Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana

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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 Veterans Affairs (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 September 13-17, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

This CAP review focused on 16 areas. As indicated below, there were no concerns identified in three of the areas. The remaining 13 areas resulted in recommendations for improvement.

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

- Part-Time Physician Time and Attendance
- Quality Management Program
- Unliquidated Obligations

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

- Senior managers' support of the Quality Management Program was commendable.
- Voluntary Service and Community-Based Extended Care Program staff initiated the Volunteer In-Home Respite Care Program to improve care provided to homebound patients.

We identified 13 areas that needed additional management attention. To improve operations, the following recommendations were made:

- Correct safety and environmental deficiencies.
- Maintain accountability over controlled substances awaiting disposal.
- Ensure that the bulk oxygen utility system is properly maintained and monitored by trained employees.
- Develop and implement an action plan to address the physical plant's vulnerability to external attack.
- Reduce the backlog of unbilled episodes of medical care.

- Reduce excess medical, prosthetic, and engineering supplies and improve controls over supply inventories.
- Strengthen Supply Processing and Distribution (SPD) environment and inventory controls.
- Complete action to request appropriate background investigations for staff in high and moderate-risk positions.
- Maintain cardiopulmonary resuscitation certification of clinically active employees, ensure that medical record documentation is complete, and review moderate sedation policy.
- Strengthen procedures for conducting unannounced audits of the Agent Cashier advance.
- Improve accounts receivable follow-up collection action documentation.
- Improve contract file documentation.
- Improve timeliness of Government purchase card transaction approvals.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

VISN 11 Director Comments

The VISN Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendix A, beginning on page 22, for the full text of the Director's comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in Indianapolis, Indiana, the medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based clinics located in Terre Haute and Bloomington, Indiana. The medical center is part of VISN 11 (http://www.va.gov/directory/) and serves a veteran population of about 222,000 in a primary service area that includes 31 counties in Indiana. The referral area for the medical center includes all of Indiana and central Illinois.

Photograph 1 - Medical Center

Programs. The medical center provides medical, surgical, psychiatric, neurological, and rehabilitation care. The medical center has 150 hospital beds and operates several regional referral and treatment programs including comprehensive cardiac care, radiation oncology treatment, and community-based extended care. The medical center has sharing agreements with the Department of Defense and plays a key role in disaster preparedness as a federally designated coordinating center for the National Disaster Medical System.

Affiliations and Research. The medical center is affiliated with Indiana University School of Medicine and supports 104 medical resident positions in 22 training programs. The medical center is also affiliated with 16 other colleges and universities in a variety of healthcare disciplines including nursing, dentistry, pharmacy, and allied health sciences. In Fiscal Year (FY) 2003, the medical center research program had 311 approved projects and a budget of $10.3 million. Research topics included stroke, cholesterol, and renal disease. The Health Services Research and Development Service was designated as a Center of Excellence on Implementing Evidence Based Practice.

Resources. In FY 2003, medical care expenditures totaled $197 million. The FY 2004 medical care expenditures were $212 million, 8 percent more than FY 2003 expenditures. FY 2003 staffing was 1,481 full-time employee (FTE) equivalents, including 88 physicians, 28 contract physicians, and 424 nursing FTE.

Workload. In FY 2004, the medical center treated 46,689 unique patients, a 2 percent increase from FY 2003. The inpatient care workload totaled 6,100 discharges, and the average daily census was 109. The outpatient workload was 39,924 visits, a 5 percent increase over FY 2003.

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. As a result of the Secretary's decisions, the medical center was approved for a $25.5 million major construction project entitled "7th & 8th Floor Enhancements," which will replace the inpatient pharmacy and all medicine, surgery, intermediate care, and observation units. Funding has been approved for expansion of the Specialty and Primary Care Clinics and construction will begin in FY 2006. Additionally, a new Community-Based Outpatient Clinic (CBOC) is targeted for priority implementation by 2012. This CBOC and two others will help VISN 11 meet national access to patient care standards. Currently, VISN 11 is below the 70 percent standard for providing access to primary care within 30 miles of veterans' homes in Illinois (54 percent) and Indiana (63 percent). (Reference - Contracting for Care, Community-Based Outpatient Clinics: Crosscutting, 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 medical centers use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on the recommendations and suggestions included in our previous CAP report of the medical center (Combined Assessment Program Review Richard L. Roudebush VA Medical Center, Indianapolis, Indiana, Report No. 00-00709-088, dated May 31, 2001).

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

- Accounts Receivable
- Agent Cashier
- Bulk Oxygen Utility System
- Contracting
- Controlled Substances
- Emergency Preparedness
- Environment of Care
- Government Purchase Cards
- Information Technology Security
- Medical Care Collections Fund
- Moderate Sedation
- Part-Time Physician Time and Attendance
- Quality Management Program
- Supply Inventory Management
- Supply Processing and Distribution
- Unliquidated Obligations

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees and 162 responded. We also interviewed 30 patients during the review. The survey results were shared with medical center managers.

The review covered medical center operations for FY 2002, FY 2003, and FY 2004 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strengths

Senior Managers' Support of the Quality Management Program Was Commendable. The medical center's QM program was effective. Senior managers demonstrated their support for performance improvement through active participation on performance improvement and oversight committees. They were also members of root-cause analysis teams, and supported clinician participation on these teams. Senior managers ensured that sufficient resources were available to accomplish QM initiatives. The risk management and patient safety review findings were complete and demonstrated thorough analysis to detect trends, recommendations for corrective actions, implementation plans, and follow-up reviews.

Volunteer In-Home Respite Care Program Initiated to Enhance Primary Care Provided to Homebound Patients. Voluntary Service and Community-Based Extended Care Program staff began the Volunteer In-Home Respite Care Program in February 2004. Patients enrolled and receiving care at the medical center are eligible to receive this care. As part of the patient care plan, a Primary Care Team refers homebound patients to the Voluntary Service Respite Coordinator. The patient's primary caregiver at home completes and returns an application packet to the coordinator. The coordinator matches a suitable volunteer with the family. On the first visit, the coordinator, volunteer, patient, and caregiver establish a weekly schedule of visits. Respite care visits are from 2 to 4 hours long and are available Monday through Friday between 8:00 a.m. and 4:30 p.m. The volunteers send reports of each visit to the coordinator who shares the information with the primary care physician. The Primary Care Team is available to caregivers and patients for clinical questions and follow-up.

At the time of our review, the Volunteer In-Home Respite Care Program had served 14 patients, 8 of whom were still enrolled. Eighteen volunteers have received specialized training to provide respite care. Survey responses indicated that caregivers, patients, and physicians were positive and enthusiastic about the program.

Opportunities for Improvement

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

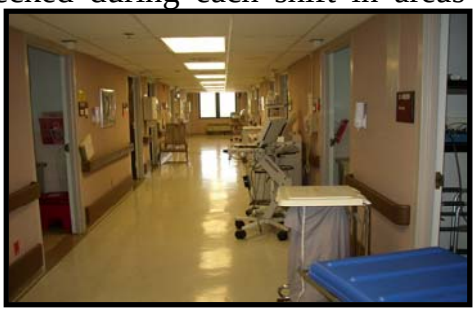
Condition Needing Improvement. Environment of care inspections were conducted on five inpatient units and six outpatient areas. Medical center managers needed to ensure that medications were secured; that patient safety, infection control, and patient privacy issues were corrected; and that computer security was maintained.

