Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Salt Lake City Health Care System Salt Lake City, Utah

Report No. 05-01248-170

July 8, 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 April 11–15, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Salt Lake City Health Care System. 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 450 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 19.

Results of Review

The CAP review covered 12 operational activities. The health care system complied with selected standards in the following four activities:

- Community Nursing Home Contracts
- Environment of Care
- Part-Time Physician Timekeeping
- Service Contracts

We identified the following organizational strengths:

- Part-time physician time and attendance was effectively monitored.
- Efficient blood ordering practices were implemented.
- Initiatives to reduce patient falls were effective.
- Patients reported high satisfaction with care and services.

We made recommendations in 8 of the 12 activities reviewed. For these activities, the health care system needed to:

- Improve clinical documentation to increase insurance billings and collections.
- Reduce excess supply inventories and improve inventory management controls.
- Improve provider profiles and ensure patients are informed about adverse events.
- Reduce the waiting time from Gastroenterology (GI) consultation to evaluation.
- Strengthen controls for automated information systems (AIS) resources.
- Improve documentation of patient skin integrity assessments.

- Strengthen controlled substances accountability controls.
- Improve pharmacy security of controlled substances.

This report was prepared under the direction of Mr. David Sumrall, Director, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

VISN 19 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.

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

Introduction

Health Care System Profile

Organization. Based in Salt Lake City, the health care system is a tertiary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at nine community-based outpatient clinics in Ogden, Orem, St. George, Roosevelt, Nephi, and Fountain Green, UT; Pocatello, ID; Ely, NV; and Green River, WY. The health care system serves a population of about 194,600 veterans in a primary service area that includes 49 counties in Utah, Idaho, Nevada, and Wyoming.

Programs. The health care system provides medical, surgical, mental health, geriatric, and advanced rehabilitation services and has 121 beds. Special programs include the North Star Residential Substance Abuse Program, a Cardiac Transplant Program, and a Women Veterans Program. The health care system also has sharing agreements with Hill Air Force Base, Fort Douglas Army Reserve Center, the Utah Air National Guard, and the U.S. Army-Baylor University Graduate Program.

Affiliations and Research. The health care system is affiliated with the University of Utah School of Medicine and supports 850 medical residents, interns, and students in 50 training programs. The health care system is also affiliated with several other universities to provide clinical training opportunities for nursing, pharmacy, dental, and physical therapy students. In fiscal year (FY) 2004, the health care system research program had 256 VA projects and 156 non-VA projects and a combined budget of $11.6 million. Important research areas include biomedical research in nephrology, stem cell research in cardiology, and rehabilitation research in strokes and amputations.

Resources. The health care system's FY 2005 medical care budget was $205.6 million, less than a 1 percent increase over FY 2004 funding of $204.4 million. FY 2004 staffing was 1,277 full-time equivalent employees (FTE), including 79 physician FTE and 322 nursing FTE.

Workload. In FY 2004, the health care system treated 36,762 unique patients, a 6 percent increase from FY 2003. The FY 2004 inpatient average daily census, including nursing home patients, was 101, and outpatient workload totaled 345,280 patient visits (a 3 percent increase from FY 2003).

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

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 12 activities:

Colorectal Cancer Management	Part-Time Physician Timekeeping
Community Nursing Home Contracts	Pharmacy Security
Controlled Substances Accountability	Pressure Ulcer Clinical Practices
Environment of Care	Quality Management
Information Technology Security	Service Contracts
Medical Care Collections Fund	Supply Inventory Management

The review covered health care system operations for FYs 2000 to 2005 through April 2005 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the health care system (*Combined Assessment Program Review of the VA Salt Lake City Health Care System*, Report No. 02-03263-68, March 7, 2003).

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with timeliness of service and the quality of care. Questionnaires were sent to all employees, and 264 employees responded. We also interviewed 30 patients during the review. We discussed the survey and interview results with health care system managers.

During this review, we also presented 6 fraud and integrity awareness briefings for 450 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.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5–13). 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. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Organizational Strengths

Part-Time Physician Time and Attendance Was Effectively Monitored. The health care system had an effective program for monitoring part-time physician time and attendance. To verify time and attendance, we selected a sample of 10 of the 89 part-time physicians. We accounted for all 10 physicians. All 89 physicians had 25 percent of their hours designated as core hours and had detailed written work schedule agreements. In an effort to ensure the quality of timekeeping practices, the health care system initiated their own series of monthly random audits of part-time physician attendance. During the random audits, timekeepers were required to account for all part-time physicians and report the results to the Chief of Staff.

