Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, California

Report No. 05-00735-160

June 27, 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 February 14–18, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Northern California Health Care System which is part of Veterans Integrated Service Network (VISN) 21. 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 fraud and integrity awareness training to 508 employees.

Results of Review

This CAP review covered 13 operational activities. The health care system complied with selected standards in the following six activities:

- Colorectal Cancer Management
- Emergency Preparedness
- Environment of Care
- Government Purchase Card Program
- Quality Management
- Service Contracts

We identified the following organizational strengths:

- Provider profiles are used to continuously monitor clinical performance.
- A comprehensive peer review program helps improve clinical performance.

We identified seven activities that needed additional management attention. To improve operations, we made the following recommendations:

- Improve Medical Care Collections Fund (MCCF) collections by reducing unbilled claims and improving clinical documentation.
- Review repayment plans and reinitiate VA Debt Management Center (DMC) collection activities when veterans do not repay debts.
- Consistently perform and document daily pressure ulcer reassessments and treatments.
- Strengthen information technology (IT) security controls.
- Strengthen Equipment Inventory Listing (EIL) controls.
- Ensure that desk audits of part-time physicians' timekeepers are conducted and that part-time physicians obtain advance approval for changes to their adjustable work schedules.
- Strengthen pharmacy security.

VISN and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14-23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Ms. Janet Mah, Director, and Mr. Jeffrey West, CAP Review Coordinator, Los Angeles Audit Operations Division.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Health Care System Profile

Organization. The health care system includes the Sacramento VA Medical Center (SVAMC) in Mather, CA; the Martinez VA Outpatient Clinic and Center for Rehabilitation and Extended Care in Martinez, CA; and seven community-based outpatient clinics (CBOCs) in Martinez, Oakland, Redding, Sacramento, Chico, Fairfield, and Vallejo, CA. The health care system serves a veteran population of about 377,700 in a primary service area that includes 17 counties in California.

Programs. The health care system's new 45-bed inpatient facility in Sacramento offers a full range of comprehensive health care services including medical, surgical, primary and mental health care, as well as outpatient and diagnostic services. The 120-bed Center for Rehabilitation and Extended Care in Martinez offers rehabilitation, restorative, palliative, respite, and transitional care. The Martinez CBOC offers a full range of medical, surgical, mental health, and diagnostic outpatient services.

Affiliations and Research. The health care system is affiliated with the University of California, Davis School of Medicine and supports 69 medical resident positions. The health care system is also affiliated with several colleges providing clinical training opportunities for allied health, nursing, and optometry students. In fiscal year (FY) 2004, the health care system's research program had 110 projects and grant awards exceeding $8 million. Important areas of research include Alzheimer's disease, cancer, endocrinology disorders, geriatrics, health systems, heart disease, and liver disease. Another noteworthy highlight is the health care system's 9-bed General Clinical Research Center, which was developed in a partnership with the University of California, Davis.

Resources. In FY 2004, the health care system's medical care budget was $262.4 million, and expenditures totaled $262.1 million. The FY 2005 medical care budget was $276.4 million, a 5.4 percent increase over FY 2004 expenditures. This increase included funds for medical care, equipment, nonrecurring maintenance, readjustment counseling, trainees, and homeless programs. FY 2004 staffing was 1,479 full-time equivalent employees (FTE), including 145 physician FTE and 382 nursing FTE.

Workload. In FY 2004, the health care system treated 66,948 unique patients, a 2 percent increase over FY 2003. Health care system officials attributed the increase to the opening of the new inpatient facility in June 2003. The health care system's inpatient care workload totaled 2,470 discharges with an average daily census of 32.4, and the nursing home care unit's average daily census was 103.75. The outpatient workload was 613,995 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 activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 13 activities:

Accounts Receivable	Information Technology Security
Colorectal Cancer Management	Medical Care Collections Fund
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Emergency Preparedness	Pressure Ulcer Clinical Practices
Environment of Care	Quality Management
Equipment Accountability	Service Contracts
Government Purchase Card Program	

The review covered facility operations for FYs 2001–2005 through February 2005 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.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, and 551 employees responded. We also

interviewed 36 patients during the review. We discussed the survey and interview results with health care system managers.

During the review, we presented 8 fraud and integrity awareness briefings to 508 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Follow-Up to Previous CAP Recommendation

As part of this review, we followed up on a recommendation from the prior CAP review of the health care system (*Combined Assessment Program Review of the VA Northern California Health Care System*, Report No. 01-00413-85, July 2, 2001). In January 2001, the OIG found that the VISN 21 Consolidated Contracting Authority needed to improve the prenegotiation process for service contracts. Our February 2005 CAP review found that cost and pricing data had been obtained and cost analyses had improved to ensure the negotiation of reasonable service contract prices. The VISN Director had adequately addressed the recommendation and condition cited in the prior CAP report.