Medication Security. On one inpatient unit, two medication carts were unattended and unlocked, and intravenous medications with patient names and identifying information were hanging unsecured on the medication carts. Unauthorized employees, such as housekeepers, knew the numeric code to access the medication room on this unit. Two inpatient medical units did not have locked areas, other than medication carts, to secure medications and patient care products. These items were stored on counter tops or in unlocked cabinets at nurses' stations. On another inpatient unit, a housekeeper had a key to the medication room. One of two medication room doors was propped open allowing access by any employee at the nurses' station. A medication cart was unattended and unlocked. Medications must be secured and accessible only to authorized employees to ensure patient safety and to prevent diversion of controlled substances.

Patient Safety Concerns. Phlebotomy supply totes with blood drawing needles were unsecured at the nurses' stations on two inpatient units. Sharp items were unsecured and accessible to patients on two inpatient units and in two outpatient clinic areas. A syringe with an uncapped needle was on the floor in the gastrointestinal laboratory. Additionally, containers used to dispose of sharp items had large openings that could allow items within them to be removed. Sharp items should be secured in patient care areas to prevent accidental or purposeful injury.

Emergency nurse call systems were inaccessible to patients on two inpatient units. Emergency call systems need to be accessible to patients.

Medical center policy requires that crash carts be checked during each shift in areas where patient care is provided 24 hours a day. These checks were not done during three day shifts on one unit and during two day shifts on another unit. Crash cart checks are necessary to ensure that carts are ready for use in the event of a medical emergency.



Photograph 2 - Items Stored on Inpatient Hallway

Several inpatient units had soiled linen receptacles, laptop computer mobile stands, treatment carts, medication carts, and chairs stored in hallways.

Patient rooms were crowded with multiple items, making exit difficult. Nurse managers told us that items must be removed from rooms to bring in other patient care equipment.

In five patient care areas, biohazardous waste and contaminated instruments were held in unlocked storage rooms. Biohazardous waste and contaminated items need to be held in designated locked rooms.

Infection Control Issues. We noted soiled fabric-covered chairs and damaged pillows that needed replacing. These items present an infection risk.

Patient Privacy and Computer Security. There was no auditory and visual privacy for patients receiving treatment in the emergency room (ER). Sensitive printed patient information was accessible to the public in two patient care areas. There were laptop computers in patient care areas that were open and unattended allowing access to software programs, the Internet, and personal files that did not require passwords. There was one personal computer with an electronic patient medical record accessible to the public. Employees are responsible for restricting access to patient information and to protect computer systems from unauthorized users.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) medications are secured and areas where medications are stored are only accessible to authorized employees; (b) sharp items in patient care areas are secured, (c) emergency nurse call systems are easily accessible to patients, (d) crash cart checks performed are documented, (e) exits are unimpeded in patient care area hallways and patient rooms, (f) biohazardous waste and contaminated items are held in designated locked rooms, (g) furniture and pillows used by patients are regularly inspected and replaced if needed, (h) visual and auditory privacy is maintained for patients in the ER, (i) printed patient information is protected, and (j) access to computerized patient information and programs is restricted to authorized employees.

The VISN Director agreed with the findings and recommendations. QM monitors have been established and nursing staff have been instructed to ensure that intravenous medications and medication carts are secured. Secure places to store unit stock medications will be identified. Funding for replacement medication carts with automatic lockdown and secure narcotic dispensing machines has been requested from the VISN. Staff will be reminded to secure all sharps in patient care areas. New sharps containers will be evaluated for improved safety. Staff will be instructed to ensure that nurse call systems are accessible to patients at all times.

The Nursing Performance Improvement Committee will review data from Performance Improvement monitors that are being established to ensure that crash cart checks are completed on every shift. The Environment of Care rounds will monitor placement of items along one side of hallways to ensure exits are unimpeded. New inpatient units, for

which funding is already approved and activation scheduled for Spring 2007, will resolve the patient room size and equipment storage issues. The Environment of Care rounds will monitor storage of biohazardous waste to ensure that it is held in a locked location. Infection Control and Design will develop a plan to assess and replace soiled and damaged chairs and bedding.

ER staff will be instructed to use only one bed in the ER treatment bays to ensure auditory and visual privacy. Staff will be reminded to protect patient information, both printed and electronic. The Information Security Officer (ISO) will monitor compliance with use of privacy screens to ensure patient information is safeguarded. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances – Accountability over Controlled Substances Awaiting Disposal Needed To Be Improved

Condition Needing Improvement. Accountability and security of controlled substances in Pharmacy Service were generally effective. Physical security was adequate, and the number of staff accessing the pharmacy vault was within permitted limits. Pharmacy Service staff maintained a perpetual inventory of controlled substances and conducted required Drug Enforcement Agency biennial inventories. However, improvement was needed in accounting for returned and wasted controlled substances that were awaiting disposal.

VA policy requires that wasted, expired, and otherwise unusable controlled substances be returned to the pharmacy, inventoried, and securely stored until destroyed. Accountability over some controlled substances that were pending destruction was inadequate because they had not been inventoried. These were stored in an open container under a worktable in the outpatient pharmacy vault. Pharmacy Service employees stated that these controlled substances had been returned by patients or were wasted. Available records were inadequate to show what controlled substances should have been in the container. Although Pharmacy Service staff kept records of controlled substances that patients had returned, they did not keep records of other controlled substances that had been added to the container such as expired and wasted controlled substances. In addition, staff did not keep records of any disposals that may have been made from the container.

At our request, Pharmacy Service staff conducted an inventory of the container and counted 5,620 doses of 26 different controlled substances. These included 1,618 oxycodone tablets of various strengths, 847 hydrocodone tablets, and 345 morphine tablets. Neither the Chief, Pharmacy Service, who had been hired only 2 months prior to our review, nor the Controlled Substances Coordinator were aware that controlled substances were in the container. Consequently, they had not been included in monthly controlled substances inspections, nor had they been included in monthly destructions of

other expired, wasted, and returned controlled substances. The Pharmacy Service technician who was responsible for the vault stated that controlled substances accumulated in the container for about a year prior to our review. This employee had not been trained in procedures to account for expired, returned, and wasted controlled substances.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to maintain accountability over controlled substances awaiting disposal and train Pharmacy Service staff in accountability procedures.