Efficient Blood Ordering Practices Were Implemented. In 2004, the health care system's Transfusion Committee implemented a comprehensive review of blood ordering and transfusion practices. Clinicians are expected to follow established blood ordering guidelines to ensure efficient use of limited blood supply and blood bank staff time. Ordering practices were reviewed to ensure blood ordered by providers was not wasted or unnecessarily held in reserve. As a result in FY 2004, blood units ordered for possible transfusions decreased by 13 percent in Surgical Service and 20 percent in Thoracic Service.

Initiatives To Reduce Patient Falls Were Effective. An interdisciplinary team developed an effective program to reduce the incidence of patient falls and resulting injuries. After reviewing the number, location, and severity of falls, the team recommended significant changes to the patient bathrooms where many of the falls occurred. The team also implemented an electronic alert system to notify staff of patients at risk for falling. In 2004, the health care system reported a fall injury incidence of 2 percent compared to the national rate of 3 percent.

Patients Reported High Satisfaction with Care and Services. The patient satisfaction score from the Veterans Health Administration's (VHA's) Survey of Healthcare Experiences of Patients (SHEP) performance measure exceeded the national average. From October 2004–January 2005, the health care system reported an average SHEP score of 84 percent for overall quality compared to the national average of 77 percent. In addition, 100 percent of the patients we interviewed would recommend care at this health care system to an eligible family member or friend, and over 90 percent generally felt they were involved in decisions about their care and rated the quality of care as excellent or very good.

Opportunities for Improvement

Medical Care Collections Fund – Clinical Documentation Needed Improvement

Condition Needing Improvement. The health care system needed to ensure that clinicians adequately documented medical care. Under the Medical Care Collections Fund (MCCF) program, VA medical facilities are authorized to bill health insurance carriers for the treatment of insured veterans. During FY 2004, the health care system collected $20.2 million. Improved clinical documentation could increase insurance billings and collections.

VHA policy requires clinicians to enter documentation into the medical record for each outpatient encounter so that MCCF staff can bill insurers for the care provided. The "Reasons Not Billable Report" ("RNB") for the 3-month period October–December 2004 listed 377 patient care encounters that had not been billed because clinical notes were missing, insufficient, or signed by nonbillable providers (value = $68,676). To determine whether the "RNB" accurately reflected missed billing opportunities, we reviewed a random sample of 50 cases (value = $8,551). We found that 36 of them (value = $4,960, or 58 percent of the total value $8,551) had not been billed because clinical notes were either missing or did not contain sufficient detail and the follow-up process did not always ensure that these deficiencies were corrected. The remaining 14 cases were not missed billing opportunities.

Using the health care system's FY 2004 insurance collection rate of 35 percent, we estimated that better clinical documentation would have resulted in additional revenue of $13,941 ($68,676 in bills with missing or insufficient documentation x 58 percent sample result x 35 percent collection rate = $13,941).

Recommendation 1. We recommended that the VISN Director ensure that the Health Care System Director takes action to require that medical records include sufficient clinical documentation to support insurance billings.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that plans had been implemented to ensure medical records include sufficient clinical documentation to support insurance billings. An employee has been hired and given the responsibility of informing clinical staff of any missing or incomplete outpatient documentation. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Conditions Needing Improvement. In FY 2004, the health care system spent $15.9 million on medical, prosthetic, and engineering supplies. VHA establishes a 30-day supply goal and requires that medical facilities 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 to determine optimum order quantities, and conduct periodic physical inventory counts.

Our March 2003 CAP review found that the health care system stock levels for medical inventories exceeded a 30-day supply, and GIP was not used to manage inventories. We recommended reducing excess inventories, correcting inventory balances, and strengthening inventory management controls.

To determine if the prior deficiencies had been corrected, we performed a follow-up review of medical supply inventory management. We also evaluated management of prosthetic and engineering supply inventories. Although the health care system made progress in complying with the prior CAP review recommendations, they still needed to reduce excess medical supply inventory and improve the accuracy of inventory balances. In addition, they needed to reduce excess inventories of prosthetic supplies and use GIP to manage engineering supplies.

Inaccurate Medical Supply Inventory. Supply Processing and Distribution (SPD) Section staff used GIP to manage medical supply inventory. As of April 11, 2005, the SPD inventory consisted of 1,408 line items with a value of $568,961. To determine the accuracy of the GIP records, we compared the recorded GIP quantities on hand with our physical counts for a judgment sample of 30 medical supply items (value = $113,222). GIP inventory records were not accurate for 14 (47 percent) of the 30 items. For the 14 items, transactions had not been posted to inventory records, resulting in the inventory balances being overstated by $16,557 (15 percent). This occurred because Surgical Service staff took supplies from SPD without recording them on the document that SPD used to update GIP. Because the GIP data was inaccurate, we could not determine the value of the excess medical supply inventory.

