Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Minneapolis VA Medical Center Minneapolis, Minnesota

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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 Department 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 November 29–December 3, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Minneapolis VA Medical Center, Minneapolis, Minnesota. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 210 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 23.

Results of Review

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

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

- Agent Cashier
- Community Nursing Home Contracts
- Part-Time Physician Timekeeping
- Pharmacy Security
- Pressure Ulcer Prevention and Management
- Service Contracts
- Unliquidated Obligations

Based on our review, the following organizational strength was identified:

- The Institute for Healthcare Improvement (IHI) Acute Care Patient Flow Collaborative improved communication, reduced waiting time for beds, and ensured timely discharge medication education.

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

- Correct safety and environmental deficiencies.
- Improve QM reviews and analysis.
- Reduce billing and collection delays and improve clinical documentation.
- Reduce excess supply inventories and improve inventory controls.
- Pursue and properly classify delinquent debts and write off uncollectible debts.

- Strengthen procedures for unannounced controlled substances inspections.
- Update equipment inventory lists and strengthen equipment accountability controls.
- Strengthen security controls for automated information systems.
- Ensure that purchase cardholders have proper warrants.

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 Director Comments

The VISN Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 16 for the full text of the Director's comments.) We will follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Minneapolis, Minnesota, the medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community-based clinics located in Mankato, Hibbing, Maplewood, and Rochester, Minnesota, and in Chippewa Falls and Superior, Wisconsin. The medical center is part of Veterans Integrated Service Network (VISN) 23 (http://www.visn23.med.va.gov/) and serves a veteran population of about 365,290 in a primary service area that includes 46 counties in Minnesota and 13 counties in Wisconsin.

Photograph 1 - Medical Center

Programs. The medical center provides medical, surgical, mental health, and extended care services. The medical center has 237 authorized hospital beds and 104 nursing home beds and provides tertiary medical care with referral and treatment programs including Traumatic Brain Injury Center, Cardiac Surgery Referral Center for VISN 23, and multiple specialty care services for veterans throughout the VISN. Clinical care includes programs such as Minnesota Obesity Center, Women Veterans Comprehensive Healthcare Center, and Healthcare for Homeless Veterans. The medical center has sharing agreements with the Minnesota State Veterans' Home, the Department of Defense, TRICARE,[1] and with several community hospitals and other healthcare providers.

Affiliations and Research. The medical center is affiliated with the University of Minnesota Schools of Medicine and Dentistry. In conjunction with affiliations, residency-training programs exist in medical, surgical, psychiatric, oral surgery, and diagnostic specialties and subspecialties. It supports 496 medical and dental residents and 158 full-time employee (FTE) equivalents. The medical center also has 96 affiliations with 64 educational institutions and provides accredited hospital-based training programs for Radiology Technicians, Nurse Anesthetists, Podiatry, Dental residents, and others.

[1] TRICARE is the healthcare program for active duty and retired service personnel and their eligible family members and survivors.

In Fiscal Year (FY) 2004, the medical center research program had 761 projects and a budget of $25.5 million. Important areas of research include cancer, heart disease, and brain function.

Resources. In FY 2004, medical care expenditures totaled $319.2 million. The FY 2005 medical care budget is estimated to be $332 million, 4 percent more than FY 2004 expenditures. FY 2004 staffing was 2,476 FTE equivalents, including 169 physicians and 725 nursing staff.

Workload. In FY 2004, the medical center treated 73,836 unique patients, a 10 percent increase from FY 2003. The inpatient care workload totaled 8,332 discharges, and the average daily census, including nursing home patients, was 217. The outpatient workload was 525,342 visits.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services (CARES). On February 12, 2004, the CARES Commission issued a report to the Secretary of Veterans Affairs describing its recommendations for improvement or replacement of VA medical facilities. The Secretary published his decisions relative to the Commission's recommendations in May 2004. As a result of the Secretary's decisions, the medical center will continue to receive inpatient medicine referrals from the St. Cloud VA Medical Center, modernize existing facilities through new construction and renovation of inpatient and outpatient areas, establish three new community-based outpatient clinics (CBOCs) by 2012, explore the feasibility of collocating the St. Paul VA Regional Office at the medical center, and include implementation plans for developing a new Spinal Cord Injury Center at the medical center in the FY 2005 VISN strategic planning submission. (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, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls.

QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information medical centers use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

- Accounts Receivable
- Agent Cashier
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Medical Care Collections Fund
- Part-Time Physician Timekeeping
- Pharmacy Security
- Pressure Ulcer Prevention and Management
- Quality Management Program
- Service Contracts
- Supply Inventory Management
- 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 193 responded. We also interviewed 30 patients during the review. The survey results were shared with medical center managers.

The review covered facility operations for FY 2004 and FY 2005 through December 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 Strength

The Institute for Healthcare Improvement Acute Care Patient Flow Collaborative Improved Patient Care Outcomes. In 2002, the medical center participated in the IHI Acute Care Patient Flow Collaborative. This collaborative focused on the movement of patients within the medical center from presentation to disposition. The goal was to improve patient flow, identify and minimize barriers to access care, and improve patient satisfaction. A daily "bed huddle" meeting was implemented, a bed coordinator was appointed, and appointments were established for discharge pharmacy education. All nurse managers attended the bed huddle, resulting in improved communication among patient care areas. Nurse managers initiated a second huddle meeting on days when beds were limited. The bed coordinator expedited identification of available beds and admission of patients. Discharge pharmacy education appointments ensured that patients received discharge medication education timely.

Opportunities for Improvement

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

Condition Needing Improvement. Emergency crash carts were not checked according to medical center policy. Sharp items, medical supplies, and potentially hazardous products were not properly secured. Additionally, managers needed to ensure that medication and nourishment refrigerator temperatures were monitored and maintained within the required range. In the intensive care units, managers also needed to establish a replacement schedule for older beds and inappropriate chairs. We conducted environment of care inspections on seven inpatient units and two outpatient areas.

Emergency Crash Cart Checks. Medical center policy requires that emergency crash carts be checked on each shift. November 2004, emergency crash cart logs showed that checks were not consistently completed on three inpatient units, the urgent care unit, and the Emergency Room. Emergency crash carts should be checked to ensure that emergency equipment and supplies are ready for use during a medical emergency.

Sharp Items, Medical Supplies, and Hazardous Products Security. Storage rooms containing syringes, needles, and medical supplies were unlocked and accessible to patients in seven patient care areas. Potentially hazardous cleaning and patient care products, such as hydrogen peroxide, were unsecured in four patient care areas. These items should be secured to ensure patient safety.

Refrigerator Temperatures Monitoring. In three of nine areas inspected, staff did not document corrective actions when refrigerator temperatures were out of range. Staff were unable to locate temperature logs for two refrigerators for the current and previous month in the surgical intensive care unit. Temperatures in both refrigerators on the day of inspection were out of range. In the emergency room, staff had documented adjusting the temperature control on the refrigerator; however, the temperature remained out of range for 7 consecutive days. Refrigerators containing patient medications and nourishments must be maintained within an acceptable temperature range to ensure the integrity of the contents.

Bed and Chair Replacement. Some patient beds in the medical and surgical intensive care units (ICUs) could not be lowered close to the floor or adjusted to a modified sitting position, as could newer beds on the unit. Patients and nursing staff used step stools at the bedsides, further creating unsafe conditions (see photograph). Additionally, nursing staff reported that the units did not have a sufficient number of

Photograph 2 - Bed with Step Stool

appropriate chairs for patients to sit in as they recuperate.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) emergency crash carts are checked according to medical center policy; (b) sharp items, medical supplies, and hazardous materials are inaccessible to patients; (c) refrigerator temperatures are monitored and maintained within the acceptable range; (d) a bed replacement schedule is developed and implemented in the ICUs; and (e) appropriate chairs are provided for patients' recuperation.