The VISN Director agreed with the findings and recommendations. The medical center developed a new procedure during the CAP review. For returned controlled substances, staff verifies quantities, maintains complete logs, and securely stores items until they can be destroyed by the designated contractor. Pharmacy Service staff responsible for the vault was trained in the new procedure. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Bulk Oxygen Utility System – Additional Guidance and Controls Were Needed

Condition Needing Improvement. The purpose of our review was to determine whether the medical center was in compliance with the Veterans Health Administration (VHA) Patient Safety Alert, published on April 5, 2004, and whether internal controls were in place to ensure a safe, secure, and available bulk oxygen supply. Medical center managers needed to establish policy detailing employee responsibilities and procedures related to the bulk oxygen utility system. The policy should ensure that employees responsible for monitoring oxygen levels are trained to recognize and respond to abnormal conditions, that bulk oxygen system levels are appropriately monitored and documented, and that gauges on the bulk oxygen tanks are accurate and functioning properly.

Bulk Oxygen Policy. Engineering Service policy addressed employees' responsibilities and procedures for the bulk oxygen system. However, Acquisition and Materiel Management Service (A&MMS) responsibilities, such as ordering oxygen deliveries and monitoring daily oxygen tank levels, were not part of that policy. The medical center needed to issue a policy to address employee responsibilities and procedures for ordering bulk oxygen, monitoring oxygen levels, and maintaining the bulk oxygen system.

Training. Training records showed that three Engineering Service employees who had bulk oxygen system responsibilities received training in June 2004. However, there was no evidence of bulk oxygen training for three A&MMS employees who had responsibility for the bulk oxygen system. Training is needed so that employees who

monitor oxygen levels are able to recognize abnormal conditions and initiate appropriate responses.

Monitoring and Documenting Oxygen Levels. A&MMS employees read gauge levels for the main and reserve oxygen tanks daily. The gauge level readings were recorded on a monthly calendar blotter in A&MMS, and the information was discarded at the end of each month.

Main Oxygen Tank. Recorded gauge level readings showed that on September 1, 2, and 3, 2004, the main oxygen tank level was 300 inches each day. However, Engineering Service managers stated that the full capacity of the main oxygen tank was 285 inches. The readings for September 7 and 8 were 200 inches each day. Engineering Service managers stated that the medical center's average daily oxygen usage was approximately 7 to 8 inches. The A&MMS employee conducting the readings did not recognize that identical readings on consecutive days or a reading of more than 285 inches indicated that the gauge could be malfunctioning. The main oxygen tank was equipped with an alarm that sounded when the gauge indicated that the level of oxygen was 60 inches. With a malfunctioning gauge, the actual level of oxygen in the main tank could be below 60 inches, and the low-level alarm would not sound. Without an accurate daily reading, it was not possible to know the actual amount of available oxygen.

Reserve Oxygen Tank. Engineering Service managers told us that the gauge level on the reserve oxygen tank remained at a constant 90 inches because the vendor made oxygen deliveries before the reserve was needed. The calendar blotter recording of the reading taken between 8:00 and 8:30 a.m. on the morning of September 14, 2004, was 90 inches. However, during our inspection at approximately 11:00 a.m. on the same day, the reserve gauge read 71 inches. The Engineering Service Operations Supervisor told us that the reserve oxygen tank reading was 64 inches on the following morning. An alarm which should have activated when the reserve oxygen tank was used did not activate.

Photograph 3 - Reserve Oxygen Tank

Oxygen Delivery. Employees monitored oxygen deliveries from the vendor. However, no recordings were made of the main and reserve oxygen tank levels after each delivery. It is important to record these readings so that the A&MMS employee who takes the readings on the following morning has a reference point to determine if there is a problem with the system.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) a medical center policy details Engineering Service and A&MMS employee responsibilities and procedures for ordering

bulk oxygen, monitoring oxygen levels, and maintaining the oxygen system; (b) employees involved in bulk oxygen system activities receive training to include recognizing abnormal conditions and initiating corrective actions; (c) a formalized record keeping system for daily oxygen tank level readings is instituted to include post-delivery recordings; and (d) gauges on bulk oxygen tanks are accurate and function properly, to including reserve tank alarms.

The VISN Director agreed with the findings and recommendations. A&MMS and Engineering Service managers will develop a medical center memorandum that will detail responsibilities and procedures including establishment of a formalized record-keeping procedure. The medical center will ensure that all employees involved in bulk oxygen system activities receive training. The medical center completed replacement of the reserve tank and piping and gauges for both the main and reserve tanks. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Preparedness – Exterior Access Vulnerabilities Needed To Be Corrected

Condition Needing Improvement. VHA has mandated that medical centers have comprehensive and effective emergency preparedness programs and that heating, ventilation, and air conditioning (HVAC) systems comply with National Institute for Occupational Safety and Health guidelines. Medical centers are required to participate in the National Disaster Medical System and collaborate with State and other public and private entities to provide health services and health-related social services in response to a public health emergency. A previous OIG report, ***Facilities and Review of Security and Inventory Controls Over Selected Biological, Chemical and Radioactive Agents owned or controlled by the Department of Veterans Affairs***, OIG Report No. 02-00266-76, dated 3/14/2002, recommended that VA redefine and strengthen security and access requirements and procedures for safeguarding high-risk agents and materials used in medical centers that might be used by terrorists. In June 2004, a consulting firm conducted an HVAC and site assessment on behalf of the medical center to identify vulnerabilities and make recommendations. Medical center managers had ordered speed bumps and barricades to correct exterior access vulnerabilities but there was no specified delivery date. The following conditions needed management attention to address exterior access vulnerabilities.

Photograph 4 - Aerial View of Medical Center

Campus Access. Pedestrian and vehicular access to the campus was not restricted. There was no screening of individuals or vehicles entering the campus and no perimeter fencing. This urban

medical center was located within a large complex of buildings and near a busy highway. Without a secure and controlled perimeter, unauthorized persons could gain access to the medical center campus and buildings.

Building Access. The medical center had three public entrances, one facing West Tenth Street and two on the east side of the main building for the Atrium and the ER. These entrances were not protected by speed bumps or barricades. A city bus made designated stops near the ER entrance. Vehicles were parked next to the building at the ER entrance and in several other locations around the medical center.

During normal business hours, there were over 40 entrances into the medical center buildings. After business hours, the number of open doors was reduced but medical center managers were unable to specify the exact number that remained open. Uncontrolled access into the building created a security vulnerability.

Surveillance System. The medical center used internal and external surveillance cameras and police officers to monitor medical center activity. One police officer monitored the surveillance cameras at all times while other officers patrolled the campus. At night, surveillance cameras provided images that were too dark to be viewed by police officers. Replacement of the current surveillance system with a new system that would provide better night images was planned but had not been installed as of our review.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director develops and implements an action plan to address the medical center's external access vulnerabilities.

The VISN Director agreed with the findings and recommendations. Medical center managers are continuing to upgrade site security. A comprehensive plan is being developed and will be implemented. The improvement plans meet the intent of our recommendations and are acceptable. We will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Billing for Medical Services Needed To Be More Timely

Condition Needing Improvement. Medical Care Collections Fund (MCCF) staff verified patient insurance, identified billable episodes of care, billed appropriate amounts, and ensured collection efforts were prompt. The medical center's collection rate for insurance receivables exceeded VHA's goals for FYs 2002 and 2003. However, the amount of time to initiate a bill after providing medical services needed to be reduced.

