Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Eastern Kansas Health Care System Leavenworth, Kansas

Report No. 04-02331-112 **March 25, 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 July 19–23, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Eastern Kansas Health Care System. The purpose of the review was to evaluate selected health care system operations focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 4 fraud and integrity awareness briefings attended by 94 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 15.

Results of Review

This CAP review covered 13 areas. The health care system complied with selected standards in three areas:

- Contract Award and Administration
- Controlled Substances Accountability
- Medical Copayment Billings to Veterans

We made recommendations to improve operations in 10 areas:

- Strengthen QM controls for tort claim settlements, resuscitation events, and patient complaint information.
- Develop a comprehensive moderate sedation policy and make sure providers are privileged and certified.
- Thoroughly analyze unliquidated obligations and cancel unnecessary obligations.
- Enhance Medical Care Collections Fund (MCCF) procedures by strengthening the billing process to reduce unbilled claims and by improving provider documentation.
- Fully implement information technology (IT) security controls.
- Improve oversight of the liquid bulk oxygen utility system.
- Segregate Government purchase card responsibilities.
- Limit access to the pharmacy controlled substances vault.
- Make sure supply inventory records match the actual quantities on hand.
- Ensure all overbed light pull cords are the appropriate length and are properly cleaned.

This report was prepared under the direction of Mr. William H. Withrow, Director, and Mr. Larry M. Reinkemeyer, CAP Review Coordinator, Kansas City Audit Operations Division.

VISN 15 and Health Care System Directors Comments

The VISN 15 and the Health Care System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 15–23 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Health Care System Profile

Organization. The health care system provides primary and secondary care in medicine and surgery, tertiary care in psychiatry, and a broad range of inpatient and outpatient services at medical centers in Topeka and Leavenworth, KS. Outpatient care is also provided at community-based outpatient clinics in Abilene, Chanute, Emporia, Fort Scott, Garnett, Holton, Junction City, Kansas City, Lawrence, Russell, Salina, and Seneca, KS and in St. Joseph, MO. The health care system is part of VISN 15 and serves a veteran population of about 104,000 in a primary service area that includes 33 counties in Kansas and 12 counties in Missouri.

Programs. The health care system provides medical, surgical, and mental health services and has 233 hospital beds, 138 nursing home beds, and 178 domiciliary beds. In addition, the health care system has several sharing agreements with the U.S. Army, U.S. Army Reserves, U.S. Coast Guard, and the Kansas Army and Air National Guards.

Affiliations and Research. The health care system is affiliated with the University of Kansas Medical Center and the University of Missouri School of Medicine and supports 32 medical resident positions in 6 training programs. In Fiscal Year (FY) 2004 (as of June 30), the health care system's research program had seven projects and a budget of $66,000.

Resources. The health care system's FY 2004 medical care budget was $146 million, a 6 percent increase over the FY 2003 budget of $138 million. FY 2004 (as of June 30) staffing was 1,532 full-time equivalent employees (FTE), including 86 physician and 477 nursing FTE. FY 2003 staffing was 1,514 FTE, including 80 physician and 464 nursing FTE.

Workload. In FY 2004 (as of June 30), the health care system treated 32,147 unique patients. The health care system provided 41,892 inpatient days of care in the medical center, 25,331 days of care in the nursing home, and 51,364 days of care in the domiciliary. The health care system's inpatient care workload totaled 4,098 discharges. The average daily census, including nursing home patients, was 353. The outpatient workload was 250,682 visits.

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 areas to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered selected facility operations for FYs 2002, 2003, and 2004 (through June 30) and was done in accordance with OIG standard operating procedures for CAP reviews.

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 13 areas:

Contract Award and Administration	Medical Copayment Billings to Veterans
Controlled Substances Accountability	Moderate Sedation Practices
Environment of Care	Pharmacy Security
Government Purchase Card Program	Quality Management
Information Technology Security	Supply Inventory Management
Liquid Bulk Oxygen Utility System	Unliquidated Obligations
Medical Care Collections Fund	

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. We sent electronic survey questionnaires to all health care system employees, 222 of whom responded. We also interviewed 16 inpatients and 15 outpatients during our review. We provided the survey results to health care system managers.

During the review, we presented 4 fraud and integrity awareness briefings attended by 94 health care system employees. These briefings 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.