Excess Prosthetic Supply Inventory. The Prosthetics and Sensory Aids Service (PSAS) used VA's Prosthetics Inventory Package (PIP) to control inventory. As of April 12, 2005, the PSAS maintained an inventory of 545 supply items (value = $146,106). We reviewed the quantities on hand and usage rates for a judgment sample of 10 items (value = $8,375). Three of the 10 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 89 to 100 days of supply. The estimated value of stock exceeding 30 days was $1,020, or 12 percent of the total value for the 10 items. The excess occurred because staff made large purchases and did not adequately manage changes in demand. By applying the 12 percent estimate of excess stock for the

sampled items to the entire stock, we estimate that the value of all excess stock was $17,533 (12 percent x $146,106 actual PIP value of stock).

GIP Not Used to Manage Engineering Inventory. In October 2004, VHA suspended the 30-day stock level requirement for engineering inventories until they make a decision on what supplies should and should not be subject to the requirement. Therefore, we only focused our review on determining whether the health care system was using GIP to manage engineering supplies. We determined that Engineering Section staff was not using GIP to establish normal stock levels, analyze usage data, and perform periodic physical inventories. The Chief of Engineering Section acknowledged the need to fully implement GIP controls for all engineering supplies.

Recommendation 2. We recommended that the VISN Director ensure that the Health Care System Director requires: (a) SPD staff to identify and update inaccurate GIP records and keep GIP inventory records accurate by ensuring Surgical Service staff record supplies taken from inventory, (b) PSAS staff to monitor item usage rates and reduce excess prosthetic inventory, and (c) Engineering Section staff to implement GIP for all engineering supplies.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that plans were being implemented to automate inventories and increase their accuracy. The target date for full implementation of these plans is October 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Quality Management – Provider Profiles and Informing Patients About Adverse Events Needed Improvement

Conditions Needing Improvement. Appropriate QM review structures were in place for 10 of the 12 program areas reviewed. However, provider profiles and informing patients about adverse events needed improvement.

Provider Profiles Not Available. Clinical managers needed to collect and analyze provider-specific information from QM activities at the time of reprivileging. Joint Commission on Accreditation of Healthcare Organizations standards require that QM information be considered for each licensed independent practitioner every 2 years (prior to renewing clinical privileges). Provider-specific QM information was not available for four of five sampled practitioners who had been reprivileged in the past 6 months. QM information that may be used includes results of medical records, utilization management, and procedure complications reviews. In our 2003 CAP review, we identified the same condition and suggested that provider profiles be improved.

Patients Not Informed About Adverse Events. When adverse events occur as a result of patient care, VHA policy requires medical facility staff to discuss the events with the