During FY 2004 through July 2004, MCCF staff took an average of 62 days to initiate a bill from the date a medical service was provided. In addition, among a sample of 55 episodes of medical care that occurred between October 2002 and June 2004, there were

only 25 that had been billed as of September 10, 2004. These averaged 61 days to initiate. This was in comparison to VISN 11's standard of 45 days. To maximize collections, the MCCF Coordinator prioritized bills based on the type of care provided. Usually, higher cost services, such as inpatient care and surgery, took precedence over outpatient services. Consequently, lower cost episodes of care remained unbilled for inordinate lengths of time.

As of August 31, 2004, there was a backlog of 5,506 unbilled episodes of medical care valued at $1.8 million. Based on our experience at other VA medical facilities, about 25 percent of these episodes will prove unbillable for a variety of legitimate reasons. Therefore, there was about $1.35 million worth of billable episodes of care that MCCF staff had not yet billed. Based on the medical center's historical collection rate of about 40 percent for its MCCF billings, the medical center could collect about $540,000 if it billed for these episodes of care.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to reduce the backlog of unbilled episodes of care.

The VISN Director agreed with the findings and recommendations. The VISN has developed a plan to address unbilled episodes of care which includes increasing staffing that will focus on smaller billable and collectable amounts. Existing staff will focus on high-yield collections. The medical center will continue to prioritize unbilled episodes of care to assure billing cost effectiveness. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Excess Inventories Needed To Be Reduced and Inventory Controls Improved

Condition Needing Improvement. VHA policy establishes a goal that medical facilities carry no more than a 30-day supply of medical, prosthetic, and engineering supplies. To assist medical facilities in meeting this goal, VHA policy requires use of the automated Generic Inventory Package (GIP) for medical supplies and recommends its use for other types of supplies. In addition, VHA policy recommends use of the Prosthetics Inventory Package (PIP) for prosthetic supplies. Inventory managers can use GIP and PIP to establish normal stock levels, analyze usage patterns, determine optimum order quantities, and conduct physical inventories.

In FY 2003, the medical center spent approximately $19 million on medical, prosthetic, and engineering supplies. In FY 2004, through August 31, 2004, it spent approximately $18 million for these supplies. To determine the accuracy of data recorded in GIP and PIP and to test the reasonableness of inventory levels, we reviewed inventory data and selected a judgment sample of supply line items from each system. Two conditions

needed corrective action. Excess inventory needed to be reduced, and the accuracy of GIP and PIP data needed to be improved.

Excess Inventory. Medical center staff needed to monitor supply usage rates and adjust stock levels to achieve VHA's 30-day supply goal. Excess supply inventories consume medical center funds that could be put to other uses. As of September 14, 2004:

- Nine of 10 sampled Radiology Service and Cardiac Catheterization Laboratory medical supply items had stock levels ranging from 31 days to over 3 years. The value of supplies that exceeded 30 days was $13,870.
- Six of 10 SPD sampled medical supply items had inventory levels ranging from 45 days to 3 years. The value of supplies that exceeded 30 days was $3,756.
- Based on estimates by Engineering Service staff, 3 of 10 sampled engineering supply line items[1] had stock levels ranging from 75 days to 6 months. The estimated value of supplies that exceeded 30 days was $2,729.
- All 11 prosthetic supply line items sampled had stock levels of 1 year or more. The value of supplies that exceeded 30 days was $24,770.

In addition, as of September 14, 2004, "Days of Stock" on Hand reports from GIP showed:

- 1,110 Radiology Service and Cardiac Catheterization Laboratory medical supply line items valued at $521,000 had stock levels in excess of 30 days. These included 769 inactive line items valued at $314,818 for which usage rates were so low that GIP could not calculate a figure for days of stock on hand. Inactive line items may include some that have inherently low usage rates but which the medical center may nevertheless require for emergency or special situations.
- 1,155 SPD medical supply line items valued at $404,000 had stock levels in excess of 30 days. These included 376 inactive items valued at $160,000. However, over the 3 years preceding our review, SPD staff had successfully reduced the overall supply inventory value from $754,366 to $481,000.

Inventory Accuracy. Information in GIP and PIP did not accurately reflect the supply levels on hand of sampled medical, prosthetic, and engineering supplies. Inaccuracies in inventory data can lead to unexpected shortages of needed supplies or premature orders for their replenishment. As of September 14, 2004:

- GIP reported for 10 sampled Radiology Service and Cardiac Catheterization Laboratory medical supply line items that there were 365 units on hand, valued at $25,560. However, our physical inventory disclosed that there were only 113 units on

[1] GIP usage data was unavailable for these three items.

hand, resulting in an overstatement of 252 units with a recorded value of $5,720. GIP overstated the units on hand by 223 percent (252 ÷ 113).

- PIP reported that there were 64 units, valued at $41,280, of 11 sampled prosthetic line items on hand. Our physical inventory disclosed that there were only 36 units on hand, resulting in an overstatement of 28 units with a recorded value of $16,510. PIP overstated sampled prosthetics supplies by 78 percent (28 ÷ 36). In addition, PIP data was inaccurate for other unsampled line items because, according to the Prosthetics Service supervisor, some supplies received between July 2004 and September 14, 2004, had not been entered into PIP.
- GIP reported that there were 6,263 units, valued at $15,717, of 10 sampled engineering line items on hand. A physical inventory disclosed that there were only 5,507 units on hand, resulting in an overstatement of 756 units with a recorded value of $3,237. GIP overstated sampled engineering supplies by 14 percent (756 ÷ 5,507).

Different factors contributed to inaccuracies in GIP and PIP data. Errors in GIP data for Radiology Service and Cardiac Catheterization Laboratory medical supplies were attributed to staff failing to record distributions from stock, particularly in Radiology Service where staff had unrestricted access to radiology supplies. Prosthetics Service staff did not use bar coding technology to automatically identify and track prosthetic supplies, although its future use was under discussion at the time of our review. In addition, Prosthetics Service staff had not been conducting physical inventories of supplies, which would have permitted identification and correction of errors in PIP data.

Due to storage space constraints, Engineering Service staff mixed supplies intended for specific construction or maintenance projects with GIP inventory supplies.[2] In addition, Engineering Service staff stated that they occasionally "borrowed" supplies from GIP inventory to support a construction or maintenance project and replaced those supplies later. Although Engineering Service staff conducted physical inventories of some supplies daily and of others monthly, the practices of mixing GIP with non-GIP inventory and of borrowing from GIP inventory likely contributed to inaccuracies in GIP data.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) reduce supply levels to a 30-day supply and eliminate unnecessary inactive line items from inventory, (b) record all supply inventory transactions into GIP and PIP, (c) obtain and use bar coding technology for prosthetic supplies, (d) conduct periodic physical inventories of prosthetic supplies, and (e) tighten controls over engineering supplies.