Areas needing improvement are discussed in the Opportunities for Improvement section (pages 4–14). For these activities, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the

OIG until corrective actions are implemented. For the areas not discussed in this section, there were no reportable conditions.

Results of Review

Opportunities for Improvement

Quality Management – Controls Needed Strengthening

Condition Needing Improvement. QM controls needed strengthening to ensure:

- Physicians involved in tort claim settlements were reported to the National Practitioner Data Bank.[1]
- Resuscitation data was collected and evaluated.
- Patient complaints were reported to the Performance Improvement Leadership Council for recommendations and actions.

Tort Claim Settlements. The Credentialing and Privileging Coordinator did not have access to the National Practitioner Data Bank to ensure the health care system was in compliance with national reporting requirements. In March 2004, the coordinator contacted VISN 15 requesting access to the data bank, but as of July 2004 she still did not have access. As a result, health care system managers did not report three physicians who were involved in tort claim settlements.

Resuscitation Events. The Intensive Care Unit (ICU) Advisory Committee did not analyze resuscitation events. Joint Commission on Accreditation of Health Care Organization standards require medical facility managers to collect data and evaluate the effectiveness of resuscitation events to identify opportunities to improve patient care. The ICU Advisory Committee met quarterly and received a brief summary of resuscitation events but did not analyze the data to identify trends by location, time, provider, and problem.

Patient Complaints. The patient representative did not report patient complaints to the Performance Improvement Leadership Council. The representative did collect and trend patient complaints but made no recommendations and took no actions to improve performance and services related to patient complaints.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director: (a) obtains the required access to the National Practitioner Data Bank for the Credentialing and Privileging Coordinator; (b) requires the ICU Advisory Committee to collect and evaluate resuscitation events by location, time, provider, and problem; and (c) provides patient complaints to the Performance Improvement Leadership Council for appropriate actions.

[1] The National Practitioner Data Bank is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials.

The VISN and Health Care System Directors agreed with the findings and recommendations. The health care system assigned the QM and Performance Improvement Coordinator to coordinate tort claim management in July 2004. In October 2004, the coordinator applied for and received entity registration verification from the National Practitioner Data Bank. All resuscitative events are evaluated for quality assurance and opportunities to improve patient care. The results of the analysis, which include locations, time, provider and problems, are forwarded to the ICU Committee for review and recommendations.

In August 2004, the patient representative began reporting patient satisfaction to the Performance Improvement Leadership Council. The patient representative position will be restructured into a Service Recovery Coordinator, who will aggregate and analyze patient satisfaction data and report to the council on an ongoing basis for recommendations. Until the position is established, QM staff will collect and trend patient complaints and report to the council. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Moderate Sedation Practices – Policy Needed To Be Revised and Providers Needed To Have Current Privileges

Condition Needing Improvement. Health care system managers needed to improve their management of moderate sedation practices. The system's moderate sedation policy did not include guidelines for patient monitoring, staffing requirements, or performance monitoring. However, both Surgical and Anesthesia Services had moderate sedation guidelines that included this information. Health care system managers needed to incorporate these guidelines into the health care system policy and issue a unified policy that would govern all moderate sedation procedures.

The health care system's moderate sedation policy requires that all providers giving moderate sedation be privileged and have Basic Life Support (BLS) certification. We reviewed files on a judgment sample of five providers and found that three did not have current privileges for the health care system and one did not have a BLS certification.

Recommended Improvement Action 2. We recommended that the VISN Director ensure the Health Care System Director takes action to: (a) develop a comprehensive policy to govern moderate sedation that includes guidelines for patient monitoring, staffing requirements, and performance monitoring; and (b) make sure that all providers administering moderate sedation have current privileges and are BLS certified.

The VISN and Health Care System Directors agreed with the findings and recommendations. The health care system developed a comprehensive moderate sedation policy that meets VA standards. Moderate sedation privileges have been added to the credentialing process, and all providers who have moderate sedation privileges have been BLS certified and have taken a moderate sedation training course. The improvement

actions are acceptable, and we will follow up on the planned actions until they are completed.

Unliquidated Obligations – Controls Needed Strengthening

Condition Needing Improvement. Fiscal Service controls to monitor unliquidated obligations needed strengthening. We identified $135,582 in unliquidated obligations that were no longer necessary. Fiscal Service employees reviewed obligations monthly as required by VA policy but did not thoroughly analyze obligations and cancel unnecessary obligations.