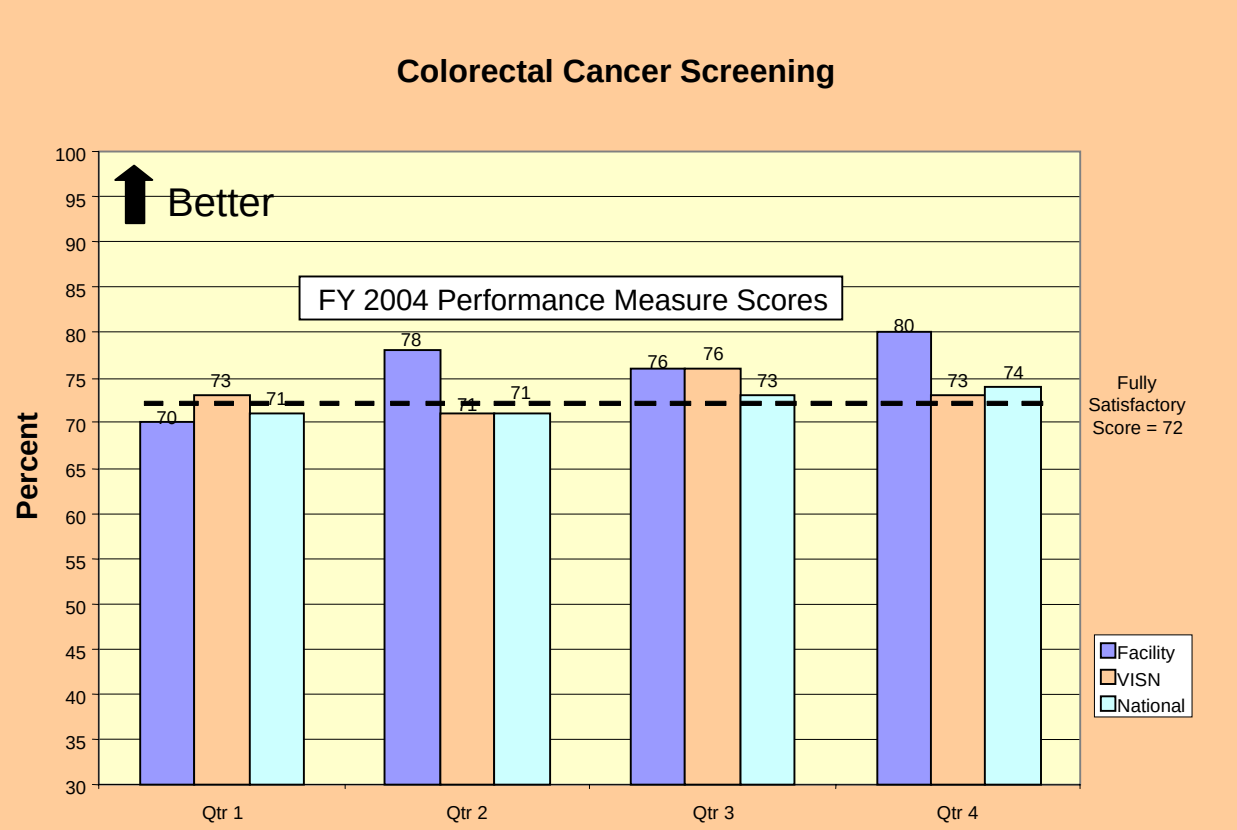
patients and, with input from VA Regional Counsel, inform them of their rights to file tort or benefits claims. From January 2004–January 2005, two patients experienced adverse events during inpatient care. Health care system staff had discussed the events with both patients and documented the discussions in the progress notes. However, health care system staff had advised only one patient about his right to file claims. Local policy did not include informing patients of their rights to file claims.

Recommendation 3. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) provider-specific QM information be available and considered for all licensed independent practitioners prior to reprivileging, (b) responsible clinicians and administrative staff fully inform patients who experience adverse events and document the discussions, and (c) the QM Coordinator revises the local policy to include informing patients of their rights to file claims.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that provider-specific QM information will be considered before re-privileging, and corrective actions for the other identified deficiencies will be completed by August 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Colorectal Cancer Management – Waiting Times for GI Evaluations Should Be Reduced

Condition Needing Improvement. Clinicians needed to improve the timeliness of colorectal cancer diagnosis by reducing the time from GI consultation to patient evaluation. The VHA colorectal cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. As the graph on the following page shows, in 3 of the 4 quarters of FY 2004 the health care system's overall performance met the VHA standard (72 percent or better) for colorectal cancer screening:



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a random sample of 10 patients who were diagnosed with colorectal cancer during FY 2004. To determine reasonableness, we used the health care system's goal of performing GI consultations within 120 days of screening for expedited cases (taking into consideration factors outside the health care system's control). For the purposes of this review, we considered the timeframe of 45 days from diagnosis to earliest treatment as reasonable.

As the following table shows, all 10 patients were properly screened and received interdisciplinary treatment plans, and 9 were appropriately notified of their diagnoses and received initial treatment within 45 days, but only 4 were diagnosed within 120 days of screening:

Patients appropriately screened	Patients diagnosed within 120 days	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients who received initial treatment within 45 days
10/10	**4/10**	**9/10**	**10/10**	**9/10**

Diagnostic GI procedures were frequently not performed within 120 days of screening because of increased workload and limited resources. Our review of workload data confirmed an 80 percent increase in procedures from 3,278 in FY 2000 to 5,895 in FY 2004. Health care system managers told us that they had reached maximum capacity for the existing space, equipment, and personnel.

Recommendation 4. We recommended that the VISN Director ensure that the Health Care System Director takes action to improve the waiting time from GI consultation to patient evaluation.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that by September 2005 procedures will be implemented to improve the patient waiting time from GI consultation to patient evaluation. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Information Technology Security – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed health care system AIS policies and procedures to determine whether controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that adequate service-level contingency plans had been developed, and policies were in place to ensure sensitive data was removed from computers prior to disposal. However, we identified two deficiencies that needed corrective action.

