# Department of Veterans Affairs
# Office of Inspector General

# Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri

**Report No. 05-00082-198** **September 9, 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 January 24-28, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Harry S. Truman Memorial Veterans' Hospital (referred to as the hospital), Columbia, Missouri. 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 81 employees. The hospital is under the jurisdiction of Veterans Integrated Service Network (VISN) 15.

## Results of Review

This CAP review focused on 14 areas. As indicated below, there were no concerns identified in five of the areas. The remaining nine areas resulted in recommendations for improvement.

The hospital complied with selected standards in the following areas:

- Government Purchase Card Program
- Information Technology Purchases
- Quality Management
- Supply Processing and Distribution
- Timekeeping for Part-Time Physicians

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

- Quality management and patient safety education partnership with University of Missouri-Columbia is a success.
- Partnership program benefits the hospital and school.

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

- Improve controls over prescription drugs.
- Correct safety deficiencies.
- Improve medical care collections fund procedures to increase collections.
- Define nursing procedures and provide education on pressure ulcer prevention and management.
- Correct exterior access vulnerabilities, and complete and document emergency preparedness training.

- Interpret and sign patient sleep study results, document treatment plans, and generate bills as applicable.
- Improve collection of terminated employee debts.
- Enhance information technology security controls.
- Strengthen supply inventory management controls.

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

## VISN Director Comments

The VISN Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, beginning on page 18 for the full text of the Director's comments.) We will follow up on the implementation of planned improvement actions until they are completed.

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

# Introduction

## Hospital Profile

**Organization.** Located in Columbia, Missouri, the hospital provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics (CBOCs) located in Camdenton, Kirksville, Mexico, St. James, and Fort Leonard Wood, Missouri. The hospital is part of Veterans Integrated Service Network (VISN) 15 (http://www.visn15.med.va.gov/) and serves a veteran population of about 113,000 in a primary service area that includes 44 counties in central Missouri and 1 county in western Illinois.

**Photograph 1 – Harry S. Truman Memorial Veterans' Hospital**

**Programs.** The hospital provides medical, surgical, behavioral health, and long term care services. The hospital operates 77 acute care beds and 41 long term care beds and serves as a VA referral center for interventional cardiology and cardiac surgery. The hospital has sharing agreements with the University of Missouri-Columbia (MU) hospital and clinics, the MU School of Medicine, the Department of Defense at Fort Leonard Wood, and several community hospitals including Boone Hospital Center in Columbia.

**Affiliations and Research.** The hospital is affiliated with the MU School of Medicine and with other MU programs such as nursing, allied health, and health services management. Educational affiliations exist with several other institutions of higher learning for the full spectrum of nursing and allied health training programs. The hospital supports 77 MU medical resident positions in 25 residency training programs and provides annual training opportunities for approximately 900 students.

In fiscal year (FY) 2004, the hospital research program had 89 projects involving 68 investigators and a budget of $5.2 million. Important areas of research include a unique micro-imaging center for radiopharmaceutical development, endocrinology/diabetes, and respiratory disease.

**Resources.** In FY 2004, medical care expenditures totaled $137.5 million. The FY 2005 medical care budget is $138.4 million, 1.0 percent more than FY 2004 expenditures. FY 2004 staffing was 929 full-time equivalent (FTE) employees, including 49 physician and 297 nursing FTE employees.

**Workload.** In FY 2004, the hospital treated 28,776 unique patients, a 1.0 percent increase from FY 2003. The inpatient workload totaled 3,780 discharges, and the average daily census, including long term care patients, was 87.4. The outpatient workload was 220,083 visits, a 9.4 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, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information medical centers use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on the recommendations and suggestions included in our previous CAP report of the hospital (*Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri*, Report No. 00-02066-51, July 10, 2001).