The VISN Director agreed with the findings and recommendations. Prosthetics Service has eliminated all inactive items. Stock levels in other areas will be reduced to the 30-day time frame. All transactions for PIP are being entered, and receipt actions will

[2] Normally, engineering supplies purchased to support a specific construction or maintenance project are not inventoried within GIP.

continue to be entered into GIP. Physical inventories will ensure correct supply amounts. Bar coding equipment has been received and will be implemented during January 2005. Inventory sheets for Prosthetics Service physical inventories will be maintained. Engineering Service will develop a log system to document use of GIP inventory. The Director's improvement plans meet the intent of our recommendations and are acceptable. We will follow up on the planned actions until they are completed.

Supply, Processing, and Distribution – Environment and Inventory Controls Needed To Be Strengthened

Condition Needing Improvement. The SPD area was neat and orderly. In addition, SPD staff fully utilized GIP to control most aspects of inventory. However, SPD staff needed to strengthen environmental controls and improve inventory controls to prevent retention of outdated stock.

Environmental Controls. VA policy requires that sterile items be stored in carefully controlled conditions that protect against extremes in temperature and humidity. The maximum allowed temperature is 72 degrees Fahrenheit. There were three broken thermostats in the SPD sterile supply storage area. On the day of our review, according to a digital thermometer, the room temperature was 74 degrees Fahrenheit. Engineering Service staff repaired the thermostats the day of our review.

VA policy also requires that SPD's sterile preparation area be cleaned at least daily and that there be a written schedule for cleaning SPD areas. On the day of our review, the sterile preparation floor was dirty with lint. The SPD Patient Service Manager stated that she had not observed anyone from Environmental Management Service (EMS) cleaning the area during the week of our review. The EMS employee normally assigned to that duty was on extended leave. As a consequence, the area had not been cleaned. In addition, neither SPD nor EMS had a written cleaning schedule for SPD areas.

Inventory Management. VA policy requires that SPD supply inventory be checked for outdated, damaged, and obsolete inventory items. The SPD supply inventory had 1,782 line items. From a judgment sample of five sterile inventory line items, two items were out of date. A box of needles had expired in August 2004, and individually packaged cotton tipped applicators inside a box had expired in August 2003. The SPD Patient Service Manager believed that someone had improperly returned the outdated items into inventory.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to strengthen SPD environmental and inventory controls.

The VISN Director agreed with the findings and recommendations. Managers have posted the schedule of cleaning for the SPD area. Engineering Service staff repaired

thermostats and are monitoring temperatures in the area. The box of cotton tipped applicators was not dated with an expiration date by the manufacturer. The manufacturer will be changing their packaging to include lot number and expiration date on the outside of the box. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Appropriate Background Investigations Were Needed

Condition Needing Improvement. Information Technology (IT) security controls were adequate in the areas of security awareness training, contingency planning, risk assessment, virus protection, computer room security, and backup and recovery. The Information Security Officer proficiently performed system audits. There was one area where management could improve IT security.

The level of background investigations performed for certain medical center staff was not correct. VA policy defines five levels of background investigations. From the lowest level to the highest, they are:

1. National Agency Check and Inquiries (NACI)
2. Limited Background Investigation
3. Minimum Background Investigation
4. Background Investigation
5. Single Scope Background Investigation

VA staff who are identified as occupying high-risk positions are required to have background investigations (level 4 above) performed, and staff identified as occupying moderate-risk positions are required to have minimum background investigations (level 3 above) performed. Eighteen of 19 medical center staff occupying positions designated as high-risk and all 19 staff occupying positions designated as moderate-risk did not have the required level of investigation completed.

According to Human Resources Management Service (HRMS) staff, requests for background investigations and minimum background investigations sent to the Office of Personnel Management (OPM) came back from OPM with only the NACI investigation (level 1 above) performed. At the time of our review, HRMS staff were in the process of identifying those staff who required an investigation higher than NACI and resubmitting requests to OPM.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director takes action to request appropriate background investigations for staff in high and moderate-risk positions.

The VISN Director agreed with the findings and recommendations. HRMS staff have forwarded requests for appropriate background investigations to VA Central Office, Office of Police & Security for those individuals occupying high risk or moderate risk positions. HRMS staff have established a database to track such requests and follow up when results are not received timely. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Moderate Sedation – Certifications Needed To Be Maintained, Documentation Needed to be Completed, and Policy Needed To Be Revised

Condition Needing Improvement. VHA regulations require that medical 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. To evaluate the moderate sedation program, we reviewed local policy, patient medical records, and clinician training records, and we interviewed clinical employees involved in administering and monitoring patients who receive moderate sedation.

The medical center established appropriate controls over the safe delivery of moderate sedation. However, clinical managers needed to ensure that clinically active employees maintain cardiopulmonary resuscitation (CPR) certifications, medical record documentation is complete, and policy is revised to include an American Society of Anesthesiology (ASA) classification[3] and quality improvement monitoring.

Training Requirements. Among five clinician training records, one did not show evidence of CPR certification at the medical center or its affiliated university. VHA regulations and medical center policy require that all clinically active employees maintain current CPR certification. Medical center policy also required that employees involved in patient care be CPR certified.

Medical Record Documentation. Among 10 medical records reviewed, documentation on medical center-created sedation assessment and monitoring forms was incomplete in at least 1 of the following areas in all 10 records: pre-procedure note, physician physical assessment, discharge criteria, post-procedure instruction, and vital signs.

Moderate Sedation Policy. The medical center's moderate sedation policy did not specify assignments for ASA classifications or quality improvement monitoring. Senior managers agreed to revise the policy to include ASA classifications.

[3] ASA classification is used to evaluate a patient's anesthesia risk.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinical employees receive CPR certification, (b) moderate sedation medical record documentation is complete, and (c) moderate sedation policy is revised to assign ASA classifications and include quality improvement monitoring.

The VISN Director agreed with the findings and recommendations. Medical center managers will ensure that all direct patient care staff receive CPR education. Managers will implement further education sessions for those specific clinical areas that administer moderate sedation to ensure that the documentation is accurate and complete. A new policy has been drafted to include ASA classification for risk stratification and quality improvement monitoring. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Agent Cashier – Unannounced Audit Procedures Needed To Be Improved

Condition Needing Improvement. Physical security of the Agent Cashier's area and equipment was adequate, and the cash advance and turnover rate were appropriate. In addition, the Agent Cashier's safe combination and duplicate keys for cash boxes were secured in the custody of the Medical Center Director. However, there were three conditions that needed to be improved.

Audit Procedures. VA policy requires that auditors account for all cash, vouchers, and receipts during unannounced audits of the Agent Cashier advance. During the four unannounced audits prior to our review, auditors did not account for $300 in cash advanced to each of four Imprest Fund Cashiers until from 1 to 22 days after the audits. This occurred because Imprest Fund Cashiers were not on duty at the time of those audits, their cash boxes were not stored where they should have been, and auditors did not take adequate action to access or secure the cash boxes in the interim.

Location of Imprest Fund Cash Boxes. The Chief, Fiscal Service and unannounced auditors stated that unwritten medical center policy required that Imprest Fund Cashiers, when not on duty, secure their cash boxes in a safe in the Police and Security Service office. However, Imprest Fund Cashiers did not always follow this policy. As a consequence, auditors could not always access the cash boxes during unannounced audits,[4] and the integrity of audit results was compromised.

