (FMS) conducted their own customer satisfaction survey in April 2004 and found that 62 percent of employees reported their areas were not kept clean and 74 percent reported the frequency of cleaning was inadequate. Patients we surveyed also reported that they considered the facility unclean. We found that outpatient clinics, bathrooms, offices, nurse stations, and staff break rooms were dirty and cluttered.

Most patient, staff, and public restrooms had stained floor tiles, dirty grout, and foul odors, suggesting that they had not been thoroughly cleaned over a significant period. A 5th floor patient shower room had feces and blood on the toilet and floor. Several toilets had a significant buildup of dirt around the caulking. Employee bathrooms in the main kitchen needed deep cleaning and signs reminding employees to wash hands before returning to work. Paper towels and soap were not available in employee and public bathrooms throughout the facility.

Carpeting at most nurse stations and in outpatient employee offices was stained. Most housekeeping, utility, and storage rooms in inpatient areas had supplies stored on the floor. There was a general lack of organization in storage rooms throughout the facility. Computer terminals and electrical cords obstructed cleaning of floors in specialty clinic examination rooms.

On August 18 and 19, an Office of Healthcare Inspections team returned and noted that the VISN Director and System Director had taken aggressive action to correct deficiencies reported during the CAP site visit, and the EOC was improved. The Associate Director provided us with an EOC Corrective Action Plan that outlined the progress made toward correction of deficiencies.

Recommended Improvement Action 1. We recommended the VISN Director require that the System Director take action to ensure that infection control, safety, and cleanliness standards are maintained by: (a) assessing the system's vulnerability to aspergillus contamination and infection, continuing efforts to rigorously clean and maintain the environment, determining the steps needed to prevent future aspergillus outbreaks, and diverting immunocompromised patients until clearance is received from the Acting Under Secretary of Health; (b) repairing all damaged walls and ceilings; (c) replacing patient light pull cords; (d) establishing safe and effective procedures for surgical linen set-up and handling of contaminated linen; (e) ensuring that the linen contractor complies with VHA standards; (f) redesigning the Gastroenterology lab, oncology, and cystoscopy spaces to meet patient privacy and infection control standards; (g) removing staff food from patient care areas; (h) removing barriers that obstruct access to the emergency room and crash carts; (i) installing an emergency eye wash station in the main kitchen; (j) establishing controls to ensure correct dishwashing temperatures are maintained and dishwasher cycles are recorded; (k) repairing the vent above the food tray belt; (l) ensuring that contract engineering projects comply with safety standards; (m) repairing leaks; (n) cleaning patient, staff, and public restrooms; cleaning or replacing soiled carpets; and cleaning supply closets; and (o) reviewing placement of computer terminals and electrical cords to facilitate cleaning of floors by housekeeping staff.

We also recommended under separate cover that the Acting Under Secretary for Health:

(1) Identify infectious disease specialists with particular expertise in aspergillosis to assist the System Director in these efforts, including, if appropriate, assistance from non-VA experts.

(2) Identify criteria to determine when it is safe to readmit severely immunocompromised patients to the system.

(3) Survey VA medical centers nationwide to evaluate aspergillus infection risks.

The Acting Under Secretary for Health and the VISN and System Directors agreed with the findings and reported extensive efforts (as detailed in the response) were being taken to eliminate the aspergillus contamination. This includes the continued diversion of vulnerable patients. The system also reported that improvements had been made on the cleanliness and environmental concerns, which include surgical linen set-up procedures, separation of clean and dirty linens, monitoring of dishwashing temperatures, bathroom cleanliness and maintenance, and placement of computer terminals and cables. All recommended areas had been reconfigured to ensure patient privacy and infection control standards. Other recommended repairs and infection control standards had been completed as well. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Quality Management – Managers Needed To Improve Analysis, Documentation, Implementation, and Reporting Processes

Condition Needing Improvement. System management needed to improve the coordination and oversight of Performance Improvement (PI) activities. The Performance Improvement Council (PIC) needed to take action on patient complaints, and a utilization management program should be established to review the appropriateness of admissions and continued stays.

To evaluate the QM program, we assessed the program structure, data analysis, benchmarking, recommendations, and evaluation of corrective actions involving performance improvement, utilization management, and patient safety.

QM Program Structure. Service level PI programs and clinical monitoring committees did not report results to the PIC or the Clinical Executive Board (CEB), which were the oversight committees for PI. As a result, reports to system managers were fragmented and sporadic.

Patient Advocate Data. Patient advocates collected, trended, and reported data to the PIC quarterly, including frequent reports of poorly coordinated patient care, resulting in cancellation of surgeries and inconsistent or inaccurate information provided to patients. However, the PIC did not analyze the data, make recommendations, or implement actions to improve processes.

Utilization Management. QM staff were not reviewing whether patient admissions, clinical management, and the length of hospital stays were clinically appropriate. These reviews are required by JCAHO and VHA to ensure appropriate services are provided, resources are utilized efficiently, and timely service is available to the maximum number of veterans possible. The system was aware of the deficiency, but while their 2003 Strategic Plan included the establishment of a utilization review position, the position had not been established.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director take action to: (a) develop a reporting process that will coordinate service level and clinical monitoring activities, thus providing effective oversight of patient care; (b) review, analyze, and act upon patient complaints; and (c) establish a Utilization Management program that includes the review of appropriateness of admissions and continued stays.

The VISN and System Directors agreed with the recommendations, stating they would improve the good reporting system already in place. However, at the time of the review, reports from service level PI programs and clinical monitoring committees were not included in PIC or CEB minutes. Including those reviews in PIC and CEB minutes on a quarterly basis and documenting the recommendations and corrective actions will ensure that timely information is available to senior managers. In addition, actions taken to correct problems identified by the patient advocates will be documented in appropriate committee minutes. A utilization review nurse will be hired to review admissions and continued stays. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Bulk Oxygen Utilities – Internal Controls Needed Strengthening

Condition Needing Improvement. System managers needed to improve bulk oxygen policies and procedures. The system had not implemented all requirements of the VHA Patient Safety Alert dated April 5, 2004, directing that hospital oxygen utility systems be brought into compliance by April 30, 2004.