The VISN Director agreed with the findings and recommendations. Responsible staff will be reminded via e-mail regarding the emergency crash cart policy. Compliance will be monitored during weekly EOC rounds. SPD supply rooms will be locked to ensure items are inaccessible to patients. Staff will be educated regarding appropriate actions to be taken when refrigerator temperatures are out of range. Compliance will be monitored by spot checks during weekly EOC rounds. A bed replacement plan has been developed for ICU and additional chairs will be procured. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management Program – Aspects of the Program Needed Improvement

Condition Needing Improvement. The QM program, known as Continuous Improvement (CI) was effective. Senior managers were supportive of CI initiatives and actively participated in CI activities such as root cause analyses (RCAs),[2] case reviews, and CI committee meetings. CI staff supported medical center staff in a proactive approach to improving patient care processes. Selected staff received training in how to conduct RCAs.

Risk Management and Patient Safety. To assess adverse drug events, patient falls, and parasuicidal behaviors, Veterans Health Administration (VHA) policy requires that patient incidents resulting in injury be reported to Risk Management, reviewed according to the Joint Commission on Accreditation of Healthcare Organization (JCAHO) prescribed schedule, and assigned a safety assessment code (SAC)[3] score. CI staff reviewed incidents, assigned SAC scores, and entered them into the patient incident database, but CI managers had not assigned staff to conduct quarterly aggregated

[2] RCA is a widely understood methodology for dealing with patient safety-related issues allowing for clear and more rapid communication of information up and down the organization, thus speeding the process of safety improvement.

[3] SAC scores require an assessment of the severity of an injury, ranging from catastrophic to minor, and a probability rating (how often it occurs) ranging from frequent to remote. A severity category is paired with a probability category for either an actual event or a close call, and a score is determined: 3 = highest risk, 2 = intermediate risk, and 1 = lowest risk. An RCA is performed on those adverse events assigned a SAC score of 3.

reviews.[4] As a result, aggregated reviews were not completed for FY 2004. To ensure that they complete FY 2005 reviews, CI managers had trained additional staff and implemented the required schedule.

Review of Outcomes from Resuscitation. To ensure quality patient care, JCAHO requires that clinical staff evaluate resuscitation outcomes. Although numbers of resuscitations, outcomes, and locations were reported monthly to the Cardiopulmonary Resuscitation Committee, the data was not evaluated to identify opportunities to improve patient care.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) aggregated reviews are accomplished according to the JCAHO prescribed schedule; and (b) resuscitations, outcomes, and locations are evaluated.

The VISN Director agreed with the findings and recommendations. Teams were charged with the responsibility of conducting aggregated RCAs. All team members have been educated in the RCA process. A quarterly report to the Executive Committee of the Medical Staff (ECMS) will be enhanced to comply with JCAHO requirements. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Billing and Collection Delays Should Be Reduced and Clinical Documentation Improved

Condition Needing Improvement. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain insured veterans. Medical center managers needed to ensure that bills are issued promptly, outstanding bills are aggressively pursued, and clinical documentation is completed.

Insurance Bills Not Issued Promptly. As of September 30, 2004, the medical center had 2,859 unbilled episodes of outpatient care (value = $1.3 million). For FY 2004, average monthly billing delays ranged from 45 to 89 days. The average time to initiate a bill was 67 days, exceeding the VA benchmark of 50 days.

Insurance Bills Not Promptly Followed Up. As of September 30, 2004, the medical center had 31,839 insurance bills with a total value of $20.1 million, excluding bills referred to the VA Regional Counsel for collection. Of these, 6,494 (value = $3.7 million, or 18 percent of the total value) were more than 90 days old.

[4] Aggregated reviews may be used for falls, adverse drug events, missing patients, and parasuicidal behaviors. Data are collected over time and tracked and trended to discover patterns of occurrence and develop plans to improve patient care.

To evaluate collection efforts, we reviewed 50 bills (value = $360,965) that were more than 90 days old. Of the 50 bills, 15 had been appropriately cancelled, reissued, or collected after we began our review of the sample. However, based on our review and discussions with the MCCF, Coordinator the remaining 35 bills (value = $293,477 or 81 percent of $360,965 total value) required more aggressive collection.