During an OIG-caused unannounced audit, none of the four Imprest Fund Cashiers was on duty, and the safe in the Police and Security Service office contained only one of the four boxes. The three other boxes were located in Imprest Fund Cashiers' personal

[4] Envelopes containing spare keys to the cash boxes and the combination to the Police and Security Service safe were located in a safe in the Medical Center Director's office, which would have allowed Agent Cashier auditors to access the cash boxes during unannounced audits.

lockers. During the audit, auditors counted the one box in the safe and found it contained an overage of 3 cents. Later the same day, when another cashier reported for duty, auditors counted a second box and found that it contained exactly $300. At our request, auditors secured the other two cashiers' lockers with security tape until the contents of their cash boxes could be counted. One box contained exactly $300 and the other contained an overage of 1 cent.

Audit Timeliness. VA policy requires that the Director or a designee ensure that unannounced audits of the Agent Cashier's advance be conducted at least every 90 days. Three of the four unannounced audits conducted from October 2003 through August 2004 were not conducted within 90 days. The time of these audits ranged from 92 to 99 days. When unannounced audits are delayed beyond the required 90-day maximum period their timing becomes more predictable, which reduces their effectiveness as a control.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that: (a) auditors open and count all Imprest Fund Cashier cash boxes during unannounced audits; (b) when not on duty, Imprest Fund Cashiers store their cash boxes in a secure location that is accessible to auditors; and (c) unannounced audits of the Agent Cashier advance are conducted at least every 90 days.

The VISN Director agreed with the findings and recommendations. Medical center auditors will take action to secure cash boxes to complete audits timely. Imprest Fund Cashiers will store their cash boxes in the designated area. Managers have changed the procedures for unannounced audits of the Agent Cashier advance to ensure that audits are conducted at least every 90 days. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Documentation of Follow-Up Collection Actions Needed To Be Improved

Condition Needing Improvement. Medical center Fiscal Service staff ensured that accounts receivable were recorded timely, reconciled with individual accounts monthly, and reviewed periodically. However, documentation of follow-up collection actions needed to be improved.

VA policy requires that accounts receivable be aggressively pursued for collection and that follow-up collection actions be documented in accounting records. As of September 16, 2004, there were 118 accounts receivable worth $391,000. Sixty-seven of these (57 percent), worth $153,000, were delinquent. Among a judgment sample of 20 of these, worth $33,474, accounting records lacked documentation showing aggressive follow-up collection actions beyond automatically generated routine demand letters and referrals to the Treasury Offset Program, for 10 worth $24,490.

The Chief, Fiscal Service stated that follow-up collection activities had been delegated to the services where the debts had originated. The Chief followed up with the originating services every month to ensure that they aggressively pursued collections but did not require staff in the originating services to document their actions in accounting records. As a consequence, follow-up collection actions performed by staff in originating services were not documented in accounting records.

Recommended Improvement Action 11. We recommended that the VISN Director ensure that the Medical Center Director requires that Fiscal Service staff and other staff responsible for follow-up collection actions on delinquent accounts receivable document their actions in accounting records.

The VISN Director agreed with the findings and recommendations. Follow-up collection actions are documented in the medical center's computer system as e-mail messages. Fiscal Service managers will evaluate and seek a way to link the e-mail documentation with accounting records. The improvement plans meet the intent of our recommendations and are acceptable. We will follow up on the planned actions until they are completed.

Contracting – Contract File Documentation Needed To Be Improved

Condition Needing Improvement. Federal and VA Acquisition Regulations require that contract prices and terms be reasonable, that all aspects of negotiation and award processes be documented in contracting records, and that contracting officers monitor contracts to ensure that payments to vendors reflect the actual services provided. Contracting officers obtained cost and pricing data and prepared price negotiation memorandums detailing the contract processes. However, other contract file documentation needed improvement.

Some contracting records lacked required acquisition plans. Acquisition plans are required for contracts exceeding $1 million and are intended to facilitate attaining acquisition objectives. These plans should identify decision making milestones and should address all the technical, business, management, and other significant considerations controlling the acquisition. A review of a judgment sample of 12 contracts identified 6 (total original estimated value = $9.7 million) where the original estimated annual value exceeded $1 million. Files for five (total original estimated value = $8.7 million) of these six contracts did not contain acquisition plans.

In addition, files for 10 of the 12 contracts lacked various other kinds of required documentation. These included the results of background investigations on the contractor and its employees and Federal Procurement Data System worksheets that assemble and present contracting data for use by VA program officials and others.

Recommended Improvement Action 12. We recommended that the VISN Director ensure that Medical Center Director takes action to ensure contracting officers include required documents in contracting records.

The VISN Director agreed with the findings and recommendations. Medical center managers will include acquisition plans and appropriate checklists in contracting records. A second contracting specialist will review each contract folder to ensure completeness. Managers will continue to monitor the status of background investigations submitted to the VA Office of Security and Law Enforcement. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Cards – Approvals Needed To Be Timely

Condition Needing Improvement. Personnel responsible for controlling the medical center's Government Purchase Card Program (the purchase card coordinator, the billing officer, and the dispute officer) effectively monitored and audited purchase card transactions. Among sampled transactions, there were no examples of prohibited split purchases or inappropriate purchases. However, approving officials needed to approve Government purchase card transactions more timely.

VA policy requires that approving officials approve Government purchase card transactions within 14 days of cardholders' reconciliations. Among 36,027 purchase card transactions that occurred from October 1, 2003, through August 24, 2004, approving officials exceeded the 14-day requirement in 5,668 cases (16 percent). In those cases, approving officials took from 15 to 430 days to approve purchase card transactions. The value of these transactions was $2.8 million. Not approving Government purchase card transactions timely was widespread and not concentrated among particular approving officials. Prompt approval of Government purchase card transactions facilitates resolution of any disputes among cardholders, vendors, and the purchase card contractor.

Recommended Improvement Action 13. We recommended that the VISN Director ensure that the Medical Center Director establishes controls to ensure that Government purchase card transactions are approved timely.

The VISN Director agreed with the findings and recommendations. Fiscal Service managers and the Associate Medical Center Director will monitor timeliness of approvals of Government purchase card transactions. Fiscal Service and Information Management Service (IMS) staff are working to implement a system to generate and distribute reminders to approving officials in the e-mail system. This notification system should improve the timeliness of approvals. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2004

From: VISN Director

Subject: **Richard L. Roudebush VA Medical Center Indianapolis, Indiana**

To: Director, Chicago Regional Office of Healthcare Inspections

Thank you for allowing VISN 11 the opportunity to review the Draft Report of the Combined Assessment Program Review for the Richard L. Roudebush VA Medical Center. Both VISN management and facility management have thoroughly reviewed the recommendations.

Action plans and target dates have been outlined for each recommendation. The medical center management will ensure that all actions are completed as agreed upon and has established a tracking mechanism for all actions.

I am very pleased with this productive and positive survey. Especially, I am pleased with the patient survey results showing 29 out of 30 veterans responded positively to the care received at the Richard L. Roudebush VA Medical Center. Thank you for pointing out opportunities for improvement.