Typically, bulk oxygen utilities consist of a main liquid oxygen tank and a reserve tank. The main tank is the primary source of oxygen supply, and the reserve tank is available to supply oxygen if the main tank runs dry or fails. The tanks are connected to two master panels that, according to the National Fire Protection Association, must have low-oxygen-level and low-pressure alarm signals.

Low-Oxygen-Alarm Signal. The master alarm panels are monitored by trained staff and located in the telephone and airconditioning operators' control rooms. However, the panel in the telephone control room did not include the low-oxygen-level signal.

Local Policy. System policy did not describe procedures for ordering and delivering oxygen as required by the Safety Alert or the documentation required for monitoring oxygen levels.

Interim Life Safety Measures (ILSM) Training. Employees involved in bulk oxygen utilities did not have ILSM training. ILSM is a comprehensive contingency plan that fully addresses and compensates for noncompliant conditions until code requirements are met. The JCAHO standards (EC 5.50) require that employees involved in monitoring the

Bulk Oxygen Utilities have ILSM training. We found that 5 of the 12 employees who monitored oxygen utilities did not have ILSM training.

Contract Terms. The system Contracting Officer Technical Representative (COTR) needed to clarify procedures for ordering and delivering oxygen with the oxygen supplier. The VA's National Acquisition Center (NAC) requires that a Memorandum of Understanding (MOU) be established between a facility and a local bulk oxygen service vendor within 15 days of awarding the contract to the vendor. The MOU outlines the facility's contract responsibilities, the services the contractor will provide, and contractor responsibilities. A copy of the MOU must then be incorporated into the VA NAC contract.

Recommended Improvement Action 3. We recommended the VISN Director ensure that the System Director take action to assure that: (a) the telephone operator master panel includes a low-oxygen-level alarm, (b) the system policy includes all the requirements mandated by VHA in the Safety Alert, (c) all appropriate employees receive required ILSM training, and (d) the system COTR clarify ordering and delivery procedures with the oxygen supply contractor and refer the contract to the VA NAC.

The VISN and System Directors agreed and reported that telephone operator master panels had been installed with low-oxygen-level alarms. All appropriate employees have completed ILSM training, and a system policy and MOU are being developed to cover all VHA-mandated requirements. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Management of Moderate Sedation – Documentation of Clinical Privileges Needed Improvement

Condition Needing Improvement. System managers needed to ensure that clinical privileges of clinicians who administer moderate sedation are properly documented.

To evaluate documentation of clinical privileges for administration of moderate sedation, we reviewed five credentialing files of non-anesthesia clinicians who administer moderate sedation to patients. All files contained documentation that clinicians had received required training, but four did not contain documentation that the clinicians were privileged to administer moderate sedation.

In November 2003, a JCAHO review found insufficient evidence of compliance with education and privileging of clinicians who administer moderate sedation. The system had initiated corrective action, and clinicians in radiology and primary care had been privileged. However, Medical and Surgical Services had not privileged clinicians to perform moderate sedation at the time of our review.

The Chief of Staff concurred and completed privileging of all clinicians who administer moderate sedation during the CAP inspection.

Recommended Improvement Action 4. We recommended the VISN Director ensure that the System Director take action to assure clinicians who administer moderate sedation are properly trained and credentialed.

The VISN and System Directors agreed and reported that the credentialing of clinicians administering moderate sedation had been completed. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Community Nursing Home Contracts – Contracts Should Be Reasonably Priced and Documented and Invoices Properly Certified

Condition Needing Improvement. The system contracting staff needed to ensure that the daily rates established in community nursing home (CNH) contracts did not exceed the VA benchmark, that Price Negotiation Memoranda (PNMs) were prepared, and that only designated COTRs certified contractor invoices. As of April 2004, the medical center had 31 locally awarded CNH contracts (total FY 2003 cost = $6.9 million).

Rates Exceeded VA Benchmark. We evaluated the daily rates for the 31 contracts and determined that 7 contracts had rates that exceeded the VA benchmark of the Medicaid rate plus 18 percent. Contract files did not have documentation justifying these rates. We estimate that the system could have saved $146,240 if the rates for these seven contracts had been negotiated in compliance with VA policy.

Documentation Not Sufficient. To evaluate the system's management of the CNH program, we reviewed the contract files for five CNH contracts (total FY 2003 cost = $2.6 million). PNMs had not been prepared for any of the five files. After contract negotiations are completed, the contracting officer should prepare a PNM to document the most important elements of the contract negotiation process, including the purpose of the negotiations, a description of the services being procured, and an explanation of how contract prices were determined.

Invoices Not Certified By COTR. For each CNH contract, the contracting officer designates a COTR to be responsible for monitoring the contractor's performance and ensuring that services are provided in accordance with contract terms. This responsibility includes reviewing contractor invoices and certifying that the charges accurately reflect the work completed. According to system policy, COTRs may not redelegate their authority to another person. The COTR for the five contracts reviewed had not certified any of the invoices for payment. Instead, accounting staff responsible for issuing payments certified the invoices, violating a key separation-of-duties accounting control. This deficiency occurred because the COTR was not properly trained on his

responsibilities, and the accounting staff were not aware that only the COTR should certify the invoices.

Recommended Improvement Action 5. We recommended the VISN Director require that the System Director take action to ensure that: (a) contracting staff negotiate CNH contracts in compliance with VA policy, (b) PNMs are prepared for all contracts, and (c) only the designated COTRs certify contractor invoices.

The VISN and System Directors agreed and reported that all contracts are now negotiated using benchmarks, and PNMs are to be included in every contract. Beginning in October 2004, processes will be in place so that only designated COTRs are able to certify invoices prior to payment. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Pharmacy Security – Bulletproof Protection Was Needed

Condition Needing Improvement. The system needed to improve physical security in the pharmacy to ensure staff safety. To evaluate pharmacy security, we reviewed security policies and access control records, inspected pharmacy storage areas, and interviewed VA Police and pharmacy staff.

Access controls were effective, and physical security was adequate in most pharmacy areas; however, two deficiencies needed correction. A dispensing window was not made of bulletproof glass, as required by VA policy. Also, the wall in which the window was installed was constructed of drywall, not concrete or similar material that would provide protection from firearms. The Chief of Pharmacy was aware of these deficiencies, and cited cost and potential communication issues between pharmacy staff and patients as reasons corrections had not been made. Because the security requirements must be met to ensure staff safety, system management should obtain the funding needed to correct these security deficiencies.