Undelivered Orders. Undelivered orders are obligations established to pay for supplies and certain types of services that have been ordered but not delivered. As of May 31, 2004, the health care system had 426 undelivered orders totaling $6.9 million. Of these, 46 orders totaling $965,395 were at least 90 days past their delivery dates. Our review of 20 of the 46 orders found that all or parts of 7 orders totaling $129,438 were no longer needed and should have been canceled. The seven orders were obligated with "no-year" money meaning that once the funds are deobligated, the VISN can reuse the funds in current or subsequent fiscal years. Fiscal Service managers agreed with our analysis and canceled the orders.

Accrued Services Payable. Accrued services payable are obligations established to pay the estimated cost of services contracted for but not yet received. As of May 31, 2004, the health care system had 386 accrued services payable totaling $4.6 million. Of these, 13 payables totaling $104,497 were at least 90 days past their due dates. Our review of all 13 payables found that 3 totaling $6,144 were no longer needed and should have been canceled. The three payables were obligated with FY 2004 "one-year" money, meaning that if the funds are deobligated in a subsequent fiscal year, the VISN can no longer use the funds. Fiscal Service managers agreed with our analysis and canceled the payables.

Monetary Benefits. The $135,582 in monetary benefits identified by our review represents money provided to the VISN during the normal funding process. The $135,582 is not an additional revenue source and therefore does not increase the total amount of funding provided to the VISN. However, depending on when the funds are deobligated and whether the use of the funds is restricted to a particular year, canceling the unneeded obligations will free up the money and enable VA to use the funds immediately for needed goods and services that were not previously funded.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director makes certain all unliquidated obligations are thoroughly analyzed and unnecessary obligations are promptly canceled.

The VISN and Health Care System Directors agreed with the findings and recommendations. Procedures have been established to affect a thorough review of all

obligations and payables that are more than 60 days old. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Improved Procedures Could Increase Recoveries From Insurance Carriers

Condition Needing Improvement. The health care system needed to improve procedures for recovering health care costs from insurance carriers:

- The billing process for fee-basis and VA-provided inpatient and outpatient care did not make sure all potential billable claims were identified and bills were issued.
- Insurance carriers were not always identified.
- The "Reasons Not Billable Report" was not used to identify missed billing opportunities.

The health care system increased its MCCF collections from $10.5 million in FY 2002 to $12.5 million in FY 2003, exceeding its $11.5 million collection goal by $1 million. However, as discussed below, we found additional billing opportunities totaling $19,594 with estimated collections of $7,838.[2]

Fee-Basis Care. For the 6-month period ending March 31, 2004, the health care system paid 1,068 fee-basis claims totaling $290,145 to non-VA providers who provided medical care to patients with health insurance. Payments included claims for inpatient care, outpatient care, and ancillary services related to inpatient care. To determine whether the fee-basis care was billed to patients' insurance carriers, we reviewed a judgment sample of 21 claims totaling $119,646. Of these 21 claims, MCCF staff billed $116,585 for 4 of the claims. Of the remaining 17 claims, 14 were not billable to the insurance carriers because the fee-basis care was for service-connected conditions, the services provided were not covered, or reasonable charges had not been established for the care provided. The other three claims were billable. Because MCCF staff had not fully implemented new local procedures to identify potentially billable fee-basis care, they overlooked two of these claims. MCCF staff incorrectly coded the remaining claim for a service-connected condition when the care provided was for a non-service connected condition. MCCF staff issued bills totaling $1,201 for the three claims.

VA-Provided Inpatient Care. We reviewed 16 inpatient discharges occurring in March 2004 and found that MCCF staff issued bills for 14 discharges. The two remaining discharges were not billable because one veteran was treated for a service-connected condition and the other veteran's insurance was not billable.

[2] We estimated collections using the health care system's historical collection rate of 40 percent ($19,594 x 40 percent = $7,838).

For the 14 discharges, MCCF staff billed insurance carriers $314,089. However, for 2 of the 14 discharges MCCF staff overlooked billing opportunities for professional services totaling $524. MCCF staff issued bills to recover the $524.

VA-Provided Outpatient Care. We reviewed 15 outpatient visits occurring on March 24, 2004, and found that MCCF staff appropriately billed $4,844 for 5 of them. Eight of the 15 outpatient visits were not billed because veterans were treated for service-connected conditions, the care provided was not covered under the terms of the insurance plans, or the services were provided by non-billable providers.

