Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Fargo, North Dakota

Report No. 04-03071-62 **January 6, 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.

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Executive Summary

Introduction

During the week of October 18-22, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Fargo VA Medical Center (referred to as the medical center), which is a part of the Veterans Integrated Services Network (VISN) 23. 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 451 employees.

Results of Review

The CAP review covered 12 areas. As indicated below, there were no concerns identified in five of the areas. The remaining seven areas resulted in recommendations for improvement.

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

- Community Nursing Home Contracts
- Controlled Substances Accountability
- Government Purchase Card Program
- Service Contracts
- Timekeeping for Part-Time Physicians

Recommendations to improve medical center operations:

- Improve the analysis of QM data and strengthen follow-up actions.
- Correct environment of care deficiencies.
- Strengthen procedures for billing insurance companies.
- Reduce excess inventories and improve inventory controls.
- Strengthen information technology security.
- Correct equipment inventory lists and complete inventories on time.
- Improve physical security in the pharmacy.

This report was prepared under the direction of Mr. Nelson Miranda, Director, and Mr. Randall Snow, Associate Director, Washington, DC, Regional Office of Healthcare Inspections.

VISN 23 and Medical Center Director Comments

The VISN and Medical Center Directors concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 13 for the full text of the Director's comments.) We consider all review issues to be resolved but will follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Co-located in Fargo, North Dakota, with the VA Regional Office, the VA Medical Center is a primary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics located in Grafton, Bismarck, and Minot, North Dakota, and Fergus Falls, Minnesota. The medical center serves a veteran population of about 89,000 in a primary service area that includes 53 counties in North Dakota, 19 counties in Minnesota, and 1 county in South Dakota.

Programs. The medical center provides medical, surgical, mental health, and extended care services. The medical center has 59 hospital beds and 50 nursing home beds and operates referral and treatment programs, including the Healthcare for Homeless Veterans Program, the Substance Abuse Treatment Program, and the Partial Hospitalization Program. The medical center also has sharing agreements with the Department of the Air Force, 5th Medical Group, Minot Air Force Base, Minot, North Dakota and the 319th Medical Group, Grand Forks Air Force Base, Grand Forks, North Dakota.

Affiliations and Research. The medical center is affiliated with the University of North Dakota School of Medicine and supports 22 medical resident positions in Internal Medicine, Surgery, and Psychiatry programs. In Fiscal Year (FY) 2004, the medical center supported 363 students in allied health science programs affiliated with North Dakota State University School of Pharmacy, Minnesota State Community and Technical College, North Dakota State College of Science, Northland Community and Technical School, University of North Dakota Department of Social Work, and Tri-College University Nursing Consortium.

Resources. In FY 2004, the medical center expenditures totaled $80.9 million. The FY 2005 medical center budget is $84.0 million, 4.2 percent more than FY 2004. FY 2004 staffing was 648 full-time equivalent employees (FTE), including 40 physician FTE and 157 nursing FTE.

Workload. In FY 2003, the medical center treated 25,505 unique patients, a 10 percent increase from FY 2002. The inpatient care workload totaled 2,320 discharges, the average daily census, including nursing home patients, was 63, and outpatient workload was 137,753 visits. In FY 2004, the medical center treated, 25,467 unique patients, 2,042 discharges, the average daily census was 59, and outpatient workload was 146,674 visits.

Decisions Relating to Recommendations of the VA Commission on Capital Asset Realignment for Enhanced Services. On February 12, 2004, the VA Commission on Capital Asset Realignment for Enhanced Services (CARES) 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 the Fargo VA Medical Center, the Secretary concluded that the medical center would be included in construction and renovation modernization projects for VISN 23, to enhance both inpatient and outpatient care. Construction of six new community-based outpatient clinics is planned for the Fargo area. (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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful, or potentially harmful, practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

Community Nursing Home Contracts	Medical Care Collections Fund
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Equipment Accountability	Service Contracts
Government Purchase Card Program	Supply Inventory Management
Information Technology Security	Timekeeping for Part-Time Physicians

The review covered facility operations for FY 2003 and FY 2004 through October 17, 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all medical center employees, 197 of whom responded. We also interviewed 10 inpatients and 20 outpatients. The survey results were provided to medical center management.