The MCCF staff had sent initial collection letters but took an average of 128 days before making follow-up telephone calls to insurers to determine why payments had not been received. VHA guidance requires staff to initiate follow-up calls within 30 days of the billing date. To aggressively pursue bills, multiple collection letters should be sent and follow-up calls should be made. Based on discussions with the Business Office Director, we estimated that if MCCF staff pursued bills more aggressively they could increase the collection rate by about 10 percent. This would provide additional revenue of about $299,700 ($3.7 million in bills older than 90 days x 81 percent sample result x 10 percent increase in collections = $299,700).

Clinical Documentation Not Adequate. During the 6-month period April–September 2004, MCCF staff cancelled 7,656 bills (value = $1.5 million). Of these, 5,100 (value = $1.1 million or 67 percent of the bills) were cancelled because attending physicians did not provide sufficient medical record documentation, such as progress notes. We reviewed 45 bills (value = $158,689) that had been cancelled because of insufficient documentation and determined that 33 (73 percent) had collection potential. The MCCF Coordinator and the Business Office Director agreed to analyze these claims, obtain or attempt to obtain required documentation, and reissue bills as appropriate. Using the medical center's historical third-party collection rate of 26 percent, we estimated that better clinical documentation would have resulted in additional revenue of $208,780 ($1.1 million in bills with insufficient documentation x 73 percent sample result x 26 percent historical collection rate = $208,780).

In summary, we estimated that MCCF staff could have increased collections by $508,480 ($299,700 from aggressively pursuing receivables + $208,780 from better clinical documentation = $508,480).

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

The VISN Director agreed with the findings and recommendations. Medical Center Leadership and the Business Office are developing a plan to achieve a more timely collection process. The Associate Chief of Staff for Education (ACOSE) will collaborate with Patient Service Line (PSL) Directors, ECMS, Compliance Committee, Medical Records Committee, and Business Office to improve clinical documentation for billing.

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

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

Condition Needing Improvement. The medical center needed to manage supply stock levels more effectively. The VHA Inventory Management Handbook establishes a 30-day supply goal and requires that medical centers use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns, and conduct periodic physical inventories.

Excess Medical Supply Inventory. Supply Processing and Distribution (SPD) Section staff used GIP to manage medical supply inventory. As of November 24, 2004, the SPD inventory consisted of 923 items with a value of $292,052. To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 medical supply items. Eight items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 38 days to greater than a 1-year supply. Excess stock occurred because staff were not properly adjusting GIP stock levels to meet the 30-day standard. By analyzing GIP data and the results of our sample review, we estimated that the value of medical supply inventory exceeding current needs was about $62,672, or about 21 percent of the total inventory value.

Excess Prosthetics Supply Inventory. The Prosthetics and Sensory Aids Service (PSAS) used the Prosthetics Inventory Package (PIP) to manage its inventory. As of November 5, 2004, inventory maintained by PSAS consisted of 625 items with a value of $302,117. To test the reasonableness of inventory levels, we reviewed a judgment sample of 10 prosthetics supply items. Five items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 44 to 223 days of supply. The excess stock for four items occurred because staff did not adjust reorder levels based on current needs. The fifth item, continuous positive airway pressure masks, had a 59-day supply. According to the Chief, PSAS, this excess occurred because clinicians preferred a different brand and would not use the current stock. By analyzing inventory data and the results of our sample review, we estimated that the value of prosthetics supply inventory exceeding current needs was about $35,650, or about 12 percent of the total inventory value.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) SPD staff adjust GIP stock levels and reduce excess medical supply inventory; and (b) PSAS staff adjust reorder levels and reduce excess prosthetic supply inventory.

The VISN Director agreed with the findings and recommendations. GIP stock levels will be maintained at the 30-day level. Two employees have been assigned to PIP inventory

control, and since that time, compliance with the 30-day supply level has been maintained. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Delinquent Debts Should Be Pursued and Properly Classified and Uncollectible Debts Written Off

Condition Needing Improvement. VA policy requires that accounts receivable owed to the medical center be recorded in accounting records accurately, reconciled to the general ledger each month, and collected promptly. As of September 30, 2004, the medical center had 665 receivables valued at $216,229. (This total excludes patient care-related MCCF receivables.) Of these, 64 (10 percent) with a value at $117,442 (54 percent of the total value) were more than 90 days old. To evaluate the collection potential for these receivables, we reviewed 20 receivables valued at $95,183. The receivables were promptly recorded and reconciled. However, delinquent receivables should have been aggressively pursued, properly classified, and written off when appropriate.