We identified additional billing opportunities totaling $8,340 for the remaining two outpatient visits. MCCF staff had not issued bills for these two visits because an operation report had not been signed by the surgeon and a billable outpatient visit had been incorrectly coded as a non-billable visit. In addition, we identified a $127 bill that was not included in a previously billed outpatient visit. This occurred because professional fees for resident-provided care were not billable at the time of care. Under the Veterans Health Administration's (VHA) new resident supervision guidelines issued May 3, 2004, the care is retroactively billable. MCCF staff issued bills totaling $8,467 for these outpatient visits.

Verifying Insurance for Unbilled Care. The "Unbilled Care Report" for the 32-month period ending May 31, 2004, listed a single inpatient discharge and 92 outpatient visits that were at least 6 months old. Our review of the single inpatient discharge and 9 of the 92 outpatient visits found that the discharge and 3 of the 9 visits were not billable under the terms of the veterans' insurance plans. MCCF staff had issued bills totaling $379 for two of the remaining six outpatient visits. However, the other four visits should have been billed because the veterans had insurance. MCCF managers told us that at the time of care they did not know the veterans had insurance so they did not issue bills. MCCF staff issued bills totaling $974 for the care provided.

Missed Billing Opportunities. The "Reasons Not Billable Report" for the period ending March 31, 2004, listed 269 potential billings totaling $36,891 that were unbilled because of insufficient documentation, no documentation, or the care was provided by non-billable providers (residents). We reviewed 50 of the 269 potential billings totaling $14,001 and found 39 missed billing opportunities.

For 14 of the 39 missed opportunities, MCCF staff did not bill $3,465 for care because providers did not certify physical therapy treatment plans, adequately document resident supervision, or document care in the medical records. For the 25 remaining missed billing opportunities, MCCF staff did not issue:

- Fifteen bills totaling $1,916 because they were unsure of how to bill Medicare supplemental plans for physical therapy services. Upon our review, MCCF staff

determined that physician certification of treatment plans every 30 days was sufficient to comply with guidelines for billing therapy services.

- Seven bills totaling $2,089 because the bills did not have adequate supporting medical record documentation of resident supervision at the time of care. MCCF staff reviewed the bills and determined that attending physicians and residents appropriately documented resident supervision under VHA's May 2004 guidelines. MCCF staff can retroactively bill for the care provided as far back as allowed by patients' insurance policies.
- Two bills totaling $452 because providers did not promptly document the care provided. MCCF staff reviewed the bills and determined that providers had eventually documented the care.
- One bill totaling $506 for an imaging study because they overlooked it.

MCCF staff took immediate action to issue the 25 bills totaling $4,963.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Health Care System Director requires that MCCF staff make sure: (a) all bills are issued for fee-basis, inpatient, and outpatient care; (b) bills are issued when insurance is identified after the date of care; (c) bills are issued for resident-provided care that is now billable under the new guidelines; (d) physicians certify physical therapy treatment plans every 30 days; (e) resident supervision is documented; and (f) providers promptly document the care they provide.

The VISN and the Health Care System Directors agreed with the findings and recommendations. MCCF staff fully implemented a new local procedure to ensure all fee-basis, inpatient, and outpatient care is identified and billed and that the unbilled list is reviewed monthly. In addition, MCCF staff issued bills for resident-provided care under the new guidelines and provided education and training to physicians who certify physical therapy treatment plans or document resident supervision. They planned to report providers who did not adequately document care to the clinical department for action and to elevate this issue to the Compliance Officer if the providers did not improve their documentation. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Improvements Were Needed To Comply with VA and Local Policies

Condition Needing Improvement. The Information Security Officer (ISO) and Information Resource Management (IRM) Service staff needed to improve IT security controls. IRM Service staff did not regularly review server logs, control employees' access to the server during nonduty hours, include secondary telephone numbers, or

incorporate a list of computer equipment in the Veterans Health Information Systems and Technology Architecture (VistA) and Local Area Network (LAN) contingency plans.

Server Logs. IRM Service staff did not regularly review server logs. The server logs record unauthorized access attempts and other incidents, such as inappropriate alteration and use of VA data or equipment, that the ISO is required to log, investigate, review, and report to the VA Central Incident Response Capability (CIRC) office. We found no evidence that IRM Service staff reviewed the server logs. If IRM Service staff does not review the logs and they reach their maximum capacity, the logs are overwritten and critical incident information could be lost.