Recommended Improvement Action 6. We recommended the VISN Director require that the System Director take action to ensure that the dispensing window and window wall meet minimum security requirements.

The VISN and System Directors agreed and reported that security requirements have been reprioritized for completion in FY 2005. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

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

Condition Needing Improvement. System 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) are 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 Section (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 June 15, 2004, the system had 238 active EILs listing 16,177 equipment items (total value = $61.4 million). To determine if equipment was properly accounted for, we reviewed a judgment sample of 30 items (combined value = $3.4 million) assigned to 10 EILs. We identified several deficiencies that required corrective action.

Inaccurate EILs. The EILs were inaccurate for 10 of the 30 sampled items (33 percent). Three laptops (value = $9,619) could not be located during our review. The Materiel Management Section assigned the responsibility for maintaining the EILs covering certain computers to the Information Resource Management Service (IRMS). IRMS did not maintain records showing who had been assigned the laptops or where they were supposed to be located. For the remaining seven items (value = $458,689), the EILs had not been updated to reflect the current location of the equipment (four items had been moved within a service area), turn-ins (two items had been excessed), or reports of survey (one item had been reported missing in June 2002).

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

- Four of the 10 sampled EILs (40 percent) had not been inventoried in 18 months or longer. For instance, one of the Research EILs had not been inventoried since June 2000. This problem occurred because A&MMS staff did not consistently ask service chiefs to perform annual inventories, services did not submit completed inventories, or Materiel Management Section staff did not follow up on delinquent inventories.
- For completed inventories, Materiel Management Section staff did not follow up to resolve discrepancies. Also, some service chiefs did not certify whether or not all of their equipment was accounted for.
- Materiel Management Section staff and service chiefs or their designees had not performed required quarterly spot checks of completed inventories to ensure the accuracy of reported information.

Recommended Improvement Action 7. We recommended the VISN Director require that the System Director take action to ensure that the Acting Chief of A&MMS: (a)

updates EILs to reflect the accurate status of all equipment and (b) performs periodic equipment inventories in accordance with VA policy.

The VISN and System Directors agreed and reported that significant progress had been made to correct these issues. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Service Contracts – Controls Should Be Strengthened

Condition Needing Improvement. System management needed to ensure that contracting officers properly document and administer contracts, only designated COTRs certify contractor invoices, and only contracting officers execute contracts. To determine if contract administration procedures were effective, we reviewed 10 service contracts (estimated combined annual costs = $5.8 million) and interviewed the Acting Chief of A&MMS and 4 COTRs. We found five deficiencies that required corrective action.

PNMs Not Prepared. Required PNMs had not been prepared for five contracts valued at $3.6 million.

Legal/Technical Review Not Requested. Contracting officials did not request a legal/technical review by the VA Office of A&MM of a $1.6 million competitive contract for perfusionist services.

Performance Appraisals Not Documented. Before exercising a contract's option years, contracting officers are required to consider continued need and past performance and to document justification. For six contracts with exercised option years, contract files did not contain performance appraisals or the performance appraisals were inadequate.

Contractor Invoices Not Certified by COTRs. For 4 of the 10 contracts, system staff other than the designated COTRs certified the invoices, and Business Office staff had issued payments based on these certifications. These problems occurred because the COTRs had not received any training on their responsibilities until April 2004 and because Business Office staff did not verify that only designated COTRs had certified invoices before issuing payments to contractors.

Contracts Executed Without Authority. Only properly trained and warranted contracting officers are allowed to negotiate and execute contracts on behalf of the Government. Since 2001, a Patient/Nursing Services employee, who had no authority to execute contracts, had negotiated and signed several nursing services contracts. The agreements included unacceptable clauses, such as the contractor not being liable for any negligence or damages caused by contracted employees. The Acting Chief of A&MMS discovered this problem in May 2004 and plans to counsel this employee and have contracting staff review the noncompliant contracts.

Recommended Improvement Action 8. We recommended the VISN Director require that the System Director take action to ensure that: (a) PNMs are completed for all contracts and included in contract files, (b) required legal/technical reviews are requested, (c) performance appraisals are prepared and included in the contract files when exercising option years, (d) only COTRs certify vendor invoices, and (e) only properly trained and warranted contracting officers execute contracts.

The VISN and System Directors agreed and reported that necessary steps had been taken to correct these problems, including appropriately referring contracts for legal/technical review, assessing contractor performance before exercising option year contracts, and providing COTR training semiannually. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

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

Condition Needing Improvement. The system 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 system spent $13.5 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 inventories.

Medical Supplies. Although A&MMS staff used GIP to manage medical supplies, the inventory exceeded the 30-day standard. As of June 2004, the medical supply inventory consisted of 3,511 items (value = $524,448). To test the reasonableness of inventory levels, we reviewed a sample of 20 supply items (value = $8,377). Fifteen of the 20 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 100 days to several years of supply. The estimated value of the stock exceeding 30 days was $6,115 or 73 percent of the total value of the 10 items. By applying the 73 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of the medical supply inventory exceeding current needs was $382,847. The excess stock occurred because staff did not properly monitor item usage rates or adjust GIP stock levels to meet the 30-day standard.

Prosthetic Supplies. The Prosthetics Treatment Center (PTC) staff used VA's Prosthetics Inventory Package automated system to control inventory. However, prosthetic inventory exceeded the 30-day standard. The PTC staff maintained a supply inventory of 328 items (value = $69,004). To determine the reasonableness of inventory levels, we reviewed a sample of 10 items (value = $2,457). Nine of these items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 69 to 633 days of

supply. The estimated value of stock exceeding 30 days was $2,039, or 83 percent of the total value for the 10 items. Excess inventory occurred because PTC staff were not properly adjusting stock levels to reflect actual usage rates. By applying the 83 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of excess stock was $57,273.

Engineering Supplies. In April 2004, the FMS initiated limited use of GIP to manage engineering supplies. However, most engineering supplies were not controlled with GIP. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgment sample of 10 high-use engineering supply items (value = $6,426). Because most items were not in GIP, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for all 10 of the sample items, with inventory levels ranging from 75 days to over two years of supply. Without complete and accurate inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded current needs.