Results of Review

Organizational Strengths

Provider Profiles Are Used To Continuously Monitor Clinical Performance. Health care system clinical managers use provider profiles to biannually assess the competence of providers before renewing their clinical privileges. The QM staff maintain these profiles, which contain the results of medical reviews, medication management, blood usage reviews, and clinicians' implementation of computer-generated preventative medicine reminders, such as flu shots. Although VA policy requires only biannual reprivileging, the health care system's clinical managers collect and review provider profile information throughout the year to monitor the performance of individual providers and evaluate provider performance across the health care system.

A Clinical Peer Review Program Helps Improve Quality of Care. The health care system's comprehensive clinical peer review program has led to the implementation of several initiatives that improve the quality of care. Cases identified through routine QM adverse outcome reviews, incident reports, and utilization management reviews are forwarded to peer clinicians who rate the cases for consistency with the expected standard of care. Cases with identified standard of care issues are then discussed in detail with the involved clinicians, all physicians at the appropriate site, and the Clinical Advisory Board. This peer review program has resulted in the implementation of case management programs in cancer, Human Immunodeficiency Virus, and hepatitis C and the development of a well defined co-managed care policy and notification process for abnormal test results.

Opportunities for Improvement

Medical Care Collections Fund – Fee-Basis Billing Procedures and Clinical Documentation Needed Improvement

Conditions Needing Improvement. MCCF managers could further increase collections by strengthening billing procedures for fee-basis care and ensuring clinicians adequately document care provided. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the health care system collected $10.42 million (93 percent of its FY 2004 collection goal of $11.23 million), but we identified two areas that needed improvement.

Fee-Basis Billing. For the 3-month period October 2004 through December 2004, the health care system paid 4,531 fee-basis claims, totaling $691,362, to non-VA clinicians for the care of veterans with health insurance. To determine if the health care system had billed the insurance carriers for this care, we reviewed a judgment sample of 30 fee-basis claims totaling $178,655. Our review found that 24 claims were not billable to the insurance carriers either because the care was for service-connected conditions, the veterans did not have insurance coverage on the dates care was provided, or the care was not billable under the terms of the insurance plans. The remaining six claims, totaling $188,778, should have been billed.

- MCCF staff stated that three of the six claims totaling $64,100 were not identified as billable because these cases did not appear on the "Potential Cost Recovery Report" ("PCRR"), which is used to identify potentially billable services. The MCCF Coordinator could not explain why this occurred and assured us that the health care system's computer specialists were researching the problem.
- The remaining three claims totaling $124,678 had not been billed because the emergency transfer of a veteran with cardiac problems to a community hospital had not been properly classified as emergent. At our request, the Utilization Review Nurse reevaluated this case and concluded that the transfer was an emergency and that these claims were billable under the terms of the veteran's insurance.

During our review, MCCF staff prepared bills for five of the six claims. One claim of $963 could not be billed because it exceeded the insurance carrier's billing time frame. Based on the health care system's FY 2004 collection rate of 22 percent, MCCF staff could have potentially collected about $41,531 ($188,778 x 22 percent collection rate) if these six claims had been properly billed.

Clinical Documentation. Veterans Health Administration (VHA) policy requires clinicians to enter documentation into the medical record at the time of each outpatient encounter so that MCCF staff can bill insurers for the care provided. For the 3-month period October 2004 through December 2004, the health care system reported that 79

outpatient encounters totaling $78,020 had not been billed because medical record documentation did not meet the insurance carriers' billing requirements. Of the 79 encounters, we reviewed 50 valued at $59,042 and found that 39 valued at $14,813 could have been billed.

- Bills for 24 encounters totaling $13,547 had not been issued because clinicians did not adequately document encounters in the medical records as required by VHA policy. During our review, the Compliance Officer requested that these clinicians supply the required clinical documentation. As a result of our review, the Compliance Officer obtained information for all 24 encounters, and MCCF staff issued 24 bills for $13,547. Based on the facility's FY 2004 collection rate of 22 percent, we estimated additional collections of $2,980 ($13,547 x 22 percent collection rate).
- Bills for 15 encounters totaling $1,266 had to be subsequently canceled because the clinicians had not certified plans of care for physical therapy, occupational therapy, or speech pathology rehabilitation within 30 days; recorded the duration or frequency of the provided therapy in the treatment plans; or sufficiently documented resident supervision. MCCF managers stated that this occurred because clinicians were still becoming familiar with the February 2003 VA billing regulations and documentation requirements for rehabilitation therapy services. MCCF staff could have potentially collected $279 ($1,266 x 22 percent collection rate) if the clinicians had properly documented these 15 encounters.