(original signed by:)
Linda W. Belton

VISN 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 Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) medications are secured and areas where medications are stored are only accessible to authorized employees;

Concur **Target Completion Date:** 3/30/05

Performance Improvement monitors have been established on the inpatient units to monitor medication cart locks. Nursing Staff will be instructed not to leave items unattended on the medication cart, such as IV [intravenous] fluids. Inpatient units will be evaluated to identify an appropriate place to secure ward stock medications. Replacement medication carts with automatic lockdown are on the VISN equipment listing for prioritization and procurement. Additionally, narcotic dispensing machines (PYXIS or similar product) have likewise been requested for funding.

(b) sharp items in patient care areas are secured;

Concur **Target Completion Date:** 4/30/05

The sharp in GI [gastrointestinal] was immediately disposed of. Staff in the area have been reminded of policy and proper disposal procedures. Regarding the large containers, the medical center will complete a commodity standards review to identify more appropriate sharps containers that have adequate openings with improved safety. Staff will be reminded of proper security of all sharps in both inpatient and outpatient areas.

(c) emergency nurse call systems are easily accessible to patients;

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

The medical center corrected the issue during the time of review by untying the cords. Staff will be instructed to ensure that emergency nurse call systems are accessible to patients at all times.

(d) crash cart checks are documented as required;

Concur **Target Completion Date:** 1/30/05

It is the policy of the medical center that crash cart checks are completed on every shift. Performance Improvement monitors are being established to monitor and ensure completion of crash cart checks. Information will be reviewed by Nursing Performance Improvement Committee.

(e) exits are unimpeded in patient care area hallways and patient rooms;

Concur **Target Completion Date:** 1/30/05

Staff will be reminded to place all items that must be in the hallway along one side in order to ensure maximum egress. The Environment of Care rounds will include this for monitoring purposes. Construction has been approved and funded for FY 2005 and activation anticipated in Spring 2007 for new inpatient units that will solve the patient room size issue as well as equipment storage issues.

(f) biohazardous waste and contaminated items are held in designated locked rooms;

Concur **Target Completion Date:** 2/28/05

Red bag waste will not be stored outside of a biohazard, locked room. It will be picked up directly from patient rooms and taken to the appropriate locked biohazard storage areas. The Environment of Care rounds will include this item to ensure compliance.

(g) furniture and pillows used by patients are regularly inspected and replaced if needed;

Concur **Target Completion Date:** 4/30/05

Infection Control and Interior Design will complete an assessment and identify a plan to correct all deficiencies.

(h) visual and auditory privacy is maintained for patients in the ER;

Concur **Target Completion Date:** 12/30/04

The medical center is currently evaluating future construction necessary to address issues of privacy in the ER. Until such time as construction can be designed, funded and completed, except in acute emergencies, staff will be instructed to only use one bed per bay.

(i) printed patient information is protected;

Concur **Target Completion Date:** 3/30/05

Staff will be reminded of policy regarding the safeguarding of patient information. An assessment of the location and use of the locked recycling bins will be completed to ensure that staff have access to secure disposal.

and (j) access to computerized patient information and programs is restricted to authorized employees.

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

Staff will be reminded to leave privacy screens in place. The Information Security Officer will monitor the compliance with use of privacy screens and will monitor for unattended, open computers. The ISO will evaluate the placement of privacy screens and computer monitors so as to ensure that the plan previously put into place is still relevant and being followed.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to maintain accountability over controlled substances awaiting disposal and train Pharmacy Service staff in accountability procedures.

Concur **Target Completion Date:** Completed

The medical center concurs with the findings and a new procedure was developed during the review. All controlled substances returned to the pharmacy are delivered to the vault where the quantity is verified and placed in a tamper-proof bag. This bag is stored in the safe in an area marked for returns. Each return is documented on the log by date, patient name, patient social security number, name of item and quantity. The returns are verified and prepared for destruction by Guaranteed Returns. Vault staff have been trained in this procedure.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) a medical center policy details Engineering Service and A&MMS employee responsibilities and procedures for ordering bulk oxygen, monitoring oxygen levels, and maintaining the oxygen system;

Concur **Target Completion Date:** 1/30/05

A&MMS in conjunction with Engineering Service will develop a medical center memorandum that complies with all requirements and outlines responsibilities and procedures.

(b) employees involved in bulk oxygen system activities receive training to include recognizing abnormal conditions and initiating corrective actions;

Concur **Target Completion Date:** 2/28/05

The medical center has received a prototype training package and will ensure that all employees involved in bulk oxygen system activities receive training.

(c) a formalized record keeping system for daily oxygen tank level readings is instituted to include post-delivery recordings;

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

A formalized record keeping system will be instituted and involved staff will be educated. This procedure will be incorporated into the medical center memorandum.

and (d) gauges on bulk oxygen tanks are accurate and function properly to include reserve tank alarms.

Concur **Target Completion Date:** Complete

The medical center reserve tank along with piping and gauges for both the main and reserve tank had been scheduled for replacement. The replacement was completed on 12/7/04.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director develops and implements an action plan to address the medical center's external access vulnerabilities.

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

The medical center submitted a request for funding of a new camera surveillance system and other security revisions totaling $322,500 in August 2004 to the VISN which is currently prioritized as number 36 out of 44 high cost/high tech projects. Based upon the June 2004 consultation report, the medical center will continue to upgrade its site security. Engineering, Safety & Police will develop a plan that includes a prioritization and evaluation of all of the recommendations from the consultant's report and will present it to the Environment of Care Committee no later than January 31, 2005. The Environment of Care Committee will continue to monitor the application of the consultation report anticipated to be completed September 30, 2005.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director takes action to reduce the backlog of unbilled episodes of care.

Concur **Target Completion Date:** 4/30/05

The VISN has developed a plan to address unbilled episodes of care which includes increasing staffing levels prior to the implementation of the Consolidated Patient Accounts Center. The recruitment for those positions is expected to take place beginning January 2005. Space at the Indianapolis VAMC has been set aside for this use. The Indianapolis VAMC will continue to prioritize unbilled episodes of care to assure billing cost effectiveness. Many of the unbilled episodes are instances of Medicare Supplemental Insurance where the projected collection amount does not exceed the cost to bill. The existing staff will be focused upon high yield collections. The new staff will be designed to create highly efficient collections for smaller billable and collectable amounts. We will continue to monitor and decrease the backlog of unbilled episodes of care.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) reduce supply levels to a 30-day supply and eliminate unnecessary inactive line items from inventory;

Concur **Target Completion Date:** 6/30/05

Prosthetics has eliminated all inactive items. Engineering Service Inventory was implemented in August, 2004 so the levels are new and will be adjusted over time. This new inventory will continue to be monitored and adjustments made as item history is accumulated. Radiology, Cardiac Cath and SPD will reduce stock levels to the 30-day time frame with the exception items deemed critical to be on hand for patient care with low usage. All items in the inventories will be reviewed and those items deemed critical with low usage will be identified and listed as exclusions.

