Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System Omaha, Nebraska

Report No. 04-02398-70 **January 18, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of August 23–27, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Nebraska Western Iowa Health Care System (referred to as the System). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 253 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 23.

Results of Review

This CAP review focused on 11 areas. As indicated below, the System complied with selected standards in the following six areas. The remaining five areas resulted in recommendations for improvement.

The System complied with selected standards in the following areas:

- Controlled Substances Accountability
- Environment of Care
- Government Purchase Card Program
- Information Technology (IT) Security
- Part-Time Physician Time and Attendance
- QM Program

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

- Collaborative initiatives improved quality of care.
- Research Service accreditation score was exemplary.
- Controls over part-time physician time and attendance were effective.
- The Government Purchase Card Program was effectively managed.

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

- Revise the moderate sedation policy to reflect current practice and comply with physician training requirements.
- Strengthen bulk oxygen system internal controls.

- Increase Medical Care Collections Fund (MCCF) collections by improving documentation and billing procedures.
- Improve compliance with certain contracting requirements.
- Strengthen supply inventory management.

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

VISN 23 and System Directors' Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 11–17 for the full text of the Directors' comments). We will follow up on planned actions until they are completed.

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

Introduction

System Profile

Organization. The VA Nebraska Western Iowa Health Care System consists of three divisions, located in Omaha, Grand Island, and Lincoln, NE, and provides tertiary medical, surgical, psychiatric, long-term care, and outpatient services. Community-based outpatient clinics (CBOCs) are located in North Platte and Norfolk, NE. The System is part of the VA Midwest Health Care Network (VISN 23) and serves a population of about 172,500 veterans in a primary service area that includes counties in Nebraska, Iowa, Kansas, and Missouri.

Programs. The Omaha Division is a 100-bed tertiary care facility providing a broad range of inpatient and outpatient services in medicine, surgery, and psychiatry. The Grand Island Division provides outpatient services and has a 76-bed nursing home care unit providing extended care in geriatrics and rehabilitation. A large outpatient clinic is located at the Lincoln Division. The System provides comprehensive primary, specialty, and geriatrics services.

Affiliations and Research. The System is affiliated with the University of Nebraska College of Medicine and Creighton University School of Medicine and supports 87 medical resident positions in medicine, surgery, psychiatry, dentistry, pathology, and radiology training programs. The System is also affiliated with other allied health programs at the University of Nebraska, Creighton University, and other colleges in Nebraska, Iowa, Kansas, and Wyoming to provide clinical training opportunities for nursing, pharmacy, and allied health students.

In Fiscal Year (FY) 2003, the System research program had 185 active projects and a budget of $11.3 million. Important areas of research include studies in liver and pulmonary diseases, endocrinology, immunology, cancer, gastroenterology, diabetes, orthopedics, and alcohol-related diseases. In addition, a nationally funded VA Alcohol Research Center has been active at the Omaha Division since 1991.

Resources. The System's FY 2004 medical care budget was $203.5 million, a 4.95 percent increase over FY 2003 funding of $193.9 million. FY 2003 staffing was 1321.3 full-time equivalent employees (FTE), including 71.7 physician and 227.4 nursing FTE.

Workload. In FY 2003, the System treated 51,575 unique patients. The inpatient care workload at the Omaha Division totaled 4,259 discharges, and the nursing home workload at the Grand Island Division totaled 266 discharges. The FY 2003 inpatient average daily census was 73 at Omaha and 69 at the Grand Island nursing home. The System outpatient workload totaled 373,356 patient visits, a 4.1 percent increase from FY 2002.

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, and the Secretary published his decisions relative to the Commission's recommendations in May 2004. With regard to VA Nebraska Western Iowa Health Care System, the Secretary concluded that:

> VA also will modernize existing facilities through new construction and renovation at the . . . Omaha . . . [facility]. Plans for renovation of the Grand Island long-term care unit will be developed using the long-term care and mental health strategic plans. . . . VA will enhance capacity for outpatient care in VISN 23 through construction and conversion of existing space to address current and projected space needs at the . . . Omaha . . . [facility]. The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 23 has 21 new CBOCs targeted for priority implementation by 2012 [including: Shenandoah, Iowa and O'Neil, Holdredge, and Bellevue, Nebraska] . . . . These new sites of care will help the VISN, which currently is below access standards in all five of its markets, to meet national access standards . . . . 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, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 11 activities:

Bulk Oxygen Utility Systems	Moderate Sedation Practices
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Environment of Care	Quality Management
Government Purchase Card Program	Service Contracts
Information Technology Security	Supply Inventory Management
Medical Care Collections Fund	

The review covered facility operations for FY 2003 and FY 2004 through August 26 and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-10). For these activities, we made recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 253 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strengths

Collaborative Initiatives Improved Quality of Care. The System had an effective QM program that included participation in three collaborative projects with the Institute of Healthcare Improvement (IHI). IHI is a non-profit organization with a commitment to improve health by advancing the quality and value of health care. The collaborative learning activities bring together health care organizations that share a commitment to making major, rapid change that decreases costs and results in better outcomes for patients. The first initiative, Bar Code Medication Administration, improved the processes of medication administration and improved patient safety by reducing medication errors. The second initiative, Patient Flow, improved communication between health care team members, reduced patient waiting time, and resulted in better utilization of inpatient beds. The third initiative, Advanced Clinic Access, has resulted in improved access to medical care for veterans and has been adopted throughout VISN 23.

Research Service Accreditation Scores Were Exemplary. The National Committee for Quality Assurance (NCQA) visited the research service in July 2004, reviewing many elements which included human research protection, the Subcommittee of Human Studies oversight, investigational products, quality improvement, education and training, privacy, confidentiality, and informed consent. NCQA scored all elements at 100 percent and awarded the only perfect score to date. The program received a 3-year accreditation.

Controls Over Part-Time Physician Time and Attendance Were Effective. The System had established effective controls to monitor the time and attendance of part-time physicians. Before beginning each workday, part-time physicians signed in and annotated their start times on time sheets located in their respective services' administrative offices. As a result, timekeepers and administrative officers were able to observe the part-time physicians as they reported for duty. Monthly, an administrative officer outside of the part-time physicians' services audited time and attendance by physically verifying the presence of part-time physicians and by reviewing the timing of their clinical entries in IT systems.

The Government Purchase Card Program Was Effectively Managed. The System had established effective controls to ensure that purchases were appropriate and were meeting the financial and administrative requirements of the Government Purchase Card Program. Cardholder, approving official, and coordinator responsibilities were properly separated. Cardholders reconciled billing statement charges to supporting documentation promptly, and approving officials certified cardholders' purchases within timeliness standards. In addition, the purchase card coordinator audited all cardholders and approving officials each quarter. We found no evidence that System personnel used purchase cards for unauthorized purposes.

Opportunities for Improvement

Moderate Sedation Practices – Policy Needed Revision and Physicians Needed To Comply with Training Requirements

Condition Needing Improvement. Veterans Health Administration (VHA) regulations require that health care facilities establish guidance for providing care to patients receiving all types of anesthesia, including moderate sedation. Moderate sedation is a drug-induced depression of consciousness used to control pain and discomfort associated with minor surgical procedures and diagnostic examinations. Patients who receive moderate sedation retain their ability to respond to verbal and tactile commands, unlike patients who receive general anesthesia. No special measures are required to maintain the patients' cardiovascular functioning or spontaneous ventilation during the procedures, but clinicians must be trained to intervene if a deeper level of sedation occurs.

We found clinical managers established appropriate controls over the safe delivery of moderate sedation, and the Chief of Anesthesia was actively involved in performance improvement and the assessment of patients who had received moderate sedation. However, clinical managers needed to revise the System policy to clearly designate who could administer moderate sedation and define the required level of cardiopulmonary resuscitation training. Physicians needed to complete specific training on administration of moderate sedation, as defined in the System policy.

Moderate Sedation Policy. Although the System policy states that moderate sedation must be given by, or under the direct supervision of, a physician with clinical privileges to perform procedures requiring sedation, it does not specify which clinical disciplines can administer sedative agents. In practice, registered nurses were the only discipline other than physicians who were allowed to administer those agents. The policy needed to state that practice. Clinical managers needed to define the required level of cardiopulmonary resuscitation training. The policy states that clinicians must be able to provide respiratory and cardiovascular support but does not specify the level of training required.

Training Requirements. We sampled training records of two registered nurses and four physicians who provided moderate sedation. Both nurses had Advanced Cardiac Life Support certification and had completed a training course on the administration of moderate sedation. However, the four physicians did not have the required moderate sedation training, and there was no evidence they had cardiopulmonary resuscitation training. Senior managers informed us that the Chief of Anesthesia was developing a training program for physicians who administer moderate sedation.