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

| | |
|---|---|
| Accounts Receivable | Patient Sleep Studies |
| Controls Over Prescription Drugs | Pressure Ulcer Prevention and Management |
| Emergency Preparedness | Quality Management |
| Environment of Care | Supply Inventory Management |
| Government Purchase Card Program | Supply Processing and Distribution |
| Information Technology Purchases | Timekeeping for Part-Time Physicians |
| Information Technology Security | |
| Medical Care Collections Fund | |

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made

electronic survey questionnaires available to all hospital employees and 151 responded. We also interviewed 30 patients during the review. The survey results were shared with hospital managers.

The review covered hospital operations for FY 2004 and FY 2005 through January 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.

# Results of Review

## Organizational Strengths

**Quality Management and Patient Safety Education Partnership with MU Is a Success.** In 2002, the hospital's Patient Safety Manager (PSM) and Director of Specialty Care met with MU School of Medicine educators and formed the Quality and Patient Safety Education (QPSE) task group to develop QM and patient safety curriculum for medical students. The curriculum was based on VA's National Center for Patient Safety training modules and provided about 11 hours of instruction to medical students. In 2002, a similar training program was developed by the PSM for senior year Respiratory Therapy students. The PSM and Director of Specialty Care demonstrated the root cause analysis[1] (RCA) approach for analysis of patient events at a monthly MU Department of Surgery Morbidity and Mortality (M&M) conference. Medical students received QM and patient safety training in 2003. In 2004, the curriculum was enhanced, and training was provided to medical students, senior nursing students, and Health Management Masters students. In 2005, the MU Internal Medicine Department chair, in conjunction with VA's PSM, modified the M&M conference format to include a systems-based approach using RCA to review patient incidents. All resident physicians attend this M&M conference during their internal medicine rotation.

Under the direction of the QPSE task group, the QM and patient safety training curriculum continues to develop. Second year medical students, pharmacy interns, and allied health professions students will receive this training during 2005. The QPSE task group continues to meet with hospital and MU department coordinators to further expand the curriculum.

**Partnership Program Benefits Hospital and School.** Frederick Douglass High School is an alternative learning institution in Columbia. At the hospital, participating students attend classes 3 hours per day and work in a paid job status 3 hours per day. While in the classroom, students work on independent contracts, allowing them the opportunity to earn the academic credits needed to graduate. Students have filled a variety of jobs within the hospital including sterile processing, food service, accounting, supply, clerical support, housekeeping, and grounds crew. Since its beginning during the 1998-99 school year, more than 50 students have participated in this partnership program.

[1] A root cause analysis is a process for identifying basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. The review is interdisciplinary in nature with involvement of those knowledgeable about the processes involved in the event.

# Opportunities for Improvement

## Controls Over Prescription Drugs – Certain Controls Needed To Be Improved

**Condition Needing Improvement.** Veterans Health Administration (VHA) policy requires Pharmacy Service staff to maintain accountability over all pharmaceuticals and to comply with Drug Enforcement Administration (DEA) regulations for controlled substances. Controlled substances in Research Service were secure and accounted for, and a review of 15 physician orders in patient medical records showed that controlled and noncontrolled substances were dispensed to patients as ordered. However, our assessment of pharmacy inventories, inspections, drug destructions, and receipt of vendor deliveries showed that improvement was needed in four areas.

72-Hour Inventories Were Not Completed. VHA policy requires that pharmacy staff conduct a physical inventory of all controlled substances every 72 hours. VHA policy also requires that some VA medical facilities store a cache of pharmaceuticals reserved specifically for a weapons of mass destruction event that disrupts deliveries to the hospital. Caches of controlled substances are to be stored in locked containers within the controlled substances vault, and staff conducting the 72-hour inventories are required to inspect containers used to store caches of controlled substances for evidence of tampering.