Delinquent Receivables Not Aggressively Pursued. Aggressive collection efforts were not made for 10 of the 20 receivables (50 percent) reviewed (combined value = $31,854). Based on review of the available records and discussions with Fiscal Service staff, we concluded that all 10 have high collection potential.

- VA policy requires medical centers to aggressively pursue delinquent receivables. Although Fiscal Service staff had sent initial collection letters, they had not called the vendors for eight receivables (value = $27,283) to determine why payments had not been made.
- One receivable (value = $4,194) was a debt against a former employee. Fiscal Service staff should have referred this receivable to the U.S. Attorney for collection as required by policy.
- One receivable (value = $377) against a current vendor could have been offset against payments owed to the vendor.

Receivables Not Properly Classified. Fiscal Service staff had misclassified five receivables (value = $10,885) in the Integrated Fund Control Point Activity Accounting and Procurement (IFCAP) system, and, as a result, they had not used appropriate collection methods.

- Three receivables (combined value = $1,106) for former employees were mistakenly classified as debts against current employees. As a result of the misclassification, the medical center had unsuccessfully attempted to collect these receivables through payroll deductions. At our request, Fiscal Service staff reviewed these three receivables and determined that two should be terminated, and one could be pursued through the Internal Revenue Service offset program.

- One receivable (value = $128) for a current employee had been misclassified as a debt against a former employee. Debts owed by current employees can be collected through payroll deductions.
- One receivable (value = $9,651) for services sold to a Federal agency had been misclassified as a commercial vendor debt. As a result of our review, the medical center can now obtain payment for this debt through the Intragovernmental Payment and Collection System.

Uncollectible Receivables Not Written Off. Nine receivables valued at $65,638 (56 percent of $117,442) were uncollectible and should have been written off. VA policy allows receivables to be written off when certain circumstances are met, such as when the debtor cannot be located or the cost of pursuing collection exceeds the amount owed.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires Fiscal Service to: (a) establish controls for pursuing delinquent receivables; (b) properly classify receivables in the IFCAP system; and (c) properly write off uncollectible receivables.

The VISN Director agreed with the findings and recommendations. Current staff vacancies will be filled and additional overtime will be devoted to performing additional follow-up of delinquent receivables, classification, and performing write-offs of uncollectible accounts. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Inspection Program Controls Should Be Strengthened

Condition Needing Improvement. VHA policy requires that medical centers conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period October 2003–September 2004, observed unannounced inspections of selected areas where controlled substances were stored and dispensed, and interviewed the Controlled Substance Inspection Coordinator. We identified three weaknesses in the unannounced inspection program.

Inspections Not Thorough. We observed inspection procedures and discussed these procedures with three inspectors and the Coordinator. Inspectors were not performing four required inspection procedures.

- Verifying that all required periodic controlled substances inventory counts were completed in the pharmacy, units, clinics, and research laboratories.
- Checking two transfers of controlled substances from the pharmacy to ensure receipt at the dispensing locations.

- Verifying that unusable and expired controlled substances were destroyed at least quarterly.
- Reconciling logs of unissued prescription pads to prescription pads on hand to verify that none were missing.

Four Dispensing Locations Not Inspected. During FY 2004, the medical center had been conducting monthly inspections of 40 controlled substances storage locations. Our review identified four additional locations that had not been included in the Coordinator's inspection program. Three locations were clinics, and one was the pharmacy at the Twin Ports CBOC. The Coordinator agreed that these locations should be included in the inspection program.

No Element of Surprise in Some Inspections. VHA policy requires that inspections be unannounced and have an element of surprise. Employees in one unit and five clinics had refused to permit unannounced inspections, telling the inspectors it was "not a good time" and to come back later. As a result, inspections did not always have the element of surprise.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) inspections are conducted in accordance with VHA policy; (b) all controlled substances storage locations are inspected every month; and (c) inspections are unannounced.