During the review, we presented four fraud and integrity awareness briefings for medical center and Fargo VA Regional Office employees. These briefings, attended by 451 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-12). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Opportunities for Improvement

Quality Management – Data Analysis and Follow-up Actions Should Be Strengthened

Conditions Needing Improvement. We interviewed key employees and reviewed policies, plans, committee minutes, reports, credentialing and privileging files, performance improvement data, and other pertinent documents. The program was comprehensive and generally provided appropriate oversight of patient care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to gather and analyze QM data for trends in patient care that need improvement. The medical center's Medical Staff Bylaws require documentation and review of adverse patient events. Although data were collected in most of the areas required by JCAHO, they were not consistently analyzed. Service Line directors and QM program managers did not assign responsibility for follow-up of corrective actions nor document the effectiveness of the actions. As a result, it was difficult for Senior managers to monitor the effectiveness of recommendations to improve patient care. Data analysis and follow-up actions needed improvement.

Data Analysis.

- Continued stay appropriateness was not collected or analyzed.
- Service Line directors and QM program coordinators did not consistently critically analyze QM data.
- Medical staff monitors, operative and invasive procedures, and blood usage were not reported to the Surgical Specialty Steering Committee, Primary Care Committee, and Medical Steering Committee.

Follow-up on Corrective Actions.

- Service Line directors and QM program managers did not consistently implement and evaluate recommended actions regarding Root Cause Analyses, patient restraints, and patient no-shows in the Mental Health Clinic.
- Program managers did not always identify corrective actions or assign specific implementation dates for corrective actions.
- Service Line directors were not accountable for service-specific QM initiatives.

Recommended Improvement Action 1. We recommend the VISN Director ensure that the Medical Center Director requires that Service Line directors: (a) consistently analyze QM data and identify opportunities to improve the quality of patient care, (b) monitor the implementation of recommended corrective actions from QM reviews, (c) ensure

accountability for implementing improvements and reporting the effectiveness of corrective actions to appropriate committees, and (d) record corrective actions progress in committee minutes.

The VISN and Medical Center Directors agreed and reported the start of an administrative review of the medical center committee structure to be completed by May 1, 2005, which will address QM reporting requirements and education of Service Line directors, program managers, and committee chairpersons. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Environment of Care – Needed Management Attention

Conditions Needing Improvement. Federal law and Veterans Health Administration (VHA) regulations require that medical facilities safeguard confidential patient information. We inspected inpatient units, outpatient primary care and specialty clinics, the operating room, and the Supply Processing and Distribution area of the medical center and found the following violations of patient confidentiality.

- Private health information - patient names, social security numbers, and medical data - was posted on the medical center's intranet site.
- Unsecured medical records were found in the Cardiology and Primary Care clinics.
- Sensitive patient information was displayed on unattended computers in the Cardiology, Mental Health, and Primary Care clinics.

While we were onsite, managers took immediate steps to correct deficiencies and the Medical Center Director submitted a plan of action to address the unresolved issues.

Recommended Improvement Action 2. We recommend that the VISN Director ensures that the Medical Center Director requires: (a) the removal of all protected patient health information from the medical center's intranet site, (b) that employees secure medical records containing private patient information, and (c) that employees lock unattended computer screens to prevent disclosure of confidential patient information.

The VISN and Medical Center Directors agreed and reported that the information on the medical center computer site had been removed and that the issue of security of patient information is a part of employee orientation and training. Training effectiveness will be monitored during weekly environmental rounds. The improvement plans are acceptable and we consider the issue resolved.

Medical Care Collections Fund – Procedures Should Be Strengthened

Conditions Needing Improvement. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain insured veterans. Medical center managers needed to ensure that clinical providers

properly document care and that MCCF employees promptly bill insurance companies and aggressively pursue outstanding bills.

Inadequate Clinical Documentation. Before MCCF employees can bill insurance companies, clinical providers must record complete documentation in the medical records. For the 6-month period December 2003–May 2004, MCCF employees cancelled 95 bills (value = $16,401) because of inadequate clinical documentation, such as progress notes. We reviewed the medical records for a judgment sample of 45 (value = $13,645) of these bills to determine if they had collection potential. Eighteen (value = $2,628) of the 45 bills had no collection potential for various reasons, such as the patients had no insurance or the care provided was related to a service-connected condition. The remaining 27 bills (value = $11,017) could have been collected if clinical documentation had been adequate.