Pharmacy Service maintains two vaults, one in the hospital's main pharmacy in the basement of the main hospital building, and one on the fifth floor in the main hospital building. The fifth floor vault is used to secure drugs for the Missouri Veterans Home and is also used to store the hospital's controlled substances cache. Our review of inventory records for the two vaults for the 3-month period October to December 2004 showed that inventories in the main pharmacy vault were conducted within the 72-hour timeframe. However, 9 of 31 (29 percent) of the required inventories of non-cache controlled substances for the fifth floor vault were not conducted within the 72-hour timeframe; in 1 instance non-cached controlled substances were not inventoried for 17 days. In addition, 4 of 52 (8 percent) inspections of cached controlled substances were not conducted within 72 hours.

Inventories Were Not Conducted When Required. VHA policy requires pharmacy staff to conduct an annual physical inventory of all items in the pharmacy and also requires them to conduct an inventory when there is a permanent change of the Chief of Pharmacy Service. As of January 2005, no annual inventory had been performed since September 2003, a period of 17 months. In addition, when the Chief of Pharmacy Service was appointed in January 2003, pharmacy staff did not conduct an inventory until September 2003, 8 months after the appointment. The Chief of Pharmacy Service advised the Pharmacy Service staff of the need to perform inventories timely.

Drug Destructions Were Not Performed and Properly Witnessed. VHA policy requires the quarterly destruction of outdated and surplus controlled substances in accordance with DEA requirements. VHA policy also requires that a hospital employee not assigned to the pharmacy be designated as the Accountable Officer to witness and document destructions. Our review of FY 2004 drug destruction records and interviews with the Accountable Officer and the Controlled Substances Officer, who is responsible for monthly controlled substances inspections, showed that one of four quarterly destructions was not done. In addition, the hospital employee designated as the Accountable Officer did not witness two of the three destructions that were done.

Monthly Controlled Substances Inspections Did Not Include All Required Areas. VHA policy requires that staff performing monthly unannounced controlled substances inspections review documentation of 72-hour inventories and of quarterly drug destructions. However, controlled substances inspectors were not reviewing 72-hour inventories or verifying that the Accountable Officer witnessed the quarterly destructions. This contributed to the problems we identified in these two areas.

**Recommended Improvement Action 1.** We recommended that the VISN Director ensure that the Hospital Director requires that: (a) 72-hour inventories are performed timely, (b) staff perform inventories annually and at other times when required by VHA policy, (c) drug destructions are performed quarterly and drug destructions are witnessed by the Accountable Officer, and (d) controlled substances inspectors review 72-hour inventories and destructions of controlled substances.

The VISN Director agreed with the findings and recommendations. A process improvement and SOP update have been completed to address gaps in the 72-hour inventory records. Updated processes are in place and operational. Pharmacy inventory was completed on March 30, 2005. VISN 15 contracts for destruction of controlled substances. The Accountable Officer is now in full compliance with the witnessing requirement. In January 2005, the controlled substances inspectors began reviewing the 72-hour inventory records, and the Accountable Officer witnesses the release of eligible drugs for destruction by the contract vendor.

## Environment of Care – Safety Deficiencies Needed To Be Corrected

**Condition Needing Improvement.** VHA policy requires VA medical facilities to be clean and minimize risk to patients, visitors, and staff. Managers maintained a clean patient care environment; however, we identified several patient safety concerns that warranted management attention. We conducted environment of care inspections in four inpatient units and five outpatient areas.

3 East Outdoor Patio. The 3 East unit had a covered outdoor patio that was accessible to patients. The patio perimeter included the building on two sides and a pipe-style metal railing that was 43.5 inches high on the other two sides. There is a drop of at least 15 feet

to the roof surface below beyond the railing. There were no other restrictive devices, such as a screen or protective fencing, as a restriction from crossing the railing. Since 3 East has hospice and long term care patients who may have impaired cognitive abilities, the lack of restrictive barriers to keep patients from crossing the railing may pose a safety vulnerability. Additionally, patio furniture and flower pots were not permanently affixed to the patio floor and may be moved close to the railing. For these reasons, we recommended that managers conduct a risk assessment to determine if further actions were needed to protect patients using the patio. (See photographs below.)