Better clinical documentation and improved billing procedures would have resulted in increased collections. We estimated that the health care system could have increased additional collections by $44,790 [($188,778+$14,813) x 22 percent collection rate].

Recommendation 1. We recommended the VISN Director ensure that the Health Care System Director requires that: (a) MCCF managers periodically verify the accuracy and completeness of the "PCRR" and implement monitoring procedures to ensure all encounters are properly reviewed and billed and (b) clinicians promptly and completely document all patient encounters in the medical records.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that MCCF managers will review the accuracy and completeness of the "PCCR" to ensure that no potentially billable services have been missed. MCCF managers further established a process to ensure all billable fee cases are properly identified, documented, and when needed, referred to the Utilization Review Nurse to make a service-connection determination. To address problems related to the promptness of billings and medical documentation, the health care system has implemented follow-up procedures that will be performed at scheduled intervals for outpatient encounters with missing documentation. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Follow-Up Collection Activities Needed Improvement

Condition Needing Improvement. Business Office managers needed to reestablish DMC collection activities when veterans did not comply with agreed upon debt repayment plans. VA policy requires the aggressive pursuit of all accounts receivable (debts) regardless of their amount. As of December 2004, 18,876 veterans owed the health care system 63,922 first-party copayments totaling about $2.27 million. Because of the labor involved in collecting individual debts for such small amounts, the Business Office refers these debts to the DMC for collection. The DMC automated collection process generates letters to debtors, and if the debts are not paid it refers them to the Treasury Offset Program which offsets the amount owed against the veterans' Social Security benefit payments, VA benefit payments, or income tax refunds.

Of the 18,876 veterans who owed first-party copayment debts, 305 (1.6 percent) had debts in excess of $1,000 that accounted for $463,134 (20.4 percent) of the total debt. Our review of a judgment sample of 14 of the 305 veterans' debts found that the DMC had initiated collection offsets for their debts. Of the 14 veterans, only 3 had active collection offsets against their Social Security or VA benefit payments. The remaining 11 veterans, whose debts totaled $41,343, had no DMC collection activities even though the veterans received Social Security benefits, VA benefits, or income tax refunds. Business Office staff had suspended the collection offsets when these veterans had arranged debt repayment plans with the health care system but did not reinitiate them when the veterans did not repay the debts. As a result of our review, Business Office managers had the DMC reinitiate collection offsets for the 11 veterans totaling $41,343.

Recommendation 2. We recommended the VISN Director ensure that the Health Care System Director requires Business Office staff to regularly review veterans' compliance with debt repayment plans and, if necessary, reinitiate DMC collection activities when debts are not repaid.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the MCCF Coordinator had trained accounts receivable staff on the required procedures for first-party debt follow-up and established a process to ensure the completion of the required procedures, including the review of all repayment plans. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Pressure Ulcer Clinical Practices – Documentation of Reassessments and Treatments Needed Improvement

Condition Needing Improvement. Clinicians needed to consistently document patient skin integrity reassessments and treatments. Local policies required clinicians to perform skin integrity assessments for all patients at the time of admission and to reassess patients

at risk for pressure ulcers every 24 hours. All assessments must be documented in the medical records.

We reviewed a judgment sample of 10 medical records of patients with pressure ulcers and found that all cases had documented admission assessments. However, six cases did not have consistent documentation of reassessments every 24 hours, and four cases did not have consistent documentation showing that treatments had been provided as ordered.

Recommendation 3. We recommended the VISN Director ensure that the Health Care System Director requires clinicians to consistently perform and document all skin integrity reassessments and consistently document that all treatments were provided as ordered.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the health care system had established a new policy and quality review process to ensure all skin integrity reassessments are consistently performed and documented. The health care system also developed and implemented an electronic wound treatment template to ensure that ordered treatments are provided. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. Information Resources Management (IRM) managers needed to strengthen IT security controls. VA policy requires the implementation of physical devices and control measures to protect IT assets and sensitive information from misuse and damage in the event of accidents, fires, power outages, environmental hazards, or malicious acts. Accordingly, VA has implemented controls related to IT access, data security, and computer virus protection.

We evaluated IT security to determine if the controls adequately protected information system resources. IRM staff had implemented procedures to ensure IT users' levels of access were appropriate to their needs. Password controls and virus protections were in place, and safeguards were in place to protect the Local Area Network (LAN) equipment and computer room. Critical information was backed up on a regular basis, and data systems were supported by an uninterrupted power supply. However, we identified five areas where IRM managers could improve IT security.