Access to Computer Room and Telephone Switch Rooms Not Limited. VHA policy requires that access to AIS resources be limited to individuals having an official need to be in the area. There were 21 (44 percent) of 48 individuals who did not need access to the computer room and 14 (31 percent) of 45 individuals who did not need access to the 2 telephone switch rooms. In addition, the computer room and switch rooms had door lock keys that were made from the master key. VA policy requires that keys to computer rooms and switch rooms not be made from the master keys. During our review, the Manager of Information Resources Management Service (IRMS) terminated access to all the individuals who did not need access to the computer room and switch rooms and changed the door locks so that these rooms could not be opened using the master key.

Inactive Accounts Not Terminated. Veterans Health Information Systems and Technology Architecture (VistA) access accounts had not been terminated for some inactive users. We reviewed VistA access for a judgment sample of 20 accounts for users who were not shown as current health care system employees in the VA payroll system as of March 18, 2005. Fourteen of the 20 accounts were for valid users, such as contract employees and students. However, the other six accounts should have been terminated because these users no longer worked at the health care system or did not have a continued need for access.

Recommendation 5. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) limit and control access to the computer room and telephone switch rooms and (b) promptly terminate VistA accounts for individuals who do not have a continued need for access.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that actions had been completed to limit and control access to computer and switch rooms and to terminate VistA accounts for individuals who do not have a continued need for access. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Pressure Ulcer Prevention and Management – Documentation of Skin Integrity Assessments Needed Improvement

Conditions Needing Improvement. Clinicians needed to consistently document patient skin integrity assessments and reassess patients at risk for pressure ulcers. Local policy required clinicians to assess all patients at the time of admission and daily for patients at risk for pressure ulcers. All assessments must be documented in the medical records. Our review of a judgment sample of 10 medical records found that 2 contained no documentation of skin assessments at admission and 3 contained no consistent documentation of daily skin reassessments.

Recommendation 6. We recommended that the VISN Director ensure that the Health Care System Director requires clinicians to consistently perform and document skin integrity assessments for all patients at admission and daily for patients at risk for pressure ulcers.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that clinician staff training on performing and documenting skin integrity assessments will be completed by September 2005. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Controlled Substances Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed controlled substances accountability to determine if controls were adequate to prevent the loss or diversion of drugs and to ensure that controlled substances were properly accounted for. VHA policy requires medical facilities to conduct monthly unannounced inspections of all drug storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period February 2004–January 2005 and observed unannounced inspections of areas where controlled substances were stored and dispensed. We identified three inspection deficiencies.

Monthly Inspections Not Performed. Inspection procedures did not ensure that all controlled substances locations were inspected every month. During the review period, 74 (20 percent) of the required 373 inspections were not performed.

Monthly Inspections Missing Element of Surprise. Monthly unannounced inspections did not always have the element of surprise as required by VHA policy. In a monthly memorandum to the inspectors, the controlled substances coordinator instructed the inspectors to complete the inspections during a specified 2-week window during the third and fourth weeks of the month. As a result, 246 (82 percent) of the 299 inspections performed during the review period were done during the third and fourth weeks of the month.

Drugs Held for Destruction Not Properly Sealed. Controlled substances held for destruction in the inpatient pharmacy were placed in plastic bags that were stapled across the opening. VHA policy requires that controlled substances held for destruction be placed in an envelope that is dated, sealed with tape, and signed across the seal by an authorized Pharmacy Service employee.

Recommendation 7. We recommended that the VISN Director ensure that the Health Care System Director takes action to require that: (a) all required controlled substances inspections are done each month, (b) inspections are conducted with the element of surprise, and (c) the destruction of controlled substances will comply with VHA policy.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that by June 2005 controlled substances inspections will be completed each month with the element of surprise and the destruction of controlled substances will comply with VHA policy. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Security – Burglary-Resistant Safe Needed

Condition Needing Improvement. We reviewed pharmacy security to determine if controls were adequate to prevent the loss or diversion of controlled substances. Access controls were effective and physical security was adequate in most pharmacy areas. However, one deficiency needed correction.

Bulk supplies of controlled substances were stored in safes in the inpatient and outpatient pharmacies. These safes did not meet VA security standards, which require that Schedule II–V controlled substances be stored in safes that have burglary-resistant protections. In cases where a safe is not practical, controlled substances may be stored in a vault that has reinforced concrete walls and a day gate.