Recommended Improvement Action 1. We recommended the VISN Director ensure that the System Director require that: (a) the moderate sedation policy be revised to

specify which disciplines can provide moderate sedation and what level of cardiopulmonary resuscitation training is required, (b) all clinicians receive the required moderate sedation and cardiopulmonary resuscitation training, and (c) the training be documented.

The VISN and System Directors agreed and will revise the moderate sedation policy to include the recommended information. Moderate sedation and cardiopulmonary resuscitation training will be documented in the education tracking program. The improvement actions are acceptable, and we will follow up on the actions until they are completed.

Bulk Oxygen Utility System – Internal Controls Needed To Be Strengthened

Condition Needing Improvement. System managers needed to improve bulk oxygen policies and procedures. The System had not complied with the VHA Patient Safety Alert (PSA) dated April 5, 2004, requiring that hospital bulk oxygen systems be brought into compliance with the PSA by April 30. Compliance is needed to ensure an adequate and safe supply of oxygen is maintained for patient needs.

Policies. The System did not have a comprehensive bulk oxygen policy that defined procedures, supervision, and individual responsibilities. As a result, ordering instructions, maintenance, monitoring, and emergency shutdown procedures were unclear. Routine and consistent alarm testing was not performed, and alarm set points were not documented consistently.

Annual Inspection. The annual medical gases inspection at the Grand Island Division on September 29, 2003, noted several conditions that were potentially hazardous to patients and employees and which required immediate attention. These included particulates in the system and the need to relocate an emergency shut-off valve. At the time of our inspection, corrective actions had not been implemented.

Master Alarm Panel. The PSA mandates that bulk oxygen tanks must be connected to two independent, continuously monitored master alarm panels. The Omaha Division had installed two panels, but they were not functioning because electrical wiring had not been completed. One master alarm was connected to the centralized computer system. The Grand Island Division had two master alarm panels but only one was continuously monitored. They needed to monitor both panels at all times.

Interim Life Safety Measure (ILSM). Because the System did not meet National Fire Protection Association code requirements for the master alarm panels, an ILSM was required. This contingency plan must remain in effect until requirements are met. Although System managers had developed a plan, it was not comprehensive and did not assign specific responsibilities for monitoring bulk oxygen. Employees had not received

ILSM training as required by the Joint Commission on Accreditation of Healthcare Organizations and were unable to state their responsibilities. The ILSM needs to be more specific, clearly stating procedures and responsibilities. Managers then need to train employees on the contingency plan.

Contract Terms. The System Contracting Officer Technical Representative (COTR) had not developed a Memorandum of Understanding (MOU) with the local oxygen supplier. As a result, alarm set points were not clearly defined, and oxygen levels and pressures were not recorded consistently. VA's National Acquisition Center (NAC) requires that a MOU be established within 15 days of awarding the contract to the vendor. The MOU outlines contract responsibilities and specific details and responsibilities of the services the vendor will provide. The written copy of the MOU must then be incorporated into the NAC contract.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director take action to implement all requirements of the PSA including: (a) development of a comprehensive policy that defines procedures to include emergency shutdown, a clear line of authority, supervision for the bulk oxygen utility system, and responsibilities; (b) implementation of corrective actions from the annual inspection recommendations; (c) appropriate alarm panel monitoring; (d) development of a descriptive ILSM plan and training for employees; (e) verification of the correct alarm set points with the vendor; and (f) clarification of the ordering and delivery procedures with the oxygen supply contractor and transmittal of the MOU to the NAC.

The VISN and System Directors agreed with the findings and recommendations and revised the Bulk Oxygen Utility System policy to include all requirements. They reported that corrective actions had been completed for the deficiencies cited, alleviating the need for an ILSM plan. They clarified vendor and contractor procedures, including alarm set points, and forwarded this information to the NAC. The improvement actions are acceptable.

Medical Care Collections Fund – Collections from Health Insurance Carriers Could Be Increased

Condition Needing Improvement. Under the MCCF program, VA is authorized to recover the cost of treating insured veterans from health insurance carriers. In FY 2003, the System collected $18,685,251, which was 98 percent of its FY 2003 collection goal of $18,972,117. In the first 10 months of FY 2004, the System collected $18,563,656, which was 90 percent of its FY 2004 collection goal of $20,547,445.

The System could increase MCCF collections by improving documentation of medical care provided, ensuring MCCF personnel identify all billable VA care, obtaining documentation of fee-basis care, and issuing bills to insurance carriers promptly.