System Access. IRM managers did not ensure that LAN and Veterans Health Information System and Technology Architecture (VistA) access privileges were terminated when users left the health care system. VA policy requires LAN and VistA access to be promptly terminated when users leave facilities or no longer need access. The health care system's Automated Information Systems (AIS) Security Plan requires

service chiefs, the Information Security Officer (ISO), and Human Resources Management Service to work with IRM to ensure user access privileges are promptly terminated when access is no longer needed.

Of the 225 employees with LAN access who had left the health care system in calendar year 2004, 5 still had access privileges as of February 14, 2005. During our review, IRM staff terminated the access privileges for these 5 former employees. Similarly, our review of 593 contractors, medical students, and similar users who had VistA access privileges as of January 7, 2005, found that 56 still had access privileges ranging from 1 week to 12 years after they had left the health care system. IRM staff did not terminate the access privileges of these 56 users until immediately prior to the start of the CAP review. IRM staff attributed the delays in terminating LAN and VistA access to a lack of communication between the service chiefs and IRM staff when users left the health care system.

IT Security Awareness Training. The health care system did not ensure all AIS users completed required annual IT security awareness training. VA policy requires that AIS users receive training on IT security requirements based on the users' positions. During FY 2004, 1,555 (83 percent) of the health care system's 1,884 employees required to take the training had completed it. Even though the ISO and service chiefs were aware of the requirement, the ISO did not follow up with the service chiefs to ensure the remaining 329 employees (17 percent) had taken the required training.

Contingency Plans. The Contingency Disaster Recovery Plan did not meet VA requirements that the plan include a current list of computer equipment and an alternate processing location to ensure the continuity of operations during a disaster or emergency. The ISO stated that due to an oversight on her part, these items were not included in the health care system's plan.

Internet Monitoring. IRM managers and the ISO had not established a process for monitoring employee Internet usage. Improper Internet usage can lead to unauthorized users gaining access to VA information systems, loss in productivity, increased network costs, and the investment of significant resources to correct related system and network configuration problems. IRM staff did not monitor Internet usage and relied on health care system managers to notify the ISO of any suspicious Internet activity. After the ISO received notification of suspicious Internet activity, he would conduct a forensic analysis of the computer in question and review the computer's hard drive for inappropriate Internet material and other signs of inappropriate use. IRM managers stated that their lack of Internet monitoring was due to an oversight on their part. In June 2005, the health care system's network will start using VISN 21's new Enterprise Cyber Security Infrastructure Project gateway that filters inappropriate Internet content and allows the ISO and IRM managers to request Internet monitoring reports.

Documentation of System Data Backup. IRM staff did not document the completion of system backup data tests. VA policy requires LAN managers to list the critical data stored on the LAN and determine the frequency of backups that are required at least weekly. Several generations of monthly backups should be retained and routinely tested to ensure that the LAN server disks can be restored to their original state. Because of the lack of documentation, we could not verify that the required system backup data tests had been completed. The LAN manager stated that the tests were being performed, but he was unaware that it was necessary to document these tests.

Recommendation 4. We recommended the VISN Director ensure that the Health Care System Director requires that: (a) IRM staff promptly terminate LAN and VistA access for users who leave the health care system or who no longer need access, (b) the ISO and service chiefs ensure all health care system employees complete required IT security awareness training, (c) the Contingency Disaster Recovery Plan be updated to include a current list of computer equipment and an alternate processing facility, (d) IRM managers establish a process for monitoring Internet usage, and (e) IRM staff document system data backup tests.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that new access termination policy and procedures had been implemented and monitoring procedures will be performed monthly to ensure all health care system employees complete the required IT security awareness training. The health care system also updated the Contingency Disaster Recovery Plan to include a current list of computer equipment and designated the SVAMC as the alternate processing site. In addition, IRM established policies and procedures for monitoring Internet usage and documenting data backup tests. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. Acquisition and Materiel Management Service (A&MMS) managers needed to improve inventory controls to ensure adequate accountability for nonexpendable equipment (items costing more than $5,000 with an expected useful life of more than 2 years or items classified as sensitive). A&MMS is responsible for coordinating EIL physical inventory counts and updating EIL records. Health care system staff assigned responsibility for maintaining EILs are required to perform physical inventories and report transferred, excessed, or missing equipment to A&MMS.

To determine if equipment inventory controls were effective, we reviewed VHA and health care system policies and procedures, EILs, a judgment sample of 30 equipment items, and the "Reports of Survey" for missing equipment. We identified three areas that needed to be addressed.

EIL Inventories. VHA policy requires EIL inventories to be completed within 10 days of notification and A&MMS to notify responsible officials when inventories are delinquent. During FY 2004, 72 inventories were scheduled. However, six inventories were not performed and A&MMS staff did not follow up when the required inventories were not completed within 10 days.