The 27 bills had been canceled because attending physicians did not adequately document resident supervision in the medical records. Of these 27 bills, 12 (value = $8,764) could not be collected because of inadequate documentation of resident supervision and too much time had elapsed since the patient encounter for the attending physician to document supervision. The remaining 15 (value = $2,253) were for care provided by residents in mental health clinics. Based on September 2004 VA guidelines for coding and billing for mental health services, these 15 bills were collectible. During our review, MCCF employees reissued these bills.

Better clinical documentation would have resulted in additional revenue of $3,746 ($11,017 x 34 percent historical collection rate = $3,746).

Insurance Not Billed Promptly. As of September 30, 2004, the medical center had 10,547 (value = $2.9 million) unbilled outpatient episodes of care. During FY 2004, the monthly average days to bill exceeded the VA benchmark of 50 days, ranging from 66 to 121 days.

Insurance Bills Not Pursued Aggressively. As of September 30, 2004, the medical center had 11,187 insurance bills (value = $2.7 million) that had not been collected (excluding bills that had been referred to the VA Regional Counsel for collection). Of these, 4,718 with a value of about $1.2 million (44 percent of the total value) were more than 90 days old.

To evaluate collection efforts, we reviewed 50 of these bills (value = $332,366). Based on our review and discussions with the Revenue Manager, we determined that all 50 bills required more aggressive collection efforts. VHA guidance requires employees to initiate follow-up telephone calls to insurance companies within 30 days of the billing date. MCCF employees had sent collection letters but took an average of 130 days to make follow-up calls.

After discussions with the Revenue Manager, we estimated that if MCCF employees pursued bills more aggressively they could increase the collection rate by about 5 percent. This would provide additional revenue of about $60,000 ($1.2 million in bills older than 90 days x 5 percent increase in collections = $60,000).

In summary, we estimated the MCCF employees could have increased collections by $63,746 ($3,746 from better clinical documentation + $60,000 from aggressively pursuing outstanding bills from insurance companies = $63,746).

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) medical records include adequate documentation, (b) insurance bills are issued promptly, and (c) bills are pursued more aggressively.

The VISN and Medical Center Directors agreed and reported that by January 31, 2005, clinical providers will receive written guidelines on clinical documentation requirements for billing. In December 2004, an additional 0.5 FTE was hired to help reduce delays in issuing insurance bills. To improve bill collection efforts, the medical center has begun automatically printing second and third collection letters to insurance companies. When the backlog of bills is reduced, the medical center will implement a telephone call follow-up process. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

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

Conditions Needing Improvement. The medical center needed to reduce engineering shop and warehouse supply inventories and make better use of VA's Generic Inventory Package (GIP). VHA has established a 30-day stock level goal for engineering, medical, and prosthetics supplies. In addition, VHA policy requires medical centers to use GIP to manage engineering and warehouse supply inventories. GIP helps inventory managers monitor inventory levels, analyze usage patterns, and maintain supply quantities necessary to meet current demand.

Excessive Engineering Supply Inventory. Engineering Service stored substantial quantities of supplies in the engineering shops. Although the service was using GIP to manage 13 line items, it did not use GIP or any other inventory control system to manage more than 200 other items. To test the reasonableness of engineering stock levels, we reviewed inventory levels for a judgment sample of 10 of the items not managed with GIP. For eight of these items, inventory levels exceeded the 30-day goal, ranging from 48 to 270 days. The value of excess inventory for these eight items was $943.

Because GIP was not used to manage most of the engineering supply inventory, we could not determine the value of stock on hand or the value of excess stock for the entire

inventory. For engineering supply items with recurring use, GIP can be an effective inventory management tool and should be fully implemented in accordance with VHA policy.

Warehouse Inventory Too High. Environmental and Materiel Management Service (E&MMS) was using GIP to manage inventories of 157 medical and prosthetic supply items (value = $45,503) stocked in the warehouse. To test the reasonableness of warehouse stock levels, we reviewed a judgment sample of 10 items (value = $17,362). Inventory levels for five items exceeded the 30-day standard, ranging from 47 to 200 days of supplies. The estimated value of excess stock for the 5 items was $3,566, or 21 percent of the total value for the 10 sampled items.

The excess inventory occurred because GIP normal stock levels and reorder points had not been adjusted to reflect reductions in demand for the supplies. By applying the 21 percent of excess stock for the sampled items to the value of the entire warehouse stock, we estimated that the total value of excess warehouse stock was $9,556.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires Engineering Service and E&MMS to fully implement GIP and reduce excess supply inventories.