User Access. All employees had access to the LAN 24 hours a day, 7 days a week. VA policy restricts LAN user access to specific business hours to mitigate the threat of unauthorized modification of data and software.

Contingency Plans. VistA and LAN contingency plans did not include secondary telephone numbers or a list of computer equipment:

- The plans included primary telephone numbers for key personnel but did not include their secondary telephone numbers. VA policy requires facilities to have adequate information, including secondary telephone numbers, to reach key personnel during non-duty hours.
- The plans did not include an inventory of network interface cards, modems, servers, and workstation locations. VA policy requires each facility to develop and maintain an inventory of data, software, documentation, hardware, and supplies, including items that are located offsite.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Health Care System Director requires that the ISO and IRM Service staff: (a) review the server logs on a regular basis and initiate an analysis to determine an appropriate server log capacity configuration based on their log review plan; (b) restrict user access of employees to their specific business hours; (c) incorporate secondary telephone numbers for key personnel into the contingency plans; and (d) include an inventory of all network interface cards, modems, servers, and workstation locations in the contingency plans.

The VISN and the Health Care System Directors agreed with the findings and recommendations. Network Administrators will review and document server logs at least once a week or as warranted, and any security concerns will be immediately reported to the ISO. IRM Service staff will limit LAN access to designated employees whose areas are closed after business hours. As of January 2005, a list of primary and secondary telephone numbers was being incorporated into the contingency plans. In addition, IRM Service staff will develop an inventory of all network cards, modems, servers, and workstation locations and this inventory will be incorporated into the contingency plans.

The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Liquid Bulk Oxygen Utility System – Oversight Needed Strengthening

Condition Needing Improvement. Health care system managers needed to strengthen oversight of the liquid bulk oxygen utility system to ensure that an adequate and safe supply of oxygen is available to meet patient needs. Bulk oxygen utility systems consist of a main liquid oxygen tank and a reserve tank. The main tank is the primary source of oxygen supply, and the reserve tank is available to supply oxygen if the main tank goes empty or fails. The oxygen is distributed through main lines to the different areas of the hospital. The tanks are connected to two master panels that, according to the National Fire Protection Association, must have low oxygen level alarm signals.

Local Policy. The health care system policy did not include the specific oxygen ordering and delivery requirements, the documentation required for monitoring oxygen levels, or preventive maintenance information.

Master Panel Alarm Signals. At the Leavenworth facility, the master panels did not include low oxygen alarm signals for the main or reserve tanks.

Contract Requirements. The contracting officer's technical representative (COTR) did not enter into a written mutual agreement, as required by the VA National Acquisition Center (NAC) contract, with the local liquid bulk oxygen vendor prescribing the method of ordering oxygen and specific delivery instructions. A copy of the written agreement must be provided to the NAC for inclusion as a modification to the national contract.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director takes action to make sure: (a) the liquid bulk oxygen policy includes oxygen ordering and delivery requirements, oxygen level monitoring documentation requirements, and preventive maintenance information; (b) bulk oxygen master panels include all alarm signals; and (c) the COTR executes a written mutual agreement with the liquid bulk oxygen vendor and forwards a copy to the NAC.

The VISN and the Health Care System Directors agreed with the findings and recommendations. The local policy has been revised to address specific bulk oxygen ordering and delivery requirements, as well as maintenance for the bulk oxygen tanks. In addition, procedures now require that tank levels be monitored and recorded daily, and alarms were installed for both tanks. The written mutual agreement was prepared and provided to the NAC in November 2004. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Improvements Are Needed To Comply with VA and Local Policies.

Condition Needing Improvement. We reviewed Government purchase card usage for the 15-month period ending December 2003 and found that purchase card responsibilities were not adequately segregated.

Approval and Reconciliation Duties. Approval and reconciliation duties were completed by the same employee for 3,094 transactions during the 15-month period. This occurred because some of the cardholders were either on leave or not available to perform the reconciliations on time, so the approving official approved and reconciled the transactions. VA policy states that cardholders are responsible for reconciling payment charges and approving officials are responsible for certifying reconciliations. This prevents the approving official from reconciling and certifying the same transactions. The Purchase Card Coordinator agreed that another cardholder instead of the approving official should have performed the reconciliations.