Quarterly Spot Checks. VHA policy requires A&MMS to conduct quarterly spot checks of all EILs to verify accuracy. However, during FY 2004, A&MMS staff did not perform the required quarterly spot checks. A&MMS staff stated that this was due to the logistical challenges of completing the checks at several geographically dispersed health care system locations.

EIL Accuracy. VHA policy requires nonexpendable and sensitive equipment items to be listed on EILs. Our review of a judgment sample of 30 equipment items listed on VistA Equipment Accountability Reports found that 21 (70 percent) were not listed on EILs. This occurred because A&MMS warehouse staff received equipment items and sent the items to the using services before they could be assigned to EILs, and some sensitive items costing less than $5,000 were not included on services' EILs. During our review, A&MMS managers initiated the process of updating the EILs to include sensitive items.

Recommendation 5. We recommended the VISN Director ensure that the Health Care System Director requires A&MMS staff to: (a) ensure required EIL inventories are completed, (b) conduct quarterly spot checks of EILs, and (c) assign equipment items to EILs upon receipt and ensure all sensitive equipment items are included on the EILs.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the health care system will perform a 100 percent comprehensive review of all equipment and implement a quarterly spot check process that will ensure all EILs are reviewed annually. The health care system has also developed a new equipment management process to ensure equipment received, including sensitive equipment, is placed on the appropriate EIL and processed on time. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Part-Time Physician Time and Attendance – Work Hour Change Requests Needed to be Completed and Desk Audits Strengthened

Conditions Needing Improvement. Health care system managers needed to ensure that part-time physicians requested and obtained advance approval to change their adjustable work hours and that Fiscal Service strengthened desk audit policies and procedures. As of February 2005, the health care system had 81 part-time physicians, with 14 timekeepers recording their time and attendance. To evaluate part-time physician time and attendance procedures, we reviewed time and attendance records, interviewed health

care system managers and part-time physicians, and verified the attendance of selected part-time physicians. We identified two areas that needed to be corrected.

Adjustable Work Hours. VHA policy requires part-time physicians on adjustable work schedules to request and obtain advance approval for changes to their scheduled non-core hours. Thirty-three of the health care system's part-time physicians had adjustable work schedules that included designated core and non-core work hours. Physicians must be present during core hours unless they are granted leave or excused absence, but they may change their non-core hours during the pay period if it does not affect the facility's ability to provide patient care.

To determine if part-time physicians on adjustable work schedules were present during their assigned duty hours and had obtained advance approval for changes to their non-core hours, we reviewed the timesheets of five part-time physicians for the 6-week period December 26, 2004, through February 5, 2005. According to the timesheets, the five physicians worked the total number of required hours during the review period. However, one physician had not requested or obtained advance approval to change 33 non-core hours. This occurred because the physician's service chief misinterpreted VHA policy and did not require him to request and obtain advance approval for changes to his scheduled non-core hours.

Desk Audits. VA policy requires Fiscal Service to perform semiannual timekeeper desk audits to ensure timekeepers are properly recording time and attendance. Our review of the FYs 2003 and 2004 desk audit records for 14 primary timekeepers found that the completion of desk audits improved during the time period, but there were still deficiencies. Fiscal Service staff performed 44 (83 percent) of the 53 required audits during the 2-year period. Of the nine audits that were not performed, four were not done because Fiscal Service staff stated the timekeepers were located at distant outpatient clinics. The remaining five desk audits were completed for the alternate timekeepers, but not for the primary timekeepers, because health care system management believed this was sufficient to comply with VA's desk audit requirement. In addition, auditors did not adequately discuss or document deficiencies identified during 6 (14 percent) of the 44 completed desk audits.

Recommendation 6. We recommended the VISN Director ensure that the Health Care System Director requires that: (a) part-time physicians on adjustable work schedules obtain advance approval for changes to their non-core hours and (b) Fiscal Service staff perform timekeeper desk audits in accordance with VA policy.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the health care system had trained part-time physicians on their time and attendance responsibilities and established a timekeeper desk audit schedule to achieve 100 percent compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Pharmacy Physical Security Needed To Be Strengthened

Condition Needing Improvement. Pharmacy Service managers needed to improve controls over pharmacy security. VHA policy requires Pharmacy Service staff to manage medications, particularly controlled substances, to ensure patient safety and prevent diversion. In addition, VA policy requires specific physical safeguards to ensure pharmacy security. Our review found that controlled substances inventories and unannounced inspections were properly performed, controlled substances inspectors were properly trained, and employee access controls in the pharmacy were effective.