**Photograph 2 – 3 East Outdoor Patio**

**Photograph 3 – Patio railing and roof surface below**

Sharps Security and General Safety. Unlocked treatment carts with needles, scissors, and other sharp instruments were accessible to patients in two patient care areas. A container with contaminated sharp medical instruments was left in the hallway in an outpatient clinic. A nurses' work room was unlocked in the Urgent Care/Emergency Room (UC/ER), allowing access to knives and hazardous cleaning products. Unlocked storage rooms containing items such as contaminated sharp instruments, filled sharps containers with needles and syringes, and sterile medical supplies were accessible to the public in four patient care areas. Auxiliary doors from public hallways were unlocked and allowed unrestricted access to the Intensive Care Unit (ICU), the Specialty Clinic, and the UC/ER areas. Individuals could access these areas and not be immediately noticed by staff members. Additionally, on the locked mental health unit, framed pictures were loosely connected to the walls. A patient could remove a picture and use it as a weapon.

Emergency Call System. Emergency call systems must be accessible, functional, and timely answered when activated. We noted an emergency call system cord in a public restroom on unit 4 East that was only 2 inches long, a cord that was tied to a hand rail in a patient shower on unit 3 East, a cord that was not connected to the system in a public restroom near the Eye Clinic, and a cord that was incorrectly attached to the wrong mechanism to activate the emergency call system in a public restroom in the Specialty

Clinic. Additionally, we activated the emergency call system in the men's public restroom in the Specialty Clinic, and 3 minutes elapsed without staff response.

Refrigerator Temperature Monitoring. Refrigerators containing patient medications and nourishments must be maintained within an acceptable temperature range to ensure the integrity of the contents. Medication and nourishment refrigerator temperatures were not recorded daily in two patient care areas. In three patient care areas, staff did not document corrective actions when refrigerator temperatures were out of acceptable range. The medication refrigerator temperature was too cold in the Silver Team area every day from January 1 through January 27, and no corrective actions were documented. We selected a sample of refrigerated medications and found that each medication required a warmer temperature than the refrigerator's recorded temperature for the 27-day period. We recommended that managers immediately consult with Pharmacy Service to determine if the medications were compromised.

Emergency Crash Cart Checks. Hospital policy requires daily checks of emergency crash carts to ensure that equipment and supplies are ready for use. We inspected two crash carts in the ICU and found that checks were not documented for 2 days in January on each cart.

**Recommended Improvement Action 2.** We recommended that the VISN Director ensure that the Hospital Director requires that: (a) managers conduct a risk assessment of the 3 East outdoor patio; (b) sharp items, staff work rooms, patient care storage rooms, and auxiliary doors leading into clinical areas are secured; and pictures are attached securely to walls in the locked mental health unit; (c) the emergency call system is accessible, functional, and promptly answered; (d) medication and nourishment refrigerators are monitored and maintained within an acceptable temperature range; and (e) emergency crash carts are checked according to hospital policy.

The VISN Director agreed with the findings and recommendations. A risk assessment has been completed and identified vulnerabilities are being corrected. General safety is included in the Environmental Safety Rounds, and findings are shared with staff and monitored for corrective action. Auxiliary doors to the clinical areas are secured and picture frames in the mental health unit have been caulked to the wall. As part of the National Patient Safety Goal for alarm audibility, monitors are in place, data are trended, and feedback is provided to appropriate staff. Digital thermometers were purchased for each refrigerator in areas with 24-hour, 7-day operation. Digital thermometers with memory are being installed in other areas, and the refrigerator temperature log has been standardized to include documentation of action to be taken if the temperature is not within range. Crash cart audits are performed on an unannounced, ongoing basis with feedback provided to appropriate service line managers for corrective actions.

## Medical Care Collections Fund – Improved Procedures Would Increase Collections

**Condition Needing Improvement.** VA policy requires VA medical facilities to recoup the costs of providing medical care to veterans who are covered by health insurance. Although the hospital met national Medical Care Collections Fund (MCCF) collection goals, increasing collections from $7 million to $12 million (71 percent) from FY 2002 to 2004 with increases in each year, improvement was still needed in billing timeliness, collection procedures, and medical record documentation.