Care Not Properly Documented. Medical care providers needed to improve the documentation of care. The Reasons Not Billable Report lists episodes of care that MCCF personnel could not bill because medical care providers did not adequately document the care in veterans' medical records. We reviewed a judgment sample of 45 potentially billable episodes of care totaling $10,245 that were listed on the report for the 6-month period ending June 30, 2004. We identified 34 episodes of care totaling $6,500 that MCCF personnel could have billed if medical documentation had been complete.

Billable VA Care Not Identified. To determine whether MCCF personnel identified all billable VA care, we reviewed 3 judgment samples including a total of 42 episodes of care: 10 inpatient discharges that occurred during May 2004; 22 outpatient visits that occurred on May 24, 2004; and 10 potentially billable episodes of care listed on the Unbilled Amounts Detailed Report for the 6-month period ending June 30, 2004. We identified 12 missed billing opportunities for VA care totaling $1,540. MCCF personnel missed opportunities to bill for professional fees, physical therapy, a laboratory procedure, a prescription, and delivery and set-up of prosthetics equipment.

Documentation of Fee-Basis Care Not Forwarded. The Fee Basis unit of the VA Central Iowa Health Care System, Des Moines, Iowa, authorizes payments to non-VA medical care providers furnishing fee-basis care to veterans residing in the service area of the System. After authorizing payments for fee-basis care furnished to veterans with health insurance, the Fee Basis unit is required to forward to MCCF personnel the documentation needed to bill the insurance carriers.

To determine whether MCCF personnel properly billed veterans' insurance carriers for fee-basis care, we reviewed the records of a judgment sample of 13 episodes of fee-basis care furnished during the period April 25, 2003, to March 25, 2004. We identified 18 missed billing opportunities totaling $20,769 for 6 episodes of care. MCCF personnel had not billed for this care because the Fee Basis unit had not forwarded the required documentation.

Bills Not Issued Promptly. MCCF personnel did not issue bills promptly to insurance carriers. We reviewed the records of 10 potentially billable episodes of care listed on the Unbilled Amounts Detail Report for the 6-month period ending June 30, 2004. Although the VISN goal was to issue bills within 47 days after treatment, we found 4 billing delays ranging from 92 to 217 days. Because insurance carriers impose time limits on claims, billing delays may result in denied claims.

Potential Collections. We estimated that additional bills totaling $28,809 ($6,500 + $1,540 + $20,769) could have been issued for the missed billing opportunities we identified. Based on the System's historical collection rate of 21 percent, MCCF personnel could increase collections by $6,050 ($28,809 x 21 percent). As a result of our review, MCCF personnel issued 31 bills during our visit, and they were working to issue additional bills for the missed billing opportunities we identified.

Recommended Improvement Action 3. We recommended the VISN Director require the System Director to: (a) ensure that medical care providers adequately document the care provided, (b) identify and bill all billable VA care, (c) work with the Director, VA Central Iowa Health Care System to ensure that the Fee Basis unit promptly forwards the documentation needed to bill insurance carriers, and (d) issue bills to insurance carriers promptly.

The VISN and System Directors agreed with the findings and recommendations and will develop a new process to correct deficiencies in clinical documentation. The System purchased software in FY 2004 to assist with billing and coding, and staff will continue to receive software training. The MCCF Coordinator will coordinate with the VA Central Iowa Health Care System to improve billing for fee-basis care. In addition, the VISN has developed a new measure for FY 2005 to track promptness of insurance billing. The improvement actions are acceptable, and we will follow up on the actions until they are completed.

Service Contracts – Pre-Award Audits Should Be Requested, and Contract Files Should Include Required Documents

Condition Needing Improvement. To evaluate contracting activities, we reviewed a judgment sample of 15 service contracts valued at about $11.4 million. Contracting officers (CO) used noncompetitive acquisition procedures for 11 contracts and competitive bidding procedures for 4 contracts. Our review showed that COs had appropriate warrant authority, contract files were generally well-organized, all required legal and technical reviews were done, and billing and payment procedures were adequate. However, we identified two issues requiring management attention.

Pre-Award Audits Not Done. VHA policy requires pre-award audits of all noncompetitive contracts with estimated costs of $500,000 or more. Our judgment sample included three contracts requiring pre-award audits, but none of the required audits had been done.

Contract Documentation Not Complete. Although contract files generally included appropriate documentation, 3 of the 15 files reviewed did not contain required documents.