Recommended Improvement Action 9. We recommended the VISN Director require that the System Director take action to ensure that: (a) A&MMS staff monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) PTC staff adjust stock levels to reflect actual usage rates and reduce excess prosthetic inventory; and (c) FMS staff reduce excess engineering supply inventory and implement plans to fully use GIP for engineering supplies.

The VISN and System Directors agreed and reported that excess supplies and inventory in all areas had been addressed. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Controlled Substances Accountability – Inspections Should Be Performed in All Locations and Inventories Documented

Condition Needing Improvement. System management needed to ensure that all controlled substances storage and dispensing locations are inspected each month and that all 72-hour inventories are documented as required by VHA policy.

Inspections Not Performed. To evaluate the controlled substances inspection program, we reviewed inspection reports for the 12-month period May 2003–April 2004, interviewed inspectors, and observed unannounced inspections in several locations where controlled substances were stored and dispensed. Inspection procedures did not ensure that all controlled substances storage locations were inspected every month. During the 12-month review period, 176 of the 336 required inspections (52 percent) were not performed. Five controlled substances storage locations had not been inspected at all during this period.

No Documentation of 72-Hour Inventories. To verify completion of the required inventories, we reviewed records for the 3-month period March 22, 2004 – June 22, 2004. The pharmacy did not have documentation for 15 of the 43 required inventories (35 percent). The Chief of Pharmacy stated that the inventories had been performed, but he could not provide any supporting documentation.

Suggested Improvement Action 1. We suggested the VISN Director require that the System Director take action to ensure that: (a) all controlled substances storage locations are inspected every month and (b) controlled substances inventories are properly documented.

The VISN and System Directors agreed and reported that a program was developed to meet VHA requirements. Management will ensure that compliance with the program is maintained. The improvement actions are acceptable, and the VISN Director will follow up on the completion of planned actions.

Medical Care Collections Fund – Bills Should Be Processed Promptly

Condition Needing Improvement. Under the Medical Care Collections Fund (MCCF) program, VA may recover the cost of treating insured veterans from health insurance companies. MCCF staff identified veterans with insurance, billed insurance companies for the correct amounts, and pursued outstanding receivables. However, they did not bill insurance companies promptly.

As of April 2004, the system had a backlog of 1,870 unbilled outpatient episodes of care with a total value of about $1.2 million. For the first half of FY 2004, MCCF staff took an average of 68 days to initiate a bill, which is significantly higher than the VA benchmark of 45 days. Delays in billing insurance companies ranged from 48 to 90 days. According to the MCCF Coordinator, the billing backlog occurred because they were understaffed from October 2003 to January 2004. In addition, physicians did not promptly include the necessary clinical documentation, such as progress notes, in the medical records.

Suggested Improvement Action 2. We suggested the VISN Director require that the System Director take action to ensure that insurance billings are done promptly.

The VISN and System Directors agreed and reported that since the CAP inspection the timeliness of insurance billing had improved dramatically. The improvement actions are acceptable, and the VISN Director will follow up on the completion of planned actions.

Information Technology Security – Controls Need To Be Strengthened

Condition Needing Improvement. We reviewed the system's 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 adequate contingency plans had been developed, that onsite generators provided adequate emergency power for Local Area Network computers, and that critical data were backed up on a regular basis. However, we identified four compliance issues that needed corrective action.

Incomplete Documentation for Changes to Software Program. We reviewed a judgment sample of five local modifications to Veterans Health Information Systems and Technology Architecture program software and found that documentation for four of the five modifications did not include programmer identification and/or dates the software changes were made. The Information Security Officer and Chief Information Officer agreed that all programming changes should include programmer identification and software modification dates.

Unattended Computers. VHA policy requires that system resources be protected from unauthorized use. During our facility inspection, we identified 10 unattended computers that were logged onto the system.

Access Not Logged Consistently. VHA policy requires that all physical access to the computer room be logged and reviewed. Access to the computer room was only logged intermittently.

Backups Not Properly Stored. VHA policy requires that appropriate physical and environmental controls be in place to ensure that critical backup files are used. The system stored critical backup files in a non-fire resistant cabinet in a room that did not have fire sprinklers or a fire extinguisher.

Suggested Improvement Action 3. We suggested the VISN Director require that the System Director take action to ensure that: (a) all software program changes are adequately documented, (b) computer users log off the system when computers are not in use, (c) access to the computer room is logged, and (d) backup files are properly stored.

The VISN and System Directors agreed and reported that appropriate documentation was being added to all locally created changes to the software packages. IRMS will continue to emphasize the importance of security and remind staff that logs need to be completed. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Appendix A

Acting Under Secretary for Health's Comments

Department of Veterans Affairs **Memorandum**

Date: November 2, 2004

From: Acting Under Secretary for Health

Subject: **OIG Report: Combined Assessment Program Review – VA Eastern Colorado Health Care System, Denver, Colorado**

To: Assistant Inspector General for Healthcare Inspections

1. VHA program officials share OIG's concern about the unacceptable conditions reported at our Denver medical facility, and we are carefully monitoring the plans of corrective action detailed in the VISN Director's response to you. As you noted in your follow-up visit, substantial progress has been made in rectifying substandard cleanliness and environmental concerns, and we are committed to assuring that such issues will not recur.

2. I concur in the three infection control-related recommendations that were made directly to me, and have attached a plan of corrective action to address each of them. Medical center management continues to aggressively and appropriately assess vulnerability to aspergillus contamination and infection. Outside specialists have been contracted to assist in extensive efforts to identify and eliminate the source of contamination. At the same time, the facility has intensified its preventive maintenance schedules for air duct and air handling units, and vulnerable patients will continue to be diverted until there is agreement regarding protection of patients from aspergillosis.

3. To assure that infection control measures are effectively applied, I have requested that the VHA's Infectious Diseases Program Office oversee all actions. The Program Office Director, Dr. Gary Roselle, has already been in close contact with the VISN Director's office to offer his assistance and to identify experts from within and outside of the VA with special knowledge of Aspergillus detection in the environment of care. As VHA's national expert, Dr. Roselle will assure that the proposed strategy is well designed and effectively implemented. He plans to conduct an initial site visit on November 22 and 23, 2004, and will continue to be involved until the situation is appropriately resolved. The Infectious Diseases Program Office will also review and approve draft criteria that are currently being prepared by facility management with the assistance of an industrial hygienist contracted by the medical center to determine when diversion of severely immunocompromised patients can be discontinued.