Bills Were Not Processed Timely. VISN 15 MCCF goals recommend that bills to insurance carriers be initiated within 50 days of treatment. For the 3-month period July to September 2004, the average time to initiate a bill by MCCF staff was 71 days. As of September 30, 2004, MCCF staff had identified 161 unbilled outpatient cases that were more than 50 days old. These 161 cases had a value of $63,805.

Collection of Accounts Receivable Were Not Pursued Aggressively. VA policy requires prompt and aggressive collection efforts for all accounts receivable, including insurance receivables. We reviewed a judgment sample of 10 insurance receivables totaling $113,116. MCCF staff had not followed up on two receivables totaling $20,116, and four totaling $58,596 required additional follow-up. According to data provided by MCCF staff, the collection rate for MCCF receivables at the hospital was 26 percent. Based on the hospital's historical collection rate, initiating follow-up for the two cases and performing additional follow-up on the other four could result in collections of as much as $20,465 ($78,712 x 26 percent). The six cases requiring follow-up were discussed with MCCF managers.

Medical Record Documentation Was Inadequate. The September 30, 2004, "Reasons Not Billable" report listed 2,646 potentially billable cases totaling $295,965 that were not billed because they had no medical record documentation, inadequate documentation, or services that were performed by a non-billable provider. We reviewed a judgment sample of 52 potentially billable cases from the report totaling $56,794 and found that 36 cases totaling $35,510 could have been billed if adequate medical record documentation had been provided. Based on the collection rate of 26 percent, the hospital could have increased collections by about $9,233 ($35,510 x 26 percent). The MCCF Coordinator agreed and stated that MCCF staff would try to obtain adequate medical record documentation and bill these cases.

**Recommended Improvement Action 3.** We recommended that the VISN Director ensure that the Hospital Director requires that MCCF staff: (a) reduce the time taken for initiating MCCF bills, (b) aggressively follow-up on insurance receivables, (c) pursue collection on the six receivables that needed additional follow-up, (d) improve medical record documentation for potentially billable cases, and (e) review all cases on the "Reasons Not Billable" report and initiate bills where appropriate.

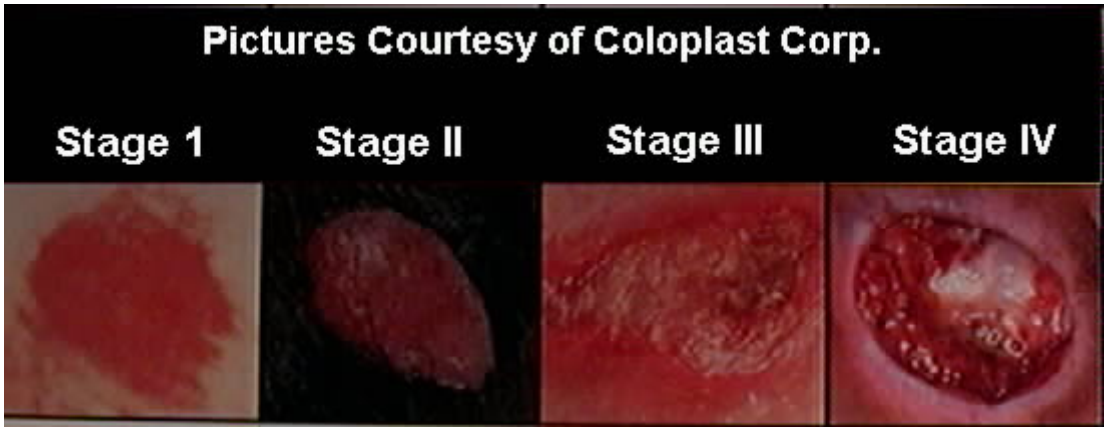
The VISN Director agreed with the findings and recommendations. The hospital has developed a corrective action plan to reduce the backlog of bills that includes approved use of overtime for billing staff and use of a contractor to assist with billing. MCCF performance levels showed that the hospital exceeded its collection target for FY 2003 and FY 2004. Appropriate action will be taken to pursue collection on six receivables that needed additional follow-up. The hospital will bring in an outside vendor, who is a physician, to provide training to hospital providers on medical record documentation practices. The Reasons Not Billable report is reviewed on a regular basis.