The VISN Director agreed with the findings and recommendations. Controlled substance inspections will be conducted thoroughly in accordance with VHA policy. All controlled substances storage locations will be inspected. Two areas were added to the current list and two areas were not added because controlled substances are no longer kept in the areas. Inspections will be unannounced. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Condition Needing Improvement. VA policy requires periodic inventories to ensure equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Materiel Management Service (A&MMS) staff is responsible for ensuring inventories are performed and updating EIL records. As of November 2004, the medical center had 161 active EILs listing 2,266 equipment items (total value = $63.9 million). To determine whether equipment accountability was adequate, we reviewed equipment inventory records and a judgment sample of 25 equipment items (value = $2.2 million) assigned to 10 EILs. We identified two deficiencies that required corrective action.

EILs Not Accurate. EILs were inaccurate for 8 of the 25 items (32 percent). For four medical equipment items with a total value of $433,424, Biomedical Instrumentation Department and Imaging Service staff stated that these items had been excessed. However, there were no "Request, Turn-In, and Receipt for Property or Services" forms or other documentation showing the items had been excessed. For the remaining four items (value = $70,146), the locations shown on the EILs were incorrect because the items had been moved within the service or excessed.

Spot Check of Inventories Not Performed. A&MMS staff and service chiefs or their designees had not performed quarterly spot checks of completed EIL counts to ensure the accuracy of reported information as required. Materiel Management Section staff was not aware of VA policy requiring these spot checks.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) EILs are accurately maintained; and (b) spot checks of equipment inventories are conducted in accordance with VA policy.

The VISN Director agreed with the findings and recommendations. EILs will be accurately maintained. Using services will be reminded to inform A&MMS when items are excessed. Equipment inventory spot checks will be completed as required by VA policy. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Controls Should Be Strengthened

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

Contingency Plans Not Developed. VHA policy requires medical centers develop and annually test contingency plans that will reduce the impact of disruptions in services, provide critical interim processing support, and ensure that normal operations will resume as soon as possible after a disaster or other emergency. All services that depend on critical information systems must have contingency plans. The medical center had 30 such services. As of December 2, 2004, 25 of these services, including patient care services such as Primary Care, did not have contingency plans. In addition, plans for the remaining five services had not been tested annually.

Inactive Accounts Not Terminated. Veterans Health Information Systems and Technology Architecture (VistA) access had not been terminated for some inactive users. We reviewed a sample of 25 VistA access accounts and concluded that access should have been terminated for 22 users (19 former employees and 3 current employees who no longer needed access).

Background Investigations Not Completed. Background investigations are required for medical center employees who have computer access to sensitive patient, employee, or financial information. VA policy requires that Human Resource Management Service (HRMS) staff initiate investigations within 14 calendar days of an employee's appointment. As of December 2, 2004, required investigations had not been completed for the Information Security Officer (ISO) and 13 IRMS employees. HRMS staff had submitted investigation requests to VA's Security and Investigation Center for the ISO and 10 of the IRMS employees. However, HRMS staff had not followed up on the status of the investigation requests. For the remaining three employees, who had been employed since at least August 2004, HRMS staff did not initiate investigations until October 2004, after receiving notice of our CAP review.

Physical Security Deficiencies Were Identified. The computer room did not have an intrusion detector; hinges on the exterior doors to the computer room and 103 telephone closets did not have non-removable pins. Intrusion detectors and non-removable pins on door hinges are required by VA policies.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) develop contingency plans for required services and test the plans annually; (b) promptly terminate VistA accounts for individuals that do not have a continued need for access; (c) initiate and follow up on all required background investigation requests; and (d) install an intrusion detector in the computer room and non-removable pins in the exterior door hinges for the computer room and telephone equipment closets.