4. Lastly, as you suggest, the Infectious Diseases Program Office will conduct, review and analyze a survey for aspergillosis risk. This will consist of a national search for all patients in the VA system with a diagnosis of aspergillosis (ICD-9-CM code) over the past three years, using data generated from VA's electronic medical record. Based on survey results, appropriate follow-up action will be determined. It is anticipated that the survey will be completed in early December 2004.

5. Thank you for the opportunity to comment on this report. My office will continue to take an active role in overseeing improvement progress through resolution of identified problems. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 273-8360.

(*original signed by:)*
Jonathan B. Perlin, MD, PhD, MSHA, FCAP

Acting Under Secretary for Health's Comments to Office of Inspector General's Report

The following Acting Under Secretary for Health's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action 1. Identify infectious disease specialists with particular expertise in aspergillosis to assist the System Director in these efforts, including, if appropriate, assistance from non-VA experts.

Concur

Denver VAMC management has already employed an outside expert in Aspergillus mold contamination and is taking aggressive steps to identify infection source through environmental culturing, air sampling and air flow studies, to name a few. The Acting Under Secretary for Health has requested that VHA's Infectious Diseases Program Office (IDPO) oversee infection control measures at the medical center, and the Program Director has already offered his assistance to the VISN Director, and has identified experts within the VA and in the private sector with special expertise in aspergillosis who might be contacted if necessary. The Program Director also plans to perform a site visit to the facility in November 2004 to further assess problem resolution efforts. The Acting Under Secretary for Health will be apprised of findings on an ongoing basis until the issues are satisfactorily resolved.

Anticipated Completion: November 2004

Recommended Improvement Action 2. Identify criteria to determine when it is safe to readmit severely immunocompromised patients to the system.

Concur

Facility management is working closely with an industrial hygienist contracted by the medical center to determine when immunocompromised patients can be safely admitted to the facility. Criteria for readmittance are currently being drafted at the facility, and will be reviewed and approved by the Infectious Diseases Program Office prior to finalization.

Anticipated Completion: November 2004

Recommended Improvement Action 3. Survey VA medical centers nationwide to evaluate aspergillus infection risks.

Concur

The Infectious Diseases Program Office will conduct, review and analyze a survey for aspergillosis risk that consists of a national data search for all patients throughout the system who have been diagnosed with aspergillosis over the past three years. Data will be generated from VA's electronic medical record system. Follow-up actions will be determined based on trending information generated by survey results. Additional actions will be reported to OIG when requests are received for action status updates.

Anticipated Completion: December 2004

Appendix B

VISN 19 Director's Comments

Department of Veterans Affairs **Memorandum**

Date: October 25, 2004

From: VISN 19 Director

Subject: **VA Eastern Colorado Health Care System, Denver, CO**

To: Director, Dallas Healthcare Operations Division

1. We are submitting written comments in response to the Combined Program Assessment Review completed June 21-25, 2004 at the VA Eastern Colorado Health Care system at Denver.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and is continuing to improve and resolve all non-compliant areas cited in the report. VISN 19 concurs with the actions being taken and those planned to correct all deficiencies.

3. VISN 19 has been in communication with the Office of the Under Secretary for Health (10). They concur with the recommendations regarding Infection control measures (Aspergillus). The comments from the Under Secretary for Health will be provided to you in a separate cover memorandum.

4. If you have any questions regarding this response, please contact Mr. Barry Sharp, Deputy Network Director for VISN 19 at 303-639-6996.

(original signed by:)
Lawrence A. Biro

Appendix C

Director's Comments

Department of Veterans Affairs **Memorandum**

Date: October 15, 2004

From: System Director

Subject: **VA Eastern Colorado Health Care System, Denver, CO**

To: Director, Dallas Healthcare Operations Division

cc: Terry Hobbs (10NA)

Margaret Seleski (10B5)

Marilyn Walls (54DA)

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended the VISN Director require that the System Director take action to ensure that infection control, safety, and cleanliness standards are maintained by: (a) assessing the system's vulnerability to aspergillus contamination and infection, continuing efforts to rigorously clean and maintain the environment, determining the steps needed to prevent future aspergillus outbreaks, and diverting immunocompromised patients until clearance is received from the Under Secretary of Health; (b) repairing all damaged walls and ceilings; (c) replacing patient light pull cords; (d) establishing safe and effective procedures for surgical linen set-up and handling of contaminated linen; (e) ensuring that the linen contractor complies with VHA standards; (f) redesigning the GI lab, oncology, and cystoscopy spaces to meet patient privacy and infection control standards; (g) removing staff food from patient care areas; (h) removing barriers that obstruct access to the emergency room and crash carts; (i) installing an emergency eye wash station in the main kitchen; (j) establishing controls to ensure correct dishwashing temperatures are maintained and dishwasher cycles are recorded; (k) repairing the vent above the food tray belt; (l) ensuring that contract engineering projects comply with safety standards; (m) repairing leaks; (n) cleaning patient, staff, and public restrooms; cleaning or replacing soiled carpets; and cleaning supply closets; and (o) reviewing placement of computer terminals and electrical cords to facilitate cleaning of floors by housekeeping staff.