## Pressure Ulcer Prevention and Management – Nursing Procedures Needed To Be Defined and Education Provided

**Condition Needing Improvement.** Managers needed to ensure that nursing procedures define expectations for documentation of pressure ulcer location, status, and treatment. Pressure ulcer education should be provided to patients and external caregivers and documented as part of the medical record. Clinical staff would also benefit from ongoing pressure ulcer education. Adhering to consistent and acceptable skin care practices will promote improved quality of care and better management of resources. We reviewed the medical records, physician orders, and documented treatments for 10 inpatients who either had hospital-acquired pressure ulcers or were admitted with a pressure ulcer.

Documentation Inconsistencies. Medical records show inconsistencies among clinical staff in the documentation of pressure ulcer locations and status. For example, a patient's pressure ulcer location was described by one nurse as the coccyx, while a second nurse described the location as the right buttock. Records also show that many clinical staff described the pressure ulcer by stage;[2] however, the documentation reflected the individual clinician's subjective interpretation of the ulcer stage, resulting in a range of opinions. For example, within a 24-hour period, three nurses documented information about a patient's pressure ulcer in the medical record. Two nurses described the ulcer as a stage II, while the third nurse described the ulcer as a stage III, yet the ulcer had not changed appreciably during this time.

[2] Pressure ulcers may be described by clinical staff as a stage I, II, III, or IV wound. A stage I pressure ulcer, the minor of the four stages, involves nonblanchable erythema of intact skin. A stage IV pressure ulcer, the most severe stage, involves full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure.




Pressure Ulcer Treatment. We reviewed the pressure ulcer treatments that were provided for the 10 patients in our sample. Staff on two patient care units were documenting treatments, such as application of a dressing, on paper treatment records. Treatment records for three patients show that some treatments were not recorded as being completed during nursing shifts (day, evening, or night). One patient's treatment was scheduled to begin on January 19, and the record shows that the treatment was started on January 22. This patient's dressing was ordered to be changed every 72 hours, yet the dressing was not changed until January 26, over 96 hours after the initial application.

Another patient care unit no longer required staff to document treatments on a paper record. Instead, staff were instructed to document treatments in a progress note in the electronic medical record. We were unable to consistently identify within the electronic notes whether or not the prescribed treatments were completed as scheduled.

Education. We reviewed the 10 medical records in our sample for documentation of pressure ulcer education provided to the patient and/or their external caregivers. Only one record reflected that pressure ulcer education was provided to the patient, and the note stated that the patient was reminded to frequently turn in bed. Additionally, no formal pressure ulcer prevention or management education has been provided to clinical staff. Clinical staff benefit from training on issues such as new treatment options and special equipment. Managers recognized this deficiency and plan to develop training for clinical staff.

**Recommended Improvement Action 4.** We recommended that the VISN Director ensure that the Hospital Director requires that: (a) pressure ulcer location and status are correctly described by clinical staff; (b) pressure ulcer treatments are completed as required and are easily identifiable in records; and (c) pressure ulcer education is provided to patients, external caregivers, and clinical staff.

The VISN Director agreed with the findings and recommendations. A wound/skin assessment template revision has been completed. Staff education continues on the guidelines for completing the template. Training was to be completed by 7/1/05. The

hospital's Skin/Wound Committee is developing a monitor to assess if treatment measures are properly documented. The patient/caregiver section on the wound/skin assessment template has been revised to include check boxes to identify specific items taught, and a statement was added to indicate that the patient/caregiver verbalized understanding of the education.