The VISN and Medical Center Directors agreed and reported that by September 30, 2005, GIP will be fully implemented, reorder points will be adjusted to reflect reductions in demand for supplies, and unnecessary engineering supplies will be excessed. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Information Technology Security – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed medical center automated information system (AIS) policies and procedures to determine whether controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that medical center employees received required computer security awareness training; also critical information was backed up on a regular basis. However, we identified three information technology security issues that needed corrective action.

Contingency Plans. VA facilities are required to develop and annually test contingency plans that will reduce the impact of disruptions in services, provide critical interim processing support, and ensure that normal operations will resume as soon as possible after a disaster or other type of emergency. All services that are dependent upon critical information systems must have contingency plans. The medical center had 19 such services. As of October 22, 2004, 10 of these services, including patient care services

such as Primary and Specialty Care and Mental Health, did not have contingency plans. In addition, plans for the other nine services had not been tested annually.

Inactive User Accounts. VHA policy requires a review of Veterans Health Information Systems and Technology Architecture (VistA) user privileges at least every 90 days to ensure users have a continued need for access and appropriate access levels. We reviewed VistA access for a judgment sample of 20 users and concluded that access should have been terminated for 6 users (1 former medical student and 5 employees of other VA medical centers). Of the six users, three had never activated their accounts, and three had not signed on to VistA since 2003 and did not have continued need for access.

In addition, to the 6 inactive accounts discussed above, the medical center had 351 inactive VistA accounts for users whose access should have been terminated because they had either not accessed the system for more than 90 days or were former employees. These VistA access problems occurred because the previous Information Security Officer (ISO) had not periodically reviewed the continued need of inactive user accounts. The recently appointed Acting ISO stated that he would immediately begin terminating VistA inactive and unneeded user accounts.

Background Investigations. Background investigations are required for medical center personnel who have been granted computer access to sensitive patient, employee, or financial information. As of October 22, 2004, the required investigations had not been completed for six Information Resource Management (IRM) employees. Human Resources (HR) employees had submitted investigation requests to VA's Security and Investigation Center for four of the six employees in March and April 2001, and for the other two employees in May 2002 and December 2003. However, HR employees had never followed up with VA's Security and Investigation Center on the status of the investigation requests.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) develop contingency plans for required services and test the plans annually, (b) promptly terminate VistA accounts for individuals that do not have a continued need for access, and (c) follow up on all background investigation requests.

The VISN and Medical Center Directors agreed and reported that inactive VistA accounts for individuals at the medical center had been terminated immediately following the CAP review. By March 31, 2005, inactive VistA accounts for individuals at other VA sites will be reviewed and terminated for those who have not signed on in 90 days. Also by March 31, 2005, formal service-specific contingency plans will be developed, and HR employees will follow up on background investigation requests. In addition, every 6 months the ISO will remind HR employees to follow up on the investigation requests. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Inventory Lists Should Be Corrected and Inventories Completed On Time

Conditions Needing Improvement. Medical center managers needed to improve procedures to properly safeguard and account for 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). VA policy requires periodic inventories to ensure equipment is properly accounted for in accountability records called Equipment Inventory Lists (EILs). E&MMS employees were responsible for performing inventories and updating EIL records.

As of September 2004, the medical center had 47 active EILs listing 487 equipment items (total value = $13 million). To determine whether equipment accountability was adequate, we reviewed equipment inventory records and a judgment sample of 25 items (value = $1.4 million). We identified three deficiencies that required corrective action.

Sensitive Equipment Policy. Although the Chief of E&MMS had developed an equipment accountability policy, it did not include procedures to identify and safeguard sensitive items. The Chief of E&MMS acknowledged this omission and immediately prepared a revised policy that included procedures to account for sensitive items.

Inaccurate EILs. We reviewed a judgment sample of 25 items assigned to 10 EILs. The EILs were inaccurate for 13 of the 25 items (52 percent). For 12 of these 13 items, the locations were either missing or incorrect. For the remaining item, the item and serial number on the EIL were incorrect.

E&MMS staff had assigned IRM Service the responsibility for maintaining the EIL covering 5 of the 13 inaccurate items (camcorder, digital camera, digital computer, barcode reader, and a pentascanner). The camcorder and barcode reader could not be located during our review, both because the EIL did not include the item locations and because IRM did not maintain records showing who had been assigned the items or where they were supposed to be located.