Approving Official and Dispute Officer. A cardholder was both an approving official and a dispute officer. VA policy states that approving officials cannot be cardholders or dispute officers.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) cardholders reconcile payment charges; and (b) cardholder, approving official, and dispute officer duties are properly segregated.

The VISN and the Health Care System Directors agreed with the findings and recommendations. All duties have been segregated to ensure that only cardholders reconcile payment charges. The dispute official is now neither a cardholder nor an approving official. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Pharmacy Security – Access to the Controlled Substances Vault Needed To Be Limited

Condition Needing Improvement. Procedures limiting access to the controlled substances vault needed improvement. VHA policy requires that access to the vault be limited to fewer than 10 employees within a 24-hour period. From May 3 to May 18, 2004, we identified 10 separate 24-hour periods when 10 or more employees had access to the vault at the Leavenworth facility. This occurred because Pharmacy Service authorized six employees plus all employees holding four job positions to have access. Authorizing access for positions instead of specific employees allowed at least 18 different employees to enter the vault.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Health Care System Director implement controls to limit access to the controlled substances vault to fewer than 10 employees within a 24-hour period.

The VISN and the Health Care System Directors agreed with the findings and recommendations. In July 2004, Pharmacy Service management limited access to the controlled substances vault in accordance with VHA policy. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Accuracy Needed To Be Improved

Condition Needing Improvement. The Logistics manager needed to improve the accuracy of the supply inventories. We found that inventory balances did not agree with our physical inventory counts. To determine the accuracy of inventory balances, we selected 40 stock items valued at $6,253 from a total of 1,654 items valued at $136,336. The recorded balances were accurate for 37 items and inaccurate for 3 items. Two of the three items with inaccurate balances were underreported (quantities on hand were higher than recorded inventory balances) by $22, and one item was overreported (recorded inventory balances were higher than quantities on hand) by $56. These inaccuracies occurred because Logistics staff did not accurately record the number of items received into inventory or the number of items taken out of inventory.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Health Care System Director makes sure that inventory records match the actual quantities on hand.

The VISN and the Health Care System Directors agreed with the findings and recommendations. The discrepancies identified during the review were generally attributed to a timing delay between issuing a supply item and entering the issue data into the Generic Inventory Package (GIP). Proper procedures and timeliness of inputs have been reemphasized to all personnel. Action has been taken to ensure that all inventory transactions are input into GIP and receipted. Also, items will be issued in a timely fashion. Issues are being monitored and verified to ensure the accuracy of the quantity issued. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care – Infection Control Deficiency Needed To Be Corrected

Condition Needing Improvement. Health care system managers needed to improve the infection control program. On some units at the Topeka and Leavenworth facilities, we found gauze strips tied to the overbed light pull cords because the pull cords were too short for many patients to reach. The gauze strips were not routinely changed between

patients and were heavily soiled and stained with what appeared to be body fluids, which put patients at risk for infections. Health care system managers took immediate action and removed the gauze strips while we were onsite.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Health Care System Director takes action to ensure all overbed light pull cords are the appropriate length and are properly cleaned.

The VISN and the Health Care System Directors agreed with the findings and recommendations. All areas have been surveyed and all noncleanable cords have been replaced with nylon cords. To further emphasize the importance of this issue, a purchase order has been completed to obtain a type of pull cord with a nylon center encased in Acrylonitrile Butadiene Styrene (ABS) plastic. The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 14, 2005

From: VISN Director

Subject: **VA Eastern Kansas Health Care System**

To: Assistant Inspector General for Audit

1. In response to the Draft Report of the Combined Assessment Program review of the VA Eastern Kansas Health Care System, attached please find comments, corrective action plans, and completion dates for each recommendation as provided by the System Director.

2. I have reviewed and concur with the response and action plans prepared by the Eastern Kansas Health Care System.

(original signed by:)

Peter L. Almenoff, M.D., FCCP

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 13, 2005

From: Health Care System Director

Subject: **VA Eastern Kansas Health Care System**

To: Department of Veterans Affairs Office of Inspector General

1. Attached please find VA Eastern Kansas Health Care System's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact Linda Long, Executive Assistant to the Director at (785) 350-4512.

(original signed by:)

ROBERT M. MALONE, JR.