Recommendation 8. We recommended that the VISN Director ensure that the Health Care System Director takes action to require that controlled substances be stored in a burglary-resistant safe.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that a project to improve security of bulk supplies of controlled substances will be completed by FY 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Appendix A

VISN 19 Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 10, 2005

From: Director, VA Rocky Mountain Network (10N19)

Subject: CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah

To: Director, Seattle Audit Operations Division (52SE)

1. Attached is the response to the OIG CAP Site Review of the VA Salt Lake City Health Care System (VASLCHCS) and comments from the Facility Director.

2. I have reviewed and concur with all of the Facility Director's comments.

3. I appreciate the courtesy and cooperativeness displayed by you and all members of the OIG team throughout this review process. If you have any questions, please contact Ms. Susan Curtis, Health Systems Specialist at (303) 756-9279.

Lawrence A. Biro

Lawrence A. Biro

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2005

From: Director, VA Salt Lake City Health Care System (660/00)

Subject: CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah

To: Myra Taylor, Audit Manager, VA Office of Inspector General (52SE)

1. Attached is the response to the OIG CAP Site Review and comments from the Network Director.

2. I appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

JAMES R. FLOYD, CHE

Attachment

VA Salt Lake City Health Care System

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Medical Care Collections Fund – Clinical Documentation Needed Improvement

Recommendation 1. We recommend that the VISN Director ensure that the Health Care System Director take action to require that medical records include sufficient clinical documentation to support insurance billings.

Concur with recommended improvement action.

Planned Action: The Revenue Coordinator will generate the "Reasons Not Billable Report ("RNB") monthly. This report lists billable visits that were canceled because of incomplete and/or missing documentation. This process was initiated on May 12, 2005.

The Coordinator will use the "RNB" report to develop a detailed "RNB" spreadsheet, which will give an expanded view of the documentation issue, and responsible provider. The spreadsheet will be reviewed and utilized starting on June 16, 2005.

The Compliance Committee will make recommendations to the provider's Service Chief for corrective action to be taken within two weeks. The Compliance Committee will analyze trends and make recommendations to the Administrative Executive Board and Clinical Executive Board monthly. This process will be initiated starting on June 16, 2005.

A new position titled the Encounter Form Completion Coordinator has recently been filled. This individual is in the process of developing a series of reports and tools designed to provide daily feedback to all clinical staff on any missing or incomplete outpatient documentation. This Encounter Form Completion Coordinator position was filled on May 23, 2005, and the needed tools and reports to provide daily feedback to the clinical staff will be finalized by July 31, 2005.

A hospital Encounter Form completion policy has been drafted and will be enforced by clinical management staff with support from the Encounter Form Completion Coordinator. These action steps will be fully in place by July 31, 2005.

2. Supply Inventory Management – Excess Inventories Should be Reduced and Controls Improved

Recommendation 2. We recommend that the VISN Director ensure that the Health Care System Director requires: (a) SPD staff to identify and update inaccurate GIP records and keep GIP inventory records accurate by ensuring Surgical Service staff record supplies taken from inventory, (b) PSAS staff to monitor item usage rates and reduce excess prosthetic inventory, and (c) Engineering Section staff to implement GIP for all engineering supplies.

Concur with recommended improvement actions.

a. SPD staff to identify and update inaccurate GIP records and keep GIP inventory records accurate by ensuring Surgical Service staff record supplies taken from inventory

Planned Action: GIP stock on hand reports will continue to be reviewed monthly for reconciliation with physical inventory and adjustments as necessary to improve the accuracy of GIP data. The Sterile Processing Section that has joint responsibility for recording the expended supplies is being realigned under the SPD of Acquisition & Materiel Management. Negotiations for this realignment are in process and anticipated to be completed within 60 days (August 1, 2005). A workload analysis will be conducted by A&MMS/SPD and process improvements will be addressed and implemented by October 1, 2006. The SPD section will have direct oversight of the staff and be able to address the issues of non-compliance as they occur.

b. Prosthetics and Sensory Aid Service (PSAS) staff to monitor item usage rates and reduce excess prosthetic inventory

Planned Action: Inventory will be reviewed and a wall-to-wall inventory of all prosthetics supplies will be conducted. An evaluation will be conducted to determine what stock levels are necessary to provide patient care without exceeding the mandated 30-day stock on hand. All excess stock will be removed and turned in. Stock levels will be adjusted and processes put in place to alert staff of when to order replacement stock in order to fall

below the 30-day stock on hand requirement. This initiative is expected to be completed by June 30, 2005.

Prosthetics patches 61 and 107 will be installed in order implement the bar code system to track, monitor, receipt, issue, and obligate stock equipment. The patch will automatically post the issue of stock equipment and lower the stock on-hand quantity. The PIP bar code system is estimated to be installed and in use by July 31, 2005.