Concur **Target Completion Date:** 3/31/05

This recommendation covers an area about which we had already placed great emphasis and had made considerable strides, prior to the CAP team's arrival. We had included the improvement of cleanliness and maintenance in our strategic plan. Since the inspection, we have greatly accelerated our plan and devoted resources and a great deal of attention to this issue. Our substantial progress in this area was noted in this report by the team's follow-up visitors. Even greater strides have been made since their visit. We have held all-employee and manager meetings to stress that cleanliness and maintenance issues are everyone's responsibility and that we are taking their concerns seriously. We followed through on our plans to establish a Facility Management Service customer service hotline. Top leadership is aggressively inspecting the building daily and assuring that follow-up action is taken on any concerns they discover or have relayed to them by employees. Frequent inspections are being conducted by VISN 19 staff, specifically, the Deputy Network Director. We are committed to providing this facility with a clean and safe environment for our Veteran patients and their families, staff and other visitors to our facility. Each item in the above recommendation has been addressed as follows: (a) we are continuing the assessment of our vulnerability to aspergillus contamination and infection. We have employed an outside expert in mold contamination. In addition, among our extensive efforts to identify the source, we are conducting environmental culturing, air sampling and air flow studies. We will be doing a tracer gas study this month. We will take whatever steps are necessary to eliminate the source. In the meantime, we are adhering to strict preventive maintenance schedules for air duct and air handling units. We will continue to divert immunocompromised patients until such time as the facility is deemed aspergillus free by the contractor and clearance is received from the Under Secretary of Health. (b) All damaged walls and ceilings have been repaired. This is a constant issue in the building due to high use and constricted space. In order to protect the walls in high use areas such as the OR and basement corridors from further damage, we are installing hard surface wainscot. We are also undertaking a massive painting project to brighten up the corridors and public waiting rooms. (c) All patient light pull cords have

been replaced and are cleaned as part of the patient discharge cleaning routine. (d) The surgical linen set-up procedure has been changed and housekeepers instructed on the proper procedure and rationale. Education on all of these points has been effective. (e) We are working with the current linen contractor and Headquarters representatives to resolve the VA's requirement for barrier separation at the contract laundry plant. Contract negotiations are ongoing to resolve this issue with the present entity as we have determined that no other service providers meet this standard. (f) The GI Lab area in question has been reconfigured, and the room is now used for its original purpose, a dirty utility room. The Nurse Manager has been relocated. Patient flow in the cystoscopy clinic has been redesigned, and another room is being used for patient intake and teaching in order to ensure patient privacy. All patient urines specimens, clothing and medical records are now secured. The Chemotherapy Clinic is being moved to an area that will provide more space and less patient crowding. (g) We have reminded all staff that food is not allowed in patient care areas and charged supervisors to monitor this issue. This will be an ongoing task for us since we have a continual flow of students and trainees in and out of the building. (h) The pallet in question in the ER entry area has been removed although it was not blocking the entrance. (i) An emergency eye wash has been installed in the kitchen as recommended by the survey team. (j) Although we had been working on this very issue for a number of months prior to the team's arrival and improvements had been seen, we have renewed our efforts to improve the monitoring of dishwashing temperatures. The Chief of Food and Nutrition is taking some immediate steps to ensure that Food Service Workers and Supervisors not only understand the requirement but what actions to take when recordings are out of tolerance. In addition, a process action team is being chartered to look at this concern. (k) The vent above the food tray belt was fully operational during the inspection. The absence of a diffuser (to spread the airflow) created the impression that it was inoperative. An air diffuser has been installed, and the vent is fully operational. (l) All engineering contracts comply with safety standards, and we will continue to monitor this for compliance. The holes in the exterior wall were covered temporarily pending work that was subsequently

accomplished in a timely manner. They became uncovered due to the unanticipated effects of an unusually windy rainstorm, thus causing the temporary leak. The covers were immediately replaced. (m) All leaks are repaired. We believe that the leak found during the inspection was the consequence of a recently completed roofing project. The warranty work was requested and has subsequently been completed. (n) We are placing great emphasis on routine bathroom cleanliness and maintenance. We have increased surveillance of public restrooms by housekeeping staff in an effort to maintain their appearance during high usage times. Project work has increased during the past 2 months to include the cleaning of many carpet surfaces. In addition, approximately 42 areas have been identified as needing replacement of the carpet with tile because the carpet cleaning has been ineffective in maintaining the cleanliness of those areas. 12 of these areas have already been converted to tile, and VISN 19 has recently supplemented the Medical Center with additional funding to accelerate this conversion process. We anticipate that these projects will be completed by 3/31/05. Supply closets have been cleaned, and all staff reminded to excess items not being used. Supervisors will continue to monitor these areas on environmental rounds. (o) A team of contract personnel was brought in to work with our staff to move computer terminals and cables off the floor to facilitate cleaning. The team, which began work the week of July 5th, has evaluated and moved CPUs and/or bundled cables, if necessary, at 99% of the workstations. An IRMS employee has joined the environmental rounds team to monitor and/correct any problems in this area and continue educating our staff in keeping cables off the floors, thus allowing easier cleaning of those areas.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director take action to: (a) develop a reporting process that will coordinate service level and clinical monitoring activities, thus providing effective oversight of patient care; (b) review, analyze, and act upon patient complaints; and (c) establish a Utilization Management program that includes the review of appropriateness of admissions and continued stays.

Concur **Target Completion Date:** 11/15/04

We continue to search for better ways to improve all of our system processes and are currently completing our annual assessment using the Baldrige quality criteria. Our comments with regard to specific items in the recommendation are as follows:

(a) We will look for ways to improve our reporting processes. Currently we have a good system of reporting through the Performance Improvement Council (PIC), Clinical Executive Board (CEB), Nursing Executive Board and Strategic Management Board to provide effective oversight of patient care. Process action teams, Six Sigma Teams and workgroups are established to look at identified problems and develop process and system changes as needed. Quality data, including reports from major monitoring committees, will be presented to the PIC and CEB on a quarterly basis, and actions taken to correct problems will be appropriately documented in committee minutes. Performance measures are closely watched by all groups.

(b) The patient advocates are responsible for monitoring and reporting patient complaints. Reporting to the PIC is done formally on a quarterly basis and actions taken to correct problems will be documented in the appropriate committee minutes. The PIC, in conjunction with Medical Center leadership, will make system changes as needed. The current outpatient surgery area renovation project and surgery scheduling changes are a result of patient complaints about the long waits for elective surgeries. The Leadership Team receives all patient concerns electronically in order to monitor the response to these concerns and ensure they are acted on quickly and to the patient's satisfaction. We will continue to look for ways to improve this process.

(c) We have posted a position for a Utilization Review Nurse who will report to the Chief of Staff. We expect this person to be hired and the program in place by 11/15/04. We will review both admissions and continued stays.

Recommended Improvement Action 3. We recommended the VISN Director ensure that the System Director take action to assure that: (a) the telephone operator master panel includes a low oxygen level alarm, (b) the system policy

includes all the requirements mandated by VHA in the Safety Alert, (c) all appropriate employees receive required ILSM training, and (d) the system COTR clarify ordering and delivery procedures with the oxygen supply contractor and refer the contract to the VA NAC.