Attachment

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

The following Health Care System Director's comments are submitted in response to the recommendation in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure the Health Care System Director: (a) obtains the required access to the National Practitioner Data Bank for the Credentialing and Privileging Coordinator; (b) requires the ICU Advisory Committee to collect and evaluate resuscitation events by location, time, provider, and problem; and (c) provides patient complaints to the Performance Improvement Oversight Committee for appropriate actions.

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

(a) The Quality Management and Performance Improvement Coordinator (QM&PI Coordinator) at VA Eastern Kansas Health Care System (VAEKHCS) hired in July 2004 now coordinates tort claim management. The QM&PI Coordinator applied for and received entity registration verification from the National Practitioner Data Bank in October 2004. Two of the three physicians who were identified as not being reported have been reported to the National Practitioner Data Bank. The third provider is pending panel review conclusion. Once the office of the Director of Medical-Legal Affairs has reviewed this case, and we are in receipt of the panel's conclusion, we will complete the reporting process. In the future, physicians identified by the malpractice payment reporting process will be reported to the National Practitioner Data Bank in accordance with VHA Handbook 1100.17.

(b) All resuscitative events are evaluated for quality assurance and opportunities to improve patient care. Criteria for the review include the Advanced Cardiac Life Support guidelines, completeness and accuracy of the record, pre-code management, staff response and equipment functions. The results of the analysis are forwarded to the ICU Committee for review and recommendations. To further address opportunities to improve patient care, the log of locations, times, provider, and problem are incorporated into the data forwarded to the ICU Committee for analysis. The data is aggregated and analyzed to identify opportunities for system improvement.

(c) The Patient Representative began reporting patient satisfaction to the Performance Improvement Leadership Council (PILC) at the August 12, 2004, meeting. This position will be restructured into a Service Recovery Coordinator position and the Service Recovery Coordinator will aggregate and analyze patient satisfaction data and report to the PILC on an ongoing basis for recommendations. Until the position is established, Quality Management staff will collect and trend patient complaints and report to the PILC.

Recommended Improvement Action 2. We recommended that the VISN Director ensure the Health Care System Director takes action to: (a) develop a comprehensive policy to govern moderate sedation that includes guidelines for patient monitoring, staffing requirements, and performance monitoring and (b) make sure that all providers administering moderate sedation have current privileges and are BLS certified.

Concur **Target Completion Date:** Completed

(a) A comprehensive health care system policy about moderate sedation has been developed and is in place that includes guidelines for patient monitoring, staffing requirements, and performance monitoring.

(b) Moderate sedation privileges have been added to the credentialing process and all providers who have moderate sedation privileges have been BLS certified and have taken a moderate sedation training course.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Health Care System Director makes certain all unliquidated obligations are thoroughly analyzed and unnecessary obligations are promptly canceled.

Concur **Target Completion Date:** Completed

Procedures have been established to effect a thorough review of all obligations and payables that are more than 60 days old. This will ensure we comply with VA Directives.

Recommended Improvement Action 4. We recommended that the VISN Director ensure sure that the Health Care System Director requires that MCCF staff make sure: (a) all bills are issued for fee-basis, inpatient, and outpatient care; (b) bills are issued when insurance is identified after the date of care; (c) bills are issued for resident-provided care that is now billable under the new guidelines; (d) physicians certify physical therapy treatment plans every 30 days; (e) resident supervision is documented; and (f) providers promptly document the care they provide.

Concur **Target Completion Date:** Completed

(a) MCCF staff have fully implemented a new local procedure to ensure all fee-basis, inpatient, and outpatient care is identified and billed.

(b) Issuing bills when insurance is identified after the date of care is a routine process. The unbilled list is reviewed monthly and action taken to back bill those cases as appropriate.

(c) Bills have been issued for resident provided care under the newest guidelines. Resident guidelines changed six times in the past year. The most recent change was in June 2004.

(d-e) The Reasons Not Billable Report is reviewed monthly and data from the report is documented with why a visit is not billable. The report is evaluated for trends that require provider education or management intervention. Education and training have been provided to physicians who are responsible for certifying physical therapy treatment plans and to physicians who are responsible for ensuring resident supervision is adequately documented. Issues identified are now referred to the Compliance Committee.

(f) Lack of provider documentation required for billing, such as operation reports, summaries, and notes will be reported to the clinical department for action when identified by the billing department. If no action is taken, the issue will be elevated to the Compliance Officer.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Health Care System Director requires that the ISO and IRM staff: (a) review the server logs on a regular basis and initiate an analysis to determine an appropriate server log capacity configuration based on their log review plan, (b) restrict user access of employees to their specific business hours, (c) incorporate secondary telephone numbers for key personnel into the contingency plans, and (d) include an inventory of all network interface cards, modems, servers, and workstation locations in the contingency plans.