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

Recommended Improvement Action 4. We recommended the VISN Director ensure that the System Director take action to: (a) request pre-award audits when required, and (b) include all required documentation in contract files.

The VISN and System Directors agreed with the findings and recommendations and reported that the VISN will implement a new review process for contract files and train contract officers by August 2005. The System will instruct contract officers to submit contracts for required reviews and include all required documents in the contract files. The improvement actions are acceptable, and we will follow up on the actions until they are completed.

Supply Inventory Management – Inventory Controls Should Be Strengthened

Condition Needing Improvement. The System needed to maintain accurate inventory records.

VHA policy requires that medical facilities use the automated Generic Inventory Package (GIP) to manage inventories. At the time of our review, GIP data showed the System's supply inventory included 3,278 line items valued at $1,093,200.

To assess the accuracy of GIP data, we inventoried a judgment sample of 27 line items with a recorded value of $45,522. The stock levels recorded in GIP for 12 of the 27 (44 percent) line items were inaccurate, with 10 shortages valued at $32,311 and 2 overages valued at $306. The inaccurate inventory records occurred primarily because System personnel did not record distributions of supplies. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Recommended Improvement Action 5. We recommended the VISN Director ensure that the System Director take action to: (a) reconcile differences between actual and recorded stock levels and correct inventory records as appropriate, and (b) record distributions promptly.

The VISN and System Directors agreed and assigned trained item managers in all areas using GIP programs. These individuals are responsible for identifying and reconciling differences between inventory records and actual stock levels. A change in a computer prompt has resulted in more timely recording of distributions. The improvement actions are acceptable, and we will follow up on the actions until they are completed.

Appendix A

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 29, 2004

From: VISN 23 Director

Subject: **Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System**

To: Office of Healthcare Inspections

Through: Ms. Peggy Seleski, Director, Management Review Service (10B5)

Enclosed in the response from Mr. Al Washko, Director, VA Nebraska-Western Iowa Health Care System, regarding the recommendations from the Combined Assessment Program completed August 23-27, 2004 at that facility. Each recommendation has been addressed with a response, an action plan and a target date for completion.

If you have any questions, please contact Teresa Kumar (Kleeb) at 402-484-3254.

(original signed by:)

Robert A. Petzel, M.D.

Network 23 Director

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 24, 2004

From: System Director

Subject: **Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System**

To: Director, Network 23 (10N23)

Enclosed you will find our response to the draft report of the OIG CAP inspection of the VA Nebraska-Western Iowa Health Care System completed August 23-27, 2004. Staff from each of the areas where a need for improvement was identified have been involved in developing the responses to this report.

If you have any questions, please contact Shirley Simons, Chief Quality Officer, at (402) 346-8800, extension 3031.

(original signed by:)

AL WASHKO

Director

Health Care System Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommended the VISN Director ensure that the System Director require that: (a) the moderate sedation policy be revised to specify which disciplines can provide moderate sedation and what level of cardiopulmonary resuscitation training is required, (b) all clinicians receive the required moderate sedation and cardiopulmonary resuscitation training, and (c) the training be documented.

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

The following actions are being taken:

The current policy on Use of Moderate Sedation will be modified to (a) include specific disciplines who can administer the sedation and the level of cardiopulmonary training required by these individuals, and (b) specify the training required for all clinicians who use moderate sedation. (c) Training will be documented in TEMPO (this is the software we use to track employee education) and the education staff will forward TEMPO reports to the clinical services for their records.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the System Director take action to implement all requirements of the PSA including: (a) development of a comprehensive policy that defines procedures to include emergency shutdown, a clear line of authority, supervision for the bulk oxygen utility system, and responsibilities; (b) implementation of corrective actions from the annual inspection recommendations; (c) appropriate alarm panel monitoring; (d) development of a descriptive ILSM plan and training for employees; (e) verification of the correct alarm set points with the vendor; and (f) clarification of the ordering and delivery procedures with the oxygen supply contractor and transmittal of the MOU to the NAC.

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

The following actions have been taken to address this recommendation.

(a) The policy FAC-016 has been revised to include procedures for emergency shutdown, assignment of duties in that process, specification of supervision for the bulk oxygen utility system and the responsibilities related to that supervision.

(b) The corrective actions recommended by the external inspector who evaluated the system in Grand Island have all been completed.

(c) The second panel in Grand Island has been moved to another area and is being monitored 24/7. The master panels in Omaha have been installed, connected, are operational and have been checked.