Concur **Target Completion Date:** 10/15/04

We have reviewed the recommendations for bulk oxygen and have addressed each item as follows:

(a) Our telephone operator master panel has been installed as planned. We also have installed master panels in the Administrative Officer of the Day (AOD) work area and the boiler room. All 3 panels have low level alarms and constant coverage is provided in these areas so that problems can be dealt with immediately.

(b) We are in the process of developing a system policy that will cover all the requirements mandated by VHA in the Safety Alert.

(c) All of the designated employees had completed the required training by July 9, 2004.

(d) The system Contracting Officers Technical Representative (COTR) for this contract is in the process of developing an MOU with the oxygen supply contractor to clarify the ordering and delivering procedures. This is now in place.

Recommended Improvement Action 4. We recommended the VISN Director ensure that the System Director take action to assure clinicians who administer moderate sedation are properly trained and credentialed.

Concur **Target Completion Date:** 06/25/04

Credentialing of clinicians administering moderate sedation has been completed.

Recommended Improvement Action 5. We recommended the VISN Director require that the System Director take action to ensure that: (a) contracting staff negotiate CNH

contracts in compliance with VA policy, (b) PNMs are prepared for all contracts, and (c) only the designated COTRs certify contractor invoices.

Concur **Target Completion Date:** 11/30/04

The issues surrounding contracting, price negotiation memorandums and COTR certification and training were known to the facility leadership, and steps were in process to correct these concerns. Corrective actions were well underway at the time of the survey. We have addressed the listed specific items as follows:

(a) All community nursing home contracts are now negotiated using the benchmark and properly documented. We have instituted new procedures to ensure further compliance. Contract nursing home files are currently reviewed quarterly by the contract manager to ensure proper documentation is included in all files. With the appointment of the Network Contract Manager (NCM), all nursing home contracts at ECHCS will be reviewed prior to award to assure appropriate pricing in an effort to realize the potential savings as listed in Appendix C.

(b) All contracting officers have been instructed that Price Negotiation Memorandums (PNM)s are to be included in every contract coming up for review as well as new nursing home contracts. The NCM will include review of PNMs for contract awards at ECHCS to ensure compliance.

(c) Every contracting officer has been instructed to provide the Business Office with written notification of the appropriate COTR. The NCM will include COTR notification as a part of the review process. The Business Office staff has been instructed to verify that only designated COTRs are certifying invoices prior to payment. The COTR for nursing home contracts is currently unable to verify payments because bills are sent directly to the Network Authorization Office (NAO). We will begin a new process with the October payments. The Payment Center staffs at NAO and the COTR were in regular communication regarding verification of days of care prior to any payment. This occurred by phone calls, e-mails and COTR visits to the

CNH; however no documentation exists to support this. The current system documentation does not show a clear separation of duties because the centralized Payment Center is certifying and paying the CNH invoices. In order to resolve the separation of duties issue, the current intense verification process will remain in place with the following changes:

1. The VISN 19 Payment Center will create a master list by individual contract.

2. The contract list will contain the contract number, contract provider, patient name, approved/verified bed days of care to be paid (invoice information).

3. Each list will be sent to the COTR for verification and certification that the charges accurately reflect the work completed. The COTR will certify that the each individual contract is correct.

4. Once the certification of the master list is received from the COTR, the payments will be processed. The master list will be the official, certified document, upon which payments will be based. The original invoices will be maintained as supporting documentation to the master list.

Recommended Improvement Action 6. We recommended the VISN Director require that the System Director take action to ensure that the dispensing window and window wall meet minimum security requirements.

Concur **Target Completion Date:** 9/30/05

The pharmacy dispensing window and window wall does not meet minimum security requirements. A non-recurring project designed to correct this condition and rated by the Network as a top priority for funding in FY06 has now been re-prioritized for completion in FY05. We will then meet or exceed the minimum requirements for security in this area.

Recommended Improvement Action 7. We recommended the VISN Director require that the System Director take action to ensure that the Acting Chief of A&MMS: (a) updates EILs to reflect the accurate status of all equipment

and (b) performs periodic equipment inventories in accordance with VA policy.

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

We have had both staff and A&MMS leadership changes and are now working to correct these problems in a timely manner. Significant progress has been made.

(a) Materiel Management personnel are working closely with EIL officials to improve accuracy of Equipment Inventory Lists (EIL)s. Changes annotated on EIL inventories are entered into AEMS/MERS within 30 days of receipt of completed inventory in A&MMS. Additionally, a simple VISTA menu option has been added for use by EIL officials allowing them to update the location while conducting an inventory. If the equipment is not found, then we will process a Report of Survey. A 100% inventory of the Pueblo, LaJunta, Alamosa, and Colorado Springs CBOCs will be completed by October 31, 2004.

(b) Materiel Management personnel have created a master log to schedule and track annual EIL inventories as well as quarterly spot check in accordance with VHS Handbook 7127. Spot checks will consist of a 10% random sampling of the EIL for accuracy. A listing of all EIL inventories will be kept in the Acquisition Chief's Office with the schedule for upcoming inventories. When an inventory is due, the responsible official (Service Chief) will be notified (electronic mail notification is acceptable) and provided a copy of the applicable EIL for inventory. The Service Chief, or designee, will, within 10 days after receipt of the notice, conduct a physical count of all nonexpendable property listed. When the EIL contains 100 or more line items, the physical count will be conducted within 20 days after receipt of the notice.

The Chief, A&MMS will review all completed inventories to ensure the EIL Responsible Official has signed the inventory and checked the appropriate box indicating the percentage of equipment inventoried. Reports of Survey are initiated when equipment cannot be located. The NX Inventory Management Specialist will provide a monthly report to the Chief,

A&MMS, on the status of completed EIL inventories and random sample procedures.

Recommended Improvement Action 8. We recommended the VISN Director require that the System Director take action to ensure that: (a) PNMs are completed for all contracts and included in contract files, (b) required legal/technical reviews are requested, (c) performance appraisals are prepared and included in the contract files when exercising option years, (d) only COTRs certify vendor invoices, and (e) only properly trained and warranted contracting officers execute contracts.