One purchasing agent and one prosthetics clerk will be assigned to monitor, order, and be accountable for all stock equipment for the station. The two FTEE will be responsible to assure stock on hand is maintained below the 30-day requirement with adequate stock on hand to provide patient care. Reassignment of the two prosthetics personnel to be completed by August 31, 2005.

A policy will be established which will address the procedures required to add, adjust levels, and remove stock equipment in the PIP. The policy will include implementing a system similar to SPD's Commodities Committee or other systems used throughout the VISN. The policy will be written and implemented by July 31, 2005.

c. Engineering Section staff to implement GIP for all engineering supplies

Planned Action: Approximately 3099 recurring line items have been entered into the Engineering Primary GIP account. The Engineering Primary account includes 14 secondary distribution points. On an interim basis, Engineering will continue to manage the physical inventory and submit purchasing requirements to A&MMS. A&MMS will continue to add new items into the GIP system and post delivered receivables to the secondary inventory points. A&MMS will run usage data reports within the Engineering Primary GIP account and furnish copies to Engineering on a monthly basis commencing on July 1, 2005. Acquisition & Materiel Management has exhausted all resources within the department and has been unable to completely assume the full responsibility for GIP. The Manager of A&MMS will complete a workload analysis to determine the additional number of FTE required to complete the GIP implementation for the Engineering department and submit to the Executive Board for review no later than August 1, 2005. Final implementation of all GIP requirements within the Engineering department will be completed by October 3, 2005.

3. Quality Management – Provider Profiles and Informing Patients About Adverse Events Needed Improvement

Recommendation 3. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) provider-specific QM information be available and considered for all licensed independent practitioners prior to re-privileging, (b) responsible clinicians and administrative staff fully inform patients who experience adverse events and document the discussions, and (c) the QM Coordinator revise the local policy to include informing patients their rights to file claims.

Concur with recommended improvement actions.

a. Provider-specific QM information be available and considered for all licensed independent practitioners prior to re-privileging

Planned Action: The Quality Management Department will maintain a database containing provider specific QM information. The provider specific information located in this data base includes: tort claims filed, patient complaints, number of Level II and Level III peer reviewed cases and performance measure data. This information will be displayed on Excel spreadsheets by individual providers and presented to service chiefs on a quarterly basis. The QM information will be considered during the re-privileging of licensed independent practitioners. The database will be completed by August 2005.

b. Responsible clinicians and administrative staff fully inform patients who experience adverse events and document the discussions

Planned Action: When an adverse event/complication occurs, the following process will be followed: The patient (or their designated legal representative) is notified as soon as the event has been identified. The clinical provider will discuss with the patient (or their designated legal representative) the events that occurred and the clinical treatments now available. This discussion will be documented in the patient record using a note template designed to specifically report this interaction. There will be a clinical note documenting the discussion and an administrative note documenting that the patient was advised of their right to file a claim for compensation using form numbers 95 or 1151. The patient's physician will lead the clinical discussion with the patient (or their designated legal representative). The patient's physician, through the Chief of Staff, will inform the Patient Safety

Coordinator of the event within 24 hours who will then provide information on compensation to the patient (or their designated legal representative) and complete the administrative note. This discussion will be documented in the patient record using a note template designed to specifically report this interaction. The clinical and administrative note templates related to adverse event reporting will be completed by August 2005.

c. The QM Coordinator to revise the local policy to include informing patients their rights to file claims

Planned Action: Policy 00Q.67 "Adverse Event Reporting-Disclosure" will be revised to reflect the changes made to this process. The policy will be updated and completed by August 2005.

4. Colorectal Cancer Management – Waiting Times for GI Evaluations Should Be Reduced

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director takes action to improve the waiting time from GI consultation to patient evaluation.

Concur with recommended improvement action.

Planned Action: All consults sent to the GI Clinic will be reviewed within 24 hours. Consults will be printed out daily and triaged for emergent, expedited and routine evaluation. All emergent consults will be dealt with within 24 hours (M-F), all expedited consults will be dealt with within 90 days and routine consults will be dealt with within a six month period. Overall clinic waiting times are reviewed frequently to further decrease backlogs for expedited and routine requests. This plan will be completed by September 30, 2005.

5. Information Technology Security – Controls Should Be Strengthened

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director takes action to (a) limit and control access to the computer room and telephone switch rooms and (b) promptly terminate VistA accounts for individuals who do not have a continued need for access.