However, we identified three deficiencies in pharmacy physical security that needed to be corrected: (1) the SVAMC outpatient and the Martinez CBOC pharmacy dispensing areas were not enclosed with bulletproof windows, (2) the ground level windows of the Martinez CBOC pharmacy did not have required security mesh screening, and (3) VA Police took 10 minutes to respond during a test of the SVAMC inpatient pharmacy panic alarm. VA Police responded promptly to our tests of the panic alarms at the SVAMC outpatient and Martinez CBOC pharmacies but arrived late at the SVAMC inpatient pharmacy because the dispatcher had directed them to the wrong pharmacy.

During our review, the Chief of Pharmacy Service provided documentation showing that the bulletproof dispensing windows had been ordered for the SVAMC outpatient and Martinez CBOC pharmacies and that an Engineering Service work order had been submitted to install security mesh screening on the ground level windows of the Martinez CBOC pharmacy.

Recommendation 7. We recommended the VISN Director ensure that the Health Care System Director requires that: (a) the Chief of Pharmacy Service ensures the SVAMC outpatient and Martinez CBOC pharmacy dispensing areas are enclosed with bulletproof windows and security mesh screening is installed on the ground level windows of the Martinez CBOC pharmacy and (b) VA Police implement procedures to ensure dispatchers direct responding officers to the proper locations when panic alarms are activated.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the required upgrades at the SVAMC and Martinez CBOC outpatient pharmacies will be completed by June 30, 2005. In addition, the health care system has implemented dispatching and testing procedures to ensure the dispatcher directs responding officers to the correct pharmacy location. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 21 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 17, 2005

From: Director, VA Sierra Pacific Network (VISN 21)

Subject: **Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, CA**

To: Director, Los Angeles Audit Operations Division (52LA)
Director, Management Review Office (10B5)

1. I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of the VA Northern California Health Care System (VANCHCS). I carefully reviewed the report, as well as my notes from the exit briefing I attended on February 18, 2005, in Sacramento, CA. In addition, I discussed the findings and recommendations with senior leadership at VANCHCS and the VISN 21 office.

2. In brief, I concur with all of the conditions needing improvement and recommended improvement actions. The implementation plan showing specific corrective actions is provided in Appendix B. As you will note, actions have already been initiated and are progressing.

3. I am pleased that you noted the organizational strengths of the quality management program in using provider profiles to monitor clinical performance and peer reviews to improve quality of care. I am very proud that questionnaires and patient interviews documented a high level of patient satisfaction.

4. In closing, I would like to express my appreciation to the CAP review team. The team members were diligent, professional and comprehensive. In addition to audit and oversight activities, the CAP team provided several educational

sessions (e.g., fraud and abuse awareness) that were helpful. The collective efforts and insights of the CAP review team have helped to improve our clinical activities and business practices at VANCHCS.

(original signed by:)
Robert L. Wiebe, M.D., M.B.A.

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2005

From: Director, VA Northern California Health Care System (612/00)

Subject: **Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, CA**

To: Director, Los Angeles Audit Operations Division (52LA)
Director, Management Review Office (10B5)

1. On behalf of VA Northern California Health Care System, I would like to thank you for the informative and constructive OIG CAP audit performed in February 2005. Attached please find comments, corrective action plans and completion dates for each recommendation.

2. You may direct questions related to our attached responses to me at (925) 372-2010.

(original signed by:)
Lawrence S. Sandler

Director's Comments to Office of Inspector General's Report

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

OIG Recommendation

Recommendation 1. We recommend the VISN Director ensure that the Health Care System Director requires that (a) MCCF managers periodically verify the accuracy and completeness of the PCRR and implement monitoring procedures to ensure all encounters are properly reviewed and billed and (b) clinicians promptly and completely document all patient encounters in the medical records.

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

(a) MCCF managers periodically verify the accuracy and completeness of the PCRR and implement monitoring procedures to ensure all encounters are properly reviewed and billed.

VANCHCS concurs that the Medical Care Collection Fund (MCCF) managers need to periodically verify the accuracy and completeness of the Potential Cost Recovery Report (PCRR). The implementation plan includes the following:

1. To improve the accuracy of the PCCR, which the OIG discovered was missing fee cases, the Austin routine has been requested and will be used to check the accuracy and completeness of our report and ensure that no potentially billable services have been dropped.

2. MCCF has established a process to ensure all billable fee cases are properly identified by the Fee Staff and documented in the Fee Basis package. Following monthly audits of the PCCR, cases that require service-connected determination are referred to the Utilization Review nurse.

(b) VANCHCS concurs that clinicians must promptly and completely document all patient encounters in the medical records. The implementation plan includes the following:

1. Once a diagnosis or procedure has been determined to meet the guidelines for coding and reporting, but has not been sufficiently documented in the medical record, coding staff will contact the provider.

2. Providers are given two weeks to respond and complete the necessary, additional documentation. If the documentation is still incomplete, the coding staff will notify the Compliance Officer who will remind the provider. Providers are given 5 days to complete documentation before notification of the Chief of Staff. If the documentation is still incomplete after 1 week the Compliance Officer will notify the Chief of Staff who will take appropriate action.