Concur **Target Completion Date:** 10/18/04

The actions taken on this recommendation are the same as the actions reported in recommendation 5. We recognized the lack of price negotiation memorandums (PNM), the lack of documented legal/technical reviews, the lack of performance appraisals and the problems with the COTR. We have made the necessary changes to rectify this situation.

(a) See recommendation 5

(b) The need for legal/technical review has been re-emphasized to the contracting staff. The NCM will ensure that all contracts meeting the thresholds for legal/technical review according to VAAR 801-602-70 are forwarded appropriately.

(c) The contracting staff has been instructed by the Acting Chief, A&MMS to include performance appraisals prior to issuing any option year contract. They have also been instructed to include the COTR evaluation of the entire contract at the expiration date of the contract. The NCM will continue to monitor all ECHCS contracts on a quarterly basis to ensure compliance.

(d) See recommendation 5 (c).

(e) Chief, A&MMS will provide a list of all current COTRs at ECHCS to the CLO and NCM. The CLO staff will provide COTR training to all current COTRs at ECHCS, and completion of this training will be recorded in the TEMPO

system. Semi-annual COTR training will be made available through the VISN Contracting Office.

Recommended Improvement Action 9. We recommended the VISN Director require that the System Director take action to ensure that: (a) A&MMS staff monitor item usage rates, adjust GIP stock levels, and reduce excess medical supply inventory; (b) PTC staff adjust stock levels to reflect actual usage rates and reduce excess prosthetic inventory; and (c) FMS staff reduce excess engineering supply inventory and implement plans to fully use GIP for engineering supplies.

Concur **Target Completion Date:** 12/1/04

We have addressed the issues of excess supplies and inventory in all areas. Through aggressive reduction of supply levels we will attempt to realize savings as listed in Appendix C.

(a) All stock items will be reviewed monthly to determine if usage has changed for level adjustments. The Days Stock on Hand Report and the Inactive Items Report will be used in conjunction with this review. This will be done monthly by the Supervisor, Total Supply Support (TSS) with a written report of findings to the Chief, Acquisition and Material Management Service (AMMS). Currently there are 15 Primary Inventory Points (PIP) utilized at ECHCS. These will be reviewed and decreased in accordance with VHA Handbook 1761-2. This will allow for closer GIP control by the Acquisition Service. GIP stock levels will be reviewed and adjusted to a 30-day level by December 31, 2004 in all PIPs. GIP stock levels will then be required to be reviewed quarterly and adjusted as necessary to the 30-day level. The Supervisor, TSS will provide a monthly report to the Chief, MMS on the results of the review. We will also be working diligently to reduce our number of PIPs, in accordance with VHA Handbook 1761-2. A list of all items in excess will be compiled and offered to other facilities. The list will be completed by Dec 04 and the excess items processed.

(b) The prosthetics package was not being used correctly and services were not reporting when prosthetic supplies were

being used. A system has been put into place to assure complete reporting and proper use of the package.

(c) FMS staff will reduce excess engineering supply inventory and implement plans to fully use GIP for engineering supplies. FMS is in the process of implementing full GIP utilization by adding the remaining Engineering inventories and creating a centralized primary distribution point. FMS recognizes that certain stock levels are in excess of the "30-day goal" and is reducing excess supply through evaluation of stocks and will physically excess unnecessary items. Excess of several pallet loads have already been completed. Items determined as required stock will be reduced through normal consumption and maintained at a 30-day goal once the par levels are achieved. There are some items that will remain above the 30-day stock level for some time, since they were obtained at no cost from another federal agency through the surplus excess property program.

OIG Suggestion(s)

Suggested Improvement Action 1. We suggested the VISN Director require that the System Director take action to ensure that: (a) all controlled substances storage locations are inspected every month and (b) controlled substances inventories are properly documented.

Concur **Target Completion Date:** 7/1/04

A new narcotics control officer was appointed in December of 2003. She revamped the existing program, trained new inspectors, and instituted new monitoring procedures which now meet VHA requirements. The program is now in full compliance with appropriate requirements. Leadership receives regular reports and will continue to ensure that compliance with the program is maintained. Inventories are being done and are now documented.

Suggested Improvement Action 2. We suggested the VISN Director require that the System Director take action to ensure that insurance billings are done promptly.

Concur **Target Completion Date:** July 1, 2004

Backlogs existed from November 2003 thru January 2004 because of normal staff recruitment delays. As of August 2004, the value of the unbilled cases greater than 60 days was a half percent of total unbilled amounts. Since the CAP visit, Days to bill 3rd party have improved dramatically. (Aug 04 - 40.2 days) and we expect continued improvement.

The Days to Bill is a complex issue affected by several items including late encounter entry, late insurance identification and fee basis billing. A Six Sigma Team has been working to identify and address these issues and shows promise of further improvement. Their assessment was confirmed by our year end results – collections of $13,260,000 represented an increase of $2 million over the previous year and $1 million above our goal.

Suggested Improvement Action 3. We suggested the VISN Director require that the System Director take action to ensure that: (a) all software program changes are adequately documented, (b) computer users log off the system when computers are not in use, (c) access to the computer room is logged, and (d) backup files are properly stored.

Concur **Target Completion Date:** 10/30/04

We have addressed each of the issues cited in the report as follows:

(a) A search of all locally created changes to VA Class I software packages is being performed and the appropriate documentation is being added. The VISN CIO will ensure that programmer identification and date of software change is documented. This will be completed by 10/30/04.

(b) IRMS will continue to emphasize the importance of security during all computer training, and the ISO will continue to monitor.

(c) All IRMS staff members who have access to the computer room will be reminded that the log needs to be completed when any non-IRMS people enter the room. The Chief of IRMS will assure that this is completed.

(d) The current backup location is physically located a safe distance from the Computer Room (nearly a block away and across the street from where the main computer room is located). We have replaced the cabinet found by the team with a fire-resistant safe. We feel this meets the letter and spirit of the relevant directives. We will continue to explore possibilities which would include a location with a sprinkler system.

Appendix D

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
9a and b	Better use of funds by reducing excess medical and prosthetic supply inventories.	$440,120
5a	Better use of funds by negotiating community nursing home contracts in compliance with VA's benchmark rates	$146,240
	Total	$586,360

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Appendix F

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