Concur with recommended improvement actions.

a. Limit and control access to the computer room and telephone switch rooms

Planned Action: As mentioned in the IG report, the Manager of Information Resources Management Service (IRMS) terminated access to all the individuals who did not need access to the computer room and switch rooms, and changed the door locks so that these rooms could not be opened using the master key.

Additionally, an IRM Service SOP has been established that requests Engineering Service to transmit, on a monthly basis to the Chief, IRM and the ISO, a list of all individuals gaining access to the computer room. The Chief, IRM and the ISO review these reports, and if there has been any unauthorized access, appropriate action is taken.

Action toward meeting this recommendation has been completed.

b. Promptly terminate VistA accounts for individuals who do not have a continued need for access

Planned Action: The IRM department has initiated a process to better obtain information regarding the termination of employees. The Health Care System Director distributed a memorandum to all managers and supervisors requesting that IRM be notified within twenty-four hours when any workforce member (employee, trainee, volunteer, etc.) terminates employment. The Health Care System Director has also charged the ISO to develop a tracking mechanism to monitor the process and report when the process is not adhered to.

Action toward meeting this recommendation has been completed.

6. Pressure Ulcer Prevention and Management – Documentation of Skin Integrity Assessments Needed Improvement

Recommendation 6. We recommend that the VISN Director ensure that the Health Care System Director requires clinicians to consistently perform and document skin integrity assessments for all patients at admission and daily for patients at risk for pressure ulcers.

Concur with recommended improvement action.

Planned Action: Implement individualized training program for all nursing staff in the acute care setting. The training program

will focus on accurate use of the Braden scale and to review the documentation requirements associated with that assessment. The training has been occurring at the annual skills (mandatory training) since January 2005. All nurses will complete training by September 30, 2005. Ongoing education will be provided to all new nursing personnel during nursing orientation**.**

A computer program has been written to view compliance with this standard. On a random day of the week, a report will be generated viewing all inpatients to determine if a daily risk assessment had been performed and documented. Weekly reports of compliance will be sent to the Nurse Managers of the following units: SICU, MICU, Telemetry, Acute Medicine and 3W-General Surgery. These reports will begin the week of June 6, 2005.

7. Controlled Substance Accountability – Controls Should Be Strengthened

Recommendation 7. We recommend that the VISN Director ensure that the Health Care System Director takes action to require that: (a) all required controlled substances inspections are done each month, (b) inspections are conducted with the element of surprise, and (c) the destruction of controlled substances will comply with VHA policy.

Concur with the recommended improvement actions.

a. All required controlled substances inspections are done each month

Planned Action: Re-educate all Controlled Substance Inspectors on the mandatory requirement of completing 100 percent of their assigned inspections monthly. The Controlled Substance Coordinator will monitor and ensure that the inspections are completed before the end of each month. Periodic reminders and tracking will occur throughout the month to ensure that 100 percent of the inspections are completed. The direct line supervisors for the Controlled Substance Inspectors will be notified if the inspectors are not being released from regular duties in order to complete monthly inspections as assigned. All future training will also address the 100 percent review requirements within the month assigned. This plan will be completed by June 2005.

b. Inspections are conducted with the element of surprise

Planned Action: The monthly inspection assignments will now be given without instructions on the specific week they need to be

completed. A completion deadline will be established, but with no recommendation of when the inspection needs to occur. This will allow for more element of surprise and a random timeframe for the inspections. This plan will be completed by June 2005.

c. The destruction of controlled substances will comply with VHA policy.

Planned Action: Pharmacy Service has reviewed procedures with all staff that dispense and process Narcotics and Controlled Substances. Pharmacy supervisors and narcotic inspectors are currently checking to ensure that narcotics and controlled substances that are to be destroyed comply with the required regulations. Non-compliance will be reported to the Chief of Pharmacy and/or the Narcotics Inspection Officer for appropriate action. Action toward meeting this recommendation has been completed.

8. Pharmacy Security – Burglary-Resistant Safe Needed

Recommendation 8. We recommend that the VISN Director ensure that the Health Care System Director takes action to require that controlled substances be stored in a burglary-resistant safe.

Concur with the recommended improvement action.

Planned Action: Pharmacy has met with Facilities Management and has developed a project proposal with several options including costs regarding recommendations for improvements in security for storage of bulk controlled substances. These plans have been reviewed locally by hospital management and sent to Central Office Pharmacy and VISN for review and discussion. Upon input from Central Office, planning will begin to mitigate this deficiency. Completion is planned for FY 2006.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by including adequate clinical documentation in the medical records.	$13,941
2	Better use of funds by reducing excess prosthetic supply inventories.	17,533
	Total	$31,474

Appendix D

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Appendix E

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