(b) record all supply inventory transactions into GIP and PIP;

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

All transactions for PIP are being entered. In areas such as Radiology and Cardiac Cath, all receipt actions will continue to be entered into GIP. The medical center will ensure that physical inventory counts are completed at least quarterly to ensure no shortages of supplies or pre-mature ordering.

(c) obtain and use bar coding technology for prosthetic supplies;

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

Bar coding equipment has been ordered and received. The medical center is waiting for software modifications with implementation during January 2005.

(d) conduct periodic physical inventories of prosthetic supplies;

Concur **Target Completion Date:** Completed

Physical inventories were conducted. The area of discrepancy was the Prosthetic primary locations; when physical inventories were conducted the individual discarded the inventory sheet upon it being updated in the PIP. Now, inventory sheets will be filed. All other areas were satisfactory.

and (e) tighten controls over engineering supplies.

Concur **Target Completion Date:** 2/28/05

Engineering will develop a log system to document when items used by Purchase & Hire labor for project work originate in GIP inventory. This will ensure that when project materials are received, the GIP inventory is replenished. Additionally, Engineering Service will continue the practice than any left over materials from projects are input into GIP inventory.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director takes action to strengthen SPD environment and inventory controls.

Concur **Target Completion Date:** Complete

There is a regular schedule of cleaning in the SPD area and it was well known to all parties. However, it was not posted, but has since been posted. Engineering has repaired the thermostats and the temperature in the area is being monitored. One of the two items there were outdated was actually due to the manufacturer's packaging. The box of cotton tipped applicators did not have an expiration date on the box, giving the impression of indefinite shelf life. The manager of SPD has contacted the manufacturer who will change the packaging to include lot number and expiration on the outside box, resulting in national impact.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director takes action to request appropriate background investigations for staff in high and moderate-risk positions.

Concur **Target Completion Date:** 8/31/05

The medical center was aware of the problems with the Security Clearances for staff in high and moderate risk positions. Human Resource Management Service was in the process of verifying individual security data to insure that the appropriate level of clearances had been requested. Requests for appropriate Security Clearances have been forwarded to VACO [Veterans Affairs Central Office] Office of Police & Security for those individuals occupying a High Risk or Moderate Risk Position. A database has been established to record the Position Sensitivity Level for all occupied positions in the medical center and ensure any initial and five year re-investigation are completed. The database will be used to track the date requested and allow for follow-up with VACO Office of Police & Security when results have not been returned in a timely fashion.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) clinical employees receive CPR certification;

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

National policy mandates that the facility ensure that clinically active staff has had CPR education. The medical center will evaluate local policy and ensure all direct care staff receive education.

(b) moderate sedation medical record documentation is complete;

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

It is the policy of the medical center that medical record documentation is complete. The medical center continues to review the medical record documentation for patients receiving moderate sedation. The medical center will implement further education sessions for those specific clinical areas administering moderate sedation to ensure that the documentation is accurate and complete. Nursing leadership has begun monitoring documentation in areas delivering moderate sedation.

and (c) moderate sedation policy is revised to assign ASA classifications and include quality improvement monitoring.

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

The change to medical center memorandum has been drafted to include ASA classification for risk stratification and quality improvement monitoring. The new policy will be presented to the Executive Committee of the Medical Staff for concurrence prior to implementation.

Recommended Improvement Action 10. We recommend that the VISN Director ensure that the Medical Center Director takes action to ensure that:

(a) auditors open and count all Imprest Fund Cashier cash boxes during unannounced audits;

Concur **Target Completion Date:** 2/28/05

Imprest Fund Cashiers will be instructed to store their cash boxes in designated areas. Auditors will take action to secure cash boxes to complete the audit in a timely manner.

(b) when not on duty, Imprest Fund Cashiers store their cash boxes in a secure location that is accessible to auditors;

Concur **Target Completion Date:** 2/28/05

A plan is being developed to monitor adherence to the policy of storing cash boxes in the designated area.

and (c) unannounced audits of the Agent Cashier advance are conducted at least every 90 days.

Concur **Target Completion Date:** Complete

The medical center agrees that the timing was often greater than 90 days. Our procedure has been changed to require audits at least every 90 days instead of quarterly.

Recommended Improvement Action 11. We recommend that the VISN Director ensure that the Medical Center Director requires that Fiscal Service staff and other staff responsible for follow-up collection actions on delinquent accounts receivable document their actions in accounting records.

Concur **Target Completion Date:** 4/30/05

Follow-up actions are documented. However, they are maintained in the computer system as e-mail messages. VA Handbook 4800.1 indicates the need to document non-computer generated letters, telephone calls etc. but does not specify how they should be maintained. The purpose of the documentation is for "a critical matter in those cases where the debtor refuses to pay a debt and the case must be referred to the Regional Counsel for litigation or other action". The e-mails are used as a collection record system. The collection record is broken out into two areas: 1) routine computer generated letters and TOP [Treasury Off-Set Payment] and 2) additional aggressive follow-up. The aggressive follow up actions are initiated after the routine computer generated letters have failed to produce collections. No debts have been referred to Regional Counsel without complete back-up. Fiscal Service will evaluate and seek a way to link current documentation in e-mail with accounting records.

Recommended Improvement Action 12. We recommend that the VISN Director ensure that Medical Center Director takes action to ensure contracting officers include required documents in contracting records.

Concur **Target Completion Date:** 1/30/05

The requirement for Acquisition plans is noted and the facility will comply immediately. The appropriate checklist will be included in every contract folder. Additionally, each contract folder will reviewed by a second contract specialist to ensure completeness.

The results of background investigations that had previously been requested are dependent on VA Office of Security and Law Enforcement (OSLE). The files show that the medical center has obtained the contractor personnel names, etc. and then forwarded the information to OSLE. It is then up to OSLE to continue to move the process forward. The medical center will continue to monitor the status of the investigations.

Recommended Improvement Action 13. We recommend that the VISN Director ensure that the Medical Center Director establishes controls to ensure that Government purchase card transactions are approved timely.

Concur **Target Completion Date:** 3/30/05

Fiscal Service will identify approving officials who are not meeting the expected timeframes and work closely with the Associate Director to ensure that appropriate measure are taken to improve performance. Reports will be given to Associate Director quarterly of non-compliant approving officials. Credit card privileges will be withdrawn from non-compliant employees and non-compliant approving officials will face performance consequences.

One of the weaknesses identified locally in the purchase card approval process is the communication of items pending approval to the approving officials. Currently, automatic notifications are displayed to the approving officials through the Veterans Health Information Systems and Technology Architecture (VistA) system. Unfortunately, many of the approving officials do not access the VistA system as often as they access their Outlook mail. In an effort to accommodate those approving officials who are not frequent users of VistA, Fiscal Service is working with the IMS department to implement a system that will generate and distribute reminders to approving officials through Outlook mail. This

system has been implemented at other facilities and has proven to be successful in improving performance.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
5	Reducing the backlog of unbilled episodes of medical care would provide additional resources sooner.	$540,000
6	Reducing excess medical, prosthetic, and engineering supply inventories would free medical center funds for other uses.	925,000
	Total	$1,465,000

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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