The VISN Director agreed with the findings and recommendations. The ISO will assist services in developing service-level contingency plans and in conducting annual testing. A 90-day review process for VistA accounts has been implemented and procedures will be written. HRMS will initiate required background investigations and follow up with VA's Security and Investigation Center regarding employees with high-level clearance whose security clearance investigations have not been completed. Pins were placed in computer room door hinges during the CAP week. An intrusion detector will be installed in the computer room and non-removable pins will be installed in all hallway telephone closet door hinges. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Cardholders Should Have Proper Warrant Authorities

Condition Needing Improvement. The Chief of A&MMS and the Purchase Card Coordinator needed to ensure that six employees with purchase cards have proper warrant authorities. VHA policy requires that purchase cards be used for all purchases under the micro-purchase level of $2,500 and, where practicable, for all purchases up to the simplified acquisition threshold of $100,000. For purchases up to the $2,500 level, cardholders are required to complete basic Government Purchase Card training but are not required to have warrant authorities. However, for purchases over $2,500 and up to $100,000, cardholders must receive additional procurement training and must be issued proper contracting warrants.

During the 6-month period April–September 2004, 157 cardholders made 16,484 purchases totaling about $12.4 million. Our review of a judgment sample of 40 purchase card transactions found that the purchases were made for valid VA purposes. However, six cardholders who had been authorized to make single purchases exceeding $2,500 did not receive the required contracting warrants and training for this authorization. Three of these cardholders had not made any purchases over $2,500 during the review period. The other three cardholders routinely made medical and pharmaceutical purchases costing from $2,600 to $20,000. Without contracting warrants, these three cardholders did not have proper authority to make purchases over $2,500.

Recommended Improvement Action 9. We recommended that the VISN Director require that the Medical Center Director ensures that all cardholders with single purchase limits exceeding $2,500 are properly trained and warranted.

The VISN Director agreed with the findings and recommendations. All cardholders with single purchase limits over $2500 will be trained and warranted. 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: February 23, 2005

From: VISN Director

Subject: **Minneapolis VA Medical Center Minneapolis, Minnesota**

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

The Draft Report, Combined Assessment Program Review for Minneapolis VA Medical Center, Project Number 2004-03408-HI-0435, is accepted with minor changes as noted below. Thank you.

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) emergency crash carts are checked according to medical center policy;

Concur **Target Completion Date:** 4/1/05

Responsible staff will receive an e-mail regarding the policy, and monitoring of compliance will be done in conjunction with weekly EOC Rounds.

(b) sharp items, medical supplies, and hazardous materials are inaccessible to patients;

Concur **Target Completion Date:** 4/15/05

SPD supply rooms will be locked.

(c) refrigerator temperatures are monitored and maintained within the acceptable range;

Concur **Target Completion Date:** 4/15/05

Staff will be educated regarding actions to be taken when a refrigerator temperature is out of range. Spot checks for monitoring compliance will be conducted in conjunction with weekly EOC Rounds.

(d) a bed replacement schedule is developed and implemented in the intensive care units;

Concur **Target Completion Date:** 9/30/06

The medical center has developed a plan, and will replace older ICU beds that do not lower close to the floor or adjust to sitting position (as the newer beds do).

and (e) appropriate chairs are provided for patients' recuperation.

Concur **Target Completion Date:** 9/30/06

Additional chairs will be procured for use in ICU, where beds do not adjust to sitting position.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) aggregated reviews are accomplished according to the JCAHO prescribed schedule;

Concur **Target Completion Date:** 4/15/05

Teams were charged with the responsibility of conducting aggregated RCAs for falls, medication errors, missing patients, and parasuicides. All team members have been educated about the RCA process.

and (b) resuscitations, outcomes, and locations are evaluated.

Concur **Target Completion Date:** 4/15/05

A quarterly report to the ECMS will be enhanced to concur with requirements.

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

(a) insurance bills are issued promptly;

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

Medical Center Leadership and the Business Office are actively developing a plan to comply with this recommendation.

(b) bills are pursued more aggressively;

Concur, In Part **Target Completion Date:** 9/30/05

Medical Center Leadership and the Business Office are actively developing a plan to achieve a more timely collection process. Our largest payor, Blue Cross/Blue Shield, has asked us to not call them within 30 days after billing, because it would increase their workload and slow claims processing. The 30-day follow-up was understood to be a guideline but not a mandate. We will work effectively and efficiently with our community partnerships to achieve timely revenue returns.

and (c) medical records include adequate clinical documentation.