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

(a) Network Administrators review and document server logs at least once a week or as warranted, and any security concerns will be immediately reported to the ISO.

(b) IRM staff is in the process of limiting logon access to designated employees whose areas are closed after business hours.

(c) A list of primary and secondary telephone numbers are currently being incorporated into the contingency plans. In addition, IRM staff are populating an inventory of all network cards, modems, servers, and workstation locations which will be incorporated into the contingency plans as well.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Health Care System Director takes action to make sure: (a) the liquid bulk oxygen policy includes oxygen ordering and delivery requirements, oxygen level monitoring documentation requirements, and preventive maintenance information; (b) bulk oxygen master panels include all alarm signals; and (c) the COTR executes a written mutual agreement with the liquid bulk oxygen vendor and forwards a copy to the NAC.

Concur **Target Completion Date:** Completed

(a) The local policy has been revised to address specific bulk oxygen ordering and delivery requirements, as well as maintenance for the bulk oxygen tanks. Procedures now require liquid tank levels to be monitored and recorded daily (normal work days excluding weekends and federal holidays). Facilities Management ensures levels are sufficient to continue operation through weekends and holidays and are monitoring all tank filling operations.

(b) An additional electrical feed was installed from the Building 91 tank farm, to both remote monitoring stations that included the addition of a main and reserve low oxygen alarm signal. After installation, alarm-set verification was performed by a third party contractor qualified in medical oxygen systems in November 2004.

(c) Reference "Contract Requirements", "written mutual agreement with the local liquid bulk oxygen vendor prescribing the method of ordering and specific delivery instruction." The information identified as not having been prepared and submitted to the NAC was prepared and provided to the NAC in November of 2004. This modification identifies delivery requirements, delivery impediments, and delivery instructions to the local vendor handling the national contract. NAC has the method of ordering, specific delivery instructions, and points of contact for inclusion in the statement of work for the oxygen contract. A new national contract is being negotiated with NAC which will likely result in a change of the local provider.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) cardholders reconcile payment charges and (b) cardholder, approving official, and dispute officer duties are properly segregated.

Concur **Target Completion Date:** Completed

All duties have been segregated. No cardholder is an approving official. The Dispute official is now neither a cardholder nor an approving official.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Health Care System Director implement controls to limit access to the controlled substances vault to fewer than 10 employees within a 24-hour period.

Concur **Target Completion Date:** Completed

Actions were taken in July of 2004 to address the issue of limiting access to the controlled substance in accordance with VHA Handbook 1108.1. Access to the controlled substances vault at each campus is currently limited to no more than nine employees per day. The Pharmacy Manager periodically monitors this to ensure compliance with this threshold level.

VHA Handbook 1108.1 was updated on October 4, 2004. The numerical threshold for limiting access to the controlled substance vault has been eliminated. Paragraph 3f in the current policy states "Each facility must limit the number of pharmacy employees who have access to scheduled drugs whether in the vault or working stocks (outside the vault) within a 24-hour period. Pharmacy Chiefs must establish access limits based on workload requirements for dispensing controlled substances." Pharmacy Service is in compliance with the requirements as outlined in this handbook.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Health Care System Director makes sure that inventory records match the actual quantities on hand.

Concur **Target Completion Date:** Completed

The discrepancies identified during the review were generally attributed to a timing delay between actual issue and input into the GIP. Proper procedures and timeliness of inputs have been reemphasized to all personnel. Action has been taken to ensure that all inventory transactions are input into the GIP, receipted and pulled in a timely fashion. Issues are being monitored and verified to ensure accuracy of quantity pulled.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Health Care System Director takes action to ensure all overbed light pull cords are the appropriate length and are properly cleaned.

Concur **Target Completion Date:** Feb 2005

All areas have been surveyed and all noncleanable cords have been replaced with nylon cord. To further emphasize the importance of this issue, a purchase order has been completed to obtain a pull cord with a nylon center encased in ABS plastic.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Canceling unneeded obligations.	$135,582
4	Ensuring all billing opportunities are realized.	7,838
	Total	$143,420

Appendix D

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Appendix E

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