Recommendation 2. We recommend the VISN Director ensure that the Health Care System Director requires Business Office staff to regularly review veterans' compliance with debt repayment plans and, if necessary, reinitiate DMC collection activities when debts are not repaid.

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

VANCHCS concurs with the OIG assessment that the MCCF Staff regularly review veterans' compliance with debt repayment plans. The implementation plan includes the following:

1. The MCCF Coordinator has provided training sessions to the accounts receivable staff on the proper procedures for follow-up on first-party debts. This training included appropriate referral of any unpaid first-party co-payment debts to the Treasury Offset Program (TOP) and the Debt Management Center (DMC); review for possible termination if the debt does not meet referral criteria; and, review for appropriate disposition of debts greater than one year at TOP/DMC.

2. The MCCF Coordinator has established a process to ensure appropriate first-party follow-up. This process includes reviewing all repayment plans to ensure that if the patient has defaulted on their repayment plan agreement it has been reinstated to the Treasury Offset Program (TOP) and Debt Management Center (DMC) for possible collection.

Recommendation 3. We recommend the VISN Director ensure that the Health Care System Director requires clinicians to consistently perform and document all skin integrity reassessments and consistently document that all treatments were provided as ordered.

Concur **Target Completion Date: 7/31/05**

VANCHCS concurs with the OIG assessment that clinicians consistently perform and document all skin integrity reassessments and that treatments are provided as ordered. The implementation plan includes the following:

1. To ensure that clinicians consistently perform and document all skin integrity reassessments, VANCHCS established a new policy on the prevention of pressure ulcers which will be fully implemented by May 31, 2005. To assist in implementing this policy, VANCHCS has established an electronic wound treatment template to ensure that ordered treatments are provided to the patient. VANCHCS has initiated training on use of this template and it will be completed by May 31, 2005.

2. VANCHCS will perform quality review audits of 15 inpatient records. The audit schedule is monthly until 100 percent compliance is reached. The audits will then occur quarterly.

Recommendation 4. We recommend the VISN Director ensure that the Health Care System Director requires that: (a) IRM staff promptly terminate LAN and VistA access for users who leave the health care system or who no longer need access, (b) the ISO and service chiefs ensure all health care system employees complete required IT security awareness training, (c) the Contingency Disaster Recovery Plan be updated to include a current list of computer equipment and an alternative processing facility, (d) IRM establishes a process for monitoring Internet usage, and (e) IRM documents system data backup tests.

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

VANCHCS concurs with the OIG assessments regarding strengthening controls related to information technology security. The implementation plans include the following:

(a) IRM staff promptly terminates LAN and VistA access for users who leave the health care system or who no longer need access.

1. Each pay period IRM receives the employee separation list from Human Resources Management Service. Accounts are terminated at that time. As a further back-up to this process, a facility policy has been implemented that at 90 days, idle accounts are automatically deactivated and at 180 days, those accounts are terminated.

2. Human Resources Management Service and the Office of Education will forward lists of separated WOC employees and trainees, in addition to the list of

separated permanent employees, to the ISO and IRMS on a biweekly basis for review and account termination, as appropriate.

(b) The ISO and service chiefs ensure all health care system employees complete required IT security awareness training.

Mandatory Information Security Awareness Training is tracked on a fiscal year cycle. The ISO will provide monthly updates to Service Chiefs and ADP Coordinators on their employees' compliance with the training. Staff is frequently reminded to take the course by email and posters. The Director and Associate Directors will become involved if any Service is in jeopardy of not achieving the 100 percent training target by the end of the fiscal year.

(c) The Contingency Disaster Recovery Plan be updated to include a current list of computer equipment and an alternative processing facility.

1. The list of computer equipment, found in the VANCHCS Vista Contingency Plan, has been updated to reflect a current list of computer equipment and will be kept current as the computing environment changes.

2. The VANCHCS alternate processing facility has been identified as the Sacramento VA Medical Center. The documentation of this designation is located in the Vista Contingency Plan as the "alternate processing site".

(d) IRM establishes a process for monitoring Internet usage.

Internet monitoring will be conducted on a random sample of users on a quarterly basis. Suspicious internet activity will be reported to the Director and Associate Directors for appropriate follow-up.

(e) IRM documents data backup tests.

The VANCHCS IT Backup Procedures Policy has been amended and regular testing of tape backups for all critical systems is now occurring on a monthly cycle. The "Backup Testing Log", which is an attachment to that policy, is being used to document the testing.