(d) Immediately following the OIG CAP inspection the plan was assessed and responsibilities were reviewed with employees. Since the panel at Omaha is now operational and monitored 24/7, all NFPA code requirements are met and the ILSM is no longer required. There is a facility policy addressing when ILSM's need to be developed and providing guidance regarding how to write and implement an ILSM.

(e) The vendor has retagged and rechecked all switches, gauges, and alarms at all three sites. This process included verification of the correct alarm set points with the vendor.

(f) Ordering and delivery procedures have been clarified with the oxygen supply contractor. The document defining the mutual agreement has been forwarded to the NAC.

Recommended Improvement Action 3. We recommended the VISN Director require the System Director to: (a) ensure that medical care providers adequately document the care provided, (b) identify and bill all billable VA care, (c) work with the Director, VA Central Iowa Health Care System to ensure that the Fee Basis unit promptly forwards the documentation needed to bill insurance carriers, and (d) issue bills to insurance carriers promptly.

Concur **Target Completion Date:** 1/31/05

The following actions will be taken to meet this recommendation,

a. A process will be developed for coders to notify the Clinical Service Chief when a documentation deficiency (missing or inadequate) is identified during the coding process. The Clinical Service Chief will follow up to correct the deficiency and ensure adequate documentation to support billing.

b. QuadraMed Compliance Suite was purchased this past year. The QuadraMed software will search our database for all billable encounters that require coding and then billing. Staff from QuadraMed have provided extensive training to billing & coding staff in the use of this software. The QuadraMed training staff is scheduled to return later this year for continued training.

c. The NWI MCCR Coordinator will contact the Manager of the Fee Basis Payment Center at VA Central Iowa to work to improve their process for identifying billable VA Care and making sure appropriate documentation is sent to NWI to support billing the insurance carriers.

d. A local action plan has been developed to address billing delays. The VISN has started a new measure for FY 05 regarding the 47 days to bill and will be collecting data to monitor this.

Recommended Improvement Action 4. We recommended the VISN Director ensure that the System Director take action to: (a) request pre-award audits when required, and (b) include all required documentation in contract files.

Concur **Target Completion Date:** 8/1/05

The following actions will be taken to meet this recommendation:

(a) Pre-Award Audits Not Done - Contracting Officers will be instructed/trained to submit for review (per VHA Directive 99-056 and IL 90-00-1) all clinical service non-competitive contracts with an estimated value of $500,000 or more.

(b) Contract Documentation Not Complete - Contracting Officers will be instructed/trained to include all required documents in the contract file. This will include justifications, determinations and findings, Price Negotiation Memorandums, COTR memorandums/documentation and other documents per the file checklists.

VISN 23 contract management is working on a process to team review/audit contract files and contract processes at each of the twelve facilities. We also plan to implement weekly one-hour training calls for all acquisition staff in the VISN. Both processes are expected to begin Summer ’05.

Recommended Improvement Action 5. We recommended the VISN Director ensure that the System Director take action to: (a) reconcile differences between actual and recorded stock levels and correct inventory records as appropriate; and (b) record distributions promptly.

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

The following actions are being taken:

(a) We have put item managers in place in all areas using GIP programs. All of these staff members have completed GIP training as offered by VA Central Office. Each item manager runs routine reports to identify differences between inventory and stock levels and reconciles differences when they are identified. The area where the largest discrepancy was found now has its own inventory manager to work directly with clinical staff.

(b) We have changed the prompt in the program to reflect manual receipt of distribution instead of the automated function used in the past. This has resulted in more timely recording of distributions.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
4	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	$6,050
	Total	$6,050

OIG Contact and Staff Acknowledgments

OIG Contact	Dorothy Duncan (214) 253-3334
Acknowledgments	Bill Bailey
	Shirley Carlile
	Theresa Cinciripini
	Linda DeLong
	Marnette Dhooghe
	Glen Gowans
	Mike Guier
	John Houston
	Heather Jones
	Jehri Lawson
	Roxanna Osegueda
	Joel Snyderman
	Virginia Solana
	Sally Stevens
	Marilyn Walls

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 23
Director, VA Nebraska Western Iowa Health Care System

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
- Charles Grassley
- Tom Harkin
- Chuck Hagel
- Ben Nelson

U.S. House of Representatives:
- Leonard Boswell
- Tom Latham
- Jim Nussle
- James Leach
- Lane Evans
- Tom Osborn
- Lee Terry

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.