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

Reports go to each PSL outlining documentation issues for PSL directors to address. The Associate Chief of Staff for Education (ACOSE) will collaborate with PSL directors, ECMS, Compliance Committee, Medical Records Committee, and Business Office to improve clinical documentation for billing.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) SPD staff adjust GIP stock levels and reduce excess medical supply inventory;

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

Compliance will be maintained with the 30-day level as it applies to the inventory as a whole, and not for each item. Some items are "just in case" that exceed 30 days, but must be on hand when requested by a surgeon.

and (b) PSAS staff adjust reorder levels and reduce excess prosthetic supply inventory.

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

After the OIG survey, two employees were assigned to inventory control, and since that time compliance with the national requirement to maintain inventory in excess of 30 days to 1% of the budget has been maintained.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires Fiscal Service to:

(a) establish controls for pursuing delinquent receivables;

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

Current vacancies will be filled and additional overtime will be devoted to performing additional follow-up of delinquent receivables.

(b) properly classify receivables in the IFCAP system;

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

Current vacancies will be filled and additional overtime will be devoted to performing additional classification.

and (c) properly write off uncollectible receivables.

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

Current vacancies will be filled and additional overtime will be devoted to performing write-offs of uncollectable accounts.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) inspections are conducted in accordance with VHA policy;

Concur **Target Completion Date:** 4/15/05

Inspections will be conducted thoroughly in accordance with VHA policy, and will a) verify that counts were completed in pharmacy, units, clinics, and research labs; b) check two transfers of controlled substances from pharmacy to ensure receipt at the dispensing location; c) verify unusable and expired controlled substances were destroyed at least quarterly; and d) reconcile logs of prescription pads not yet issued with those on hand to make sure that none are missing.

(b) all controlled substances storage locations are inspected every month;

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

Two areas were added to the monthly inspections due to administration of testosterone, and two areas no longer keep controlled substances, and therefore were not added to the list.

and (c) inspections are unannounced.

Concur **Target Completion Date:** 6/1/05

Inspections will no longer be delayed due to workload in the clinical area.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) EILs are accurately maintained;

Concur **Target Completion Date:** 3/23/05

EILs will be accurately maintained, with the understanding that locations of mobile items change constantly, and can not be accurate 100% of the time. This is especially true for patient care areas. We will remind using services to inform A&MMS when items are excessed.

and (b) spot checks of equipment inventories are conducted in accordance with VA policy.

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

Equipment inventory spot checks will be completed as required.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director takes action to:

(a) develop contingency plans for required services and test the plans annually;

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

The Information Security Officer will assist services in developing service-level contingency plans and in conducting annual testing.

(b) promptly terminate VistA accounts for individuals that do not have a continued need for access;

Concur **Target Completion Date:** 7/1/05

A 90-day review process has been implemented, and procedures will be written.

(c) initiate and follow up on all required background investigation requests;

Concur **Target Completion Date:** 4/15/05

HRMS will initiate and follow up with VA's Security and Investigation Center regarding employees with high-level clearance whose security clearance investigations have not been completed. The Information Security Officer will be informed when investigations are completed.

and (d) install an intrusion detector in the computer room and non-removable pins in the exterior door hinges for the computer room and telephone equipment closets.

Concur **Target Completion Date:** 5/31/05

An intrusion detector will be installed in the computer room, and non-removable pins will be installed in all hallway telephone closet door hinges. Pins were placed in the hinges of the computer room door during the survey, first week of December 2004.

Recommended Improvement Action 9. We recommend that the VISN Director require that the Medical Center Director ensures that all cardholders with single purchase limits exceeding $2,500 are properly trained and warranted.

Concur **Target Completion Date:** 3/23/05

All cardholders with limits over $2500 will be trained and warranted.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Better use of funds through improved collection of MCCF accounts receivable.	$508,480
4	Better use of funds by reducing excess medical and prosthetic supply inventories.	$98,322
5	Better use of funds through more aggressive collection of delinquent accounts receivable.	$31,854
	Total	$638,656

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections (708) 202-2672
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Appendix D

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