Recommendation 5. We recommend the VISN Director ensure that the Health Care System Director requires A&MMS staff to: (a) ensure required EIL inventories are completed, (b) conduct quarterly spot checks of EILs, and (c) assign equipment items to EILs upon receipt and ensure all sensitive equipment items are included on the EILs.

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

VANCHCS concurs with the OIG assessment that the A&MMS staff ensures greater oversight of equipment accountability. The implementation plan includes the following:

(a) Ensure required EIL inventories are completed.

1. VANCHCS staff will perform a 100 percent comprehensive review of the current integrated system of medical supply equipment, research equipment and non-medical equipment and this will include less-than-$5,000 inventory items.

2. To accomplish this, a review will identify those items not inventoried within the last 180 days and an out of cycle inventory will be performed. This process will include designating accountability to the item user; thereby delegating inventory control to the appropriate level.

(b) Conduct quarterly spot checks of EILs.

VANCHCS will, as a component of the improved processes of equipment management oversight, establish a 120 day review of 25 percent of all assigned EIL inventories such that by the end of each fiscal year, a 100 percent spot check of all EIL inventories is conducted. This quarterly review will identify the EIL inventory reviewed, the reviewer by name, the date of review and it will be part of a new internal report matrix which will become a record of review maintained annually.

(c) Assign equipment items to EILs upon receipt and ensure all sensitive equipments items are included on the EILs.

1. VANCHCS has developed an equipment inventory update process that ensures equipment received is placed on the appropriate EIL listing which includes sensitive items regardless of price.

2. VANCHCS has developed a process of equipment management that integrates the equipment ordered with the “due-in status” to the ordering service. A tentative updated EIL listing is prepared prior to item receipt. Once the item is received, the new EIL is forwarded to the ordering service. This concurrent delivery of equipment and the EIL update ensures items are processed on time.

Recommendation 6. We recommend that the VISN Director ensure that the Health Care System Director requires that (a) part-time physicians on adjustable work schedules are to obtain approval in advance for changes to their non-core hours and (b) Fiscal Service staff to perform timekeeper desk audits in accordance with VA policy.

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

(a) part-time physicians on adjustable work schedules to obtain approval in advance for changes to their non-core hours.

VANCHCS concurs with the OIG assessment that part-time physicians on adjustable work schedules obtain prior approval for non-core hour changes. The implementation plan includes the following:

1. All part-time physicians were re-educated on their responsibilities related to part-time physician time and attendance. This included a memo from the Director and Chief of Staff to all part-time physicians and the highest levels of management at the University affiliate reconfirming the importance of time and attendance, one-to-one training sessions with each part-time physician and their confirmed receipt of Policy Statement 04-16 relating to time and attendance.

2. To further enforce compliance, VANCHCS, in addition to the VACO mandated monthly facility-based audits, will perform monthly random audits.

(b) Fiscal Service staff to perform timekeeper desk audits in accordance with VA policy.

VANCHCS concurs with the OIG assessment that Fiscal Service staff performs timekeeper desk audits in accordance with policy. The implementation plan includes the following:

As noted by the OIG examiner, VANCHCS payroll staff completed 83 percent of the timekeeper desk audits for FY2003 and 94 percent for FY2004. A timekeeper desk audit schedule has been established to achieve 100 percent compliance.

Recommendation 7. We recommend that the VISN Director ensure that the Health Care System Director requires that (a) the Chief of Pharmacy ensure the two outpatient dispensing areas are enclosed with bulletproof windows and security mesh screening is installed on the ground level windows of the inpatient

pharmacy and (b) VA Police implement procedures to ensure dispatchers direct responding officers to the proper location when panic alarms are activated.

Concur **Target Completion Date: 7/31/05**

(a) Chief of Pharmacy ensure the two outpatient dispensing areas are enclosed with bulletproof windows and security mesh screening is installed on the ground level windows of the inpatient pharmacy.

1. The Chief of Pharmacy continues to improve controls over pharmacy physical security. Materials were ordered prior to the CAP visit to upgrade the outpatient pharmacies at the Mather and Martinez sites in order to comply with VA specifications. The required construction is scheduled to be completed by June 30, 2005.

(b) VA Police implement procedures to ensure dispatchers direct responding officers to the proper location when panic alarms are activated.

VA Police have implemented procedures to ensure the dispatcher directs responding officers to the correct Mather location i.e., inpatient vs. outpatient pharmacy, by requesting that the contract monitoring station clearly delineate the two pharmacy locations in their computer data base. The Mather pharmacy panic alarm system has been tested twice (April 6, 2005 and April 22, 2005) since the additional information was added and appropriate location information was relayed by the contract monitoring station both times. This system and process will continue to be tested monthly.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds through improved MCCF billing and documentation procedures.	$44,790
2	Better use of funds through improved offset collection procedures.	41,343
	Total	$86,133

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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