EIL Inventories Untimely. VA policy requires responsible officials, such as service chiefs or their designees, to conduct EIL inventories. Inventories must be conducted semiannually, annually, or biannually depending upon the accuracy of previous inventories. Responsible officials must certify that all equipment assigned to their areas is accounted for and recorded in EILs. E&MMS employees are responsible for inventory coordination, which includes notifying all services when inventories are due and following up on delinquent inventories. For EILs with fewer than 100 items (all 47 of the medical center's EILs), inventories must be completed within 10 days of notification that the inventory is due. We found two inventory deficiencies.

- For 32 of the 47 EILs (68 percent), inventories had not been completed on time, ranging from 9 to 145 days late. This occurred because E&MMS employees did not follow the inventory schedule when notifying services that inventories were due and did not aggressively follow-up on delinquent inventories.
- For 42 of the 47 EILs (89 percent), the inventory dates were incorrect because E&MMS employees took 32 to 145 days to update the EILs after receiving certification that the inventory had been completed.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires the Chief of E&MMS to: (a) revise and implement medical center equipment accountability policy to include sensitive items, (b) ensure that EILs are updated to accurately reflect the status of all equipment, and (c) perform equipment inventories in accordance with VA policy.

The VISN and Medical Center Directors agreed and reported that in December 2004 the medical center issued an updated equipment accountability policy that included sensitive equipment items. By March 31, 2005, all EILs will be updated to accurately reflect the status of all equipment. In addition, the Inventory Management Specialist will ensure that periodic equipment inventories are conducted in accordance with VA and medical center policy. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Pharmacy Security – A Vault Wall Should Be Reinforced and Door Hinges Upgraded

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

- The east wall of the outpatient pharmacy vault, which was adjacent to a hallway with public access, was constructed of drywall with no steel reinforcement. VHA policy requires that pharmacy vault walls be reinforced with steel.
- All six pharmacy doors had exterior hinges with pins that could be easily removed. VHA policy requires that such hinges have nonremovable pins. During our onsite review, Engineering Service corrected this problem by welding the pins to the hinges so the pins could not be removed.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director takes action to have the east wall of the outpatient pharmacy vault reinforced with steel.

The VISN and Medical Center Directors agreed and reported that in November 2004 the east wall of the outpatient pharmacy vault was reinforced with steel. The improvement actions are acceptable, and we consider the issue resolved.

Appendix A

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 10, 2004

From: Director, Veterans Integrated Services Network 23 (10N23)

Subject: **Fargo VA Medical Center Fargo, ND**

To: R.G. Snow, J.D.
Department of Veterans Affairs
Office of Inspector General
Associate Director
Healthcare Inspections (54DC)

Attached is the response to your recommendations from your CAP review conducted at Fargo VAMC the week of October 18-22, 2004.

ROBERT A. PETZEL, M.D.

Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 7, 2004

From: Director, Fargo VA Medical Center

Subject: **Fargo VA Medical Center Fargo, ND**

To: R.G. Snow, J.D.
Department of Veterans Affairs
Office of Inspector General
Associate Director
Healthcare Inspections (54DC)

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(s) 1. We recommend the VISN Director ensure that the Medical Center Director requires that Service Line directors: (a) consistently analyze QM data and identify opportunities to improve the quality of patient care, (b) monitor the implementation of recommended corrective actions from QM reviews, (c) ensure accountability for implementing improvements and reporting the effectiveness of corrective actions to appropriate committees, and (d) record corrective actions progress in committee minutes.

Concur **Target Completion Date: May 1, 2005**

Concur with the findings. Currently reviewing restructuring needs in terms of committees, minutes, and reporting mechanisms that would improve the action items identified in 1(a)-(d). With the new structure; Service Line Directors, Program Managers/Coordinators, and Committee Chairpersons would require education to impart clear understanding of the expectations.

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensures that the Medical Center Director requires: (a) the removal of all protected patient health information from the medical center's intranet, (b) employees secure documents containing private patient information, and (c) employees lock unattended computer screens to prevent disclosure of confidential patient information.

Concur **Target Completion Date: March 31, 2005**

Concur with the recommendation; however feel a comment is in order on (a) of the recommendation. Modification of terminology may mitigate the severity of the found problem as stated. The Medical Center does not have an intranet site. The location referenced is an internal network shared drive accessible to authenticated local users. This does limit the number of people who would have had access to the information specified. Information of this type will be kept on a drive that is encrypted or has severely limited access. The referenced information was immediately removed at time of the OIG review and other posted minutes were reviewed.

The security of patient information has been an ongoing component of annual training of all employees and is part of all new employee orientation. An approach to review and interact in the immediate environment will provide a more proactive approach to review and promote compliance. Weekly environmental rounds provide an already established avenue to identify and track the safeguarding of patient information and will utilize this as a means for ongoing feedback.

Recommended Improvement Action(s) 3. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) medical records include adequate documentation, (b) insurance bills are issued promptly, and (c) bills are pursued more aggressively.

Concur Target Completion Date: January 31, 2005

Concur with the findings and recommendations.

3(a) Identified the need to establish written guidelines for providers regarding the clinical documentation requirements to support billing. Noted trends in regard to inadequate clinical documentation will be highlighted to facilitate focused improvements efforts.

3(b) Resources has been an issue with timely collections and a 0.5 FTE has been approved to meet workload needs. Anticipate the FTE on board December 12th, with a target to be in alignment with the national goal of 45 days to bill by the end of January.

3(c) The backlog of insurance bills has prevented the facility from adequately using telephones calls to follow up on payments that are overdue. In the absence of the telephone call follow-ups, we have employed the automatic printing of second and third notices that are forwarded to the appropriate third party. When the backlog has been eradicated, will implement a telephone follow up process at the time the third notice is sent, as outlined in MP-4, Part VIII, Chapter 19.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires Engineering Service and E&MMS to fully implement GIP and reduce excess supply inventories.

Concur Target Completion Date: September 30, 2005

As a small facility minimum reorder levels often exceed a 30 day threshold level, which is an ongoing challenge. Will continue adding inventory items to GIP and ensure the reorder points have been adjusted to reflect reductions associated with the demand of use for the supplies. Engineering will review existing supplies and those deemed unnecessary will be excessed from inventory.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) develop contingency plans for required services and test the plans annually, (b) promptly terminate VistA accounts for individuals that do not have a continued need for access, and (c) follow up on all background investigation requests.

Concur Target Completion Date: March 31, 2005

Concur with the recommendation, with the following comments.

5(a) After the review and continued conversations between Performance Improvement, ISO, and the OIG Audit Team Leader, it was agreed that the Medical Center Circulars (IM-12 & IM-16) was an acceptable contingency plan to cover the computer applications for all the patient care Service Lines and organizational functions. This ensures consistency in back up plans and same level of care in response actions. Agree that additional formalized documentation of

Contingency Plan testing & critique for computer downtime are needed and Service specific contingency plans should be devised to address automations unique to their area that is not part of an organizational function.

5(b) Concur. Termination of inactive local users was accomplished immediately after the review. A second list of inactive remote user accounts provided to the OIG reviewer included inactive remote users from other VA sites with access to Fargo's VISTA. This list is under review and used to terminate access for those who do not maintain their VISTA account by signing on every 90 days and updating their verifying code. All areas of user access will be in a continuously weekly review to ensure compliance.

5(c) The ISO will set up reminders on a six-month basis to follow up with HR on outstanding requests. HR will establish the inquiry as to status of background investigations.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires the Chief of E&MMS to: (a) update and implement medical center equipment accountability policy to include sensitive items, (b) ensure that EILs are updated to accurately reflect the status of all equipment, and (c) perform periodic equipment inventories in accordance with VA policy**.**

Concur Target Completion Date: March 31, 2005

The Medical Center equipment accountability policy was updated and published December 1, 2004. The updated policy included the sensitive equipment items. The EILs are currently being updated to accurately reflect the status of all equipment. Medical Center policy has outlined the periodic equipment inventory requirements and the Inventory Management Specialist will ensure the inventories are conducted accordingly.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director takes action to have the east wall of the outpatient pharmacy vault reinforced with steel.

Concur **Target Completion Date: Completed**

Steel was added to the east pharmacy wall with sheet rock reinstalled on November 24, 2004. The wall currently awaits completion of painting.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds	Questioned Costs
3	Better use of funds by improving MCCF procedures.	$63,746	
4	Better use of funds by reducing excess engineering supply inventories ($943) and medical and prosthetic supply inventories ($9,556).	10,499	
	Total	$74,245$0	

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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