## Emergency Preparedness – Exterior Access Vulnerabilities Needed To Be Corrected and Training Needed To Be Completed and Documented

**Condition Needing Improvement.** VHA policy requires that VA medical facilities enhance emergency preparedness (EP) by conducting heating, ventilation, and air conditioning (HVAC) and building assessments, correcting identified weaknesses, and creating a hospital emergency plan. The emergency plan should address chemical, biological, radiological (CBR), fire, weather, and other emergencies, and training of appropriate personnel to manage these emergencies. In May 2004, VA's Facilities Management Office for Strategic Management, in cooperation with hospital managers, completed a physical security assessment to identify vulnerabilities and made recommendations. As of January 28, 2005, our inspection showed that many of these vulnerabilities remained. Hospital managers needed to correct remaining physical security access vulnerabilities.

The hospital's emergency plan addressed CBR and all other emergency situations; however, it did not address training. Hospital managers needed to develop a plan that addresses disaster response, EP, and job-specific training for all employees. Managers needed to conduct the training and document it in employees' training records.

Physical Security Access Vulnerabilities. The hospital's May 2004 Physical Security Assessment Report stated that it "lacks vehicle anti-ram devices" at the main entrance, emergency room, and surrounding critical utilities. The report further states, "Anti-ram buffer zones are inadequate or non-existent," leaving the hospital vulnerable to accidental collisions, high speed vehicles, and vehicle bombs. We observed that these conditions remained at the time of our inspection. Managers agreed with recommendations from their Physical Security Assessment Report and responded that decorative bollards/barriers were to be installed.

Visitor access to the hospital was not restricted or controlled during business hours. Visitors, including contractors, did not receive visitor passes and were not readily identifiable while in the building. Eight entrances to the hospital remain open during the day. Two entrances remain open 24 hours, 7 days a week: one to access a smoking shelter and the other a pedestrian/steam tunnel connecting the hospital with MU. Uncontrolled access to the hospital created a security vulnerability.

Employee Training. The disaster and EP training that was provided was not documented in employees' training records, and job-specific training was not systematically provided to each employee. Hospital managers considered disaster drills conducted to be training for employees who participated in the drills, yet this training was not documented in the participants' training records. Hospital managers believed the required annual safety training covered disaster response and EP. For the 2004 training, hospital managers provided a copy of the electronic questions employees answered as documentation of course content. There were 13 of 53 questions that pertained to disaster and EP. For the 2005 training, hospital managers provided a copy of the electronic tutorial and corresponding questions that employees completed to receive credit. None of the content contained references to disaster response or EP.

We reviewed training records of 20 employees (10 UC/ER, 5 Police, and 5 HVAC employees) for evidence of job-specific training. There was no documentation of training in emergency evacuation procedures for patients and employees. Training records for 10 UC/ER employees showed no evidence of job-specific training in response to CBR release or in selection, use, and practice with personal protective equipment (PPE). There was no documentation that five police officers received job-specific training in use of PPE; response to national emergency or terrorist attacks; incidents involving hazardous agents; or response to thefts, accidental release, or suspicious activities in research laboratories. There was also no evidence that five HVAC employees received job-specific training in procedures to follow in suspected release of CBR agents, emergency air handling and shutdown, or actual practice with PPE.

**Recommended Improvement Action 5.** We recommended that the VISN Director ensure that the Hospital Director requires that: (a) physical security access vulnerabilities are corrected and (b) the hospital emergency plan defines employee disaster and EP training, including job-specific training expectations, and the training is completed and documented in employee training records.

The VISN Director agreed with the findings and recommendations. Concrete planters were relocated to serve as barriers. Two options have been identified to control building access via the smoking shelter entrance. Tunnel access has been previously evaluated for risk of after hours access. An emergency management plan that describes the approach to emergencies within the hospital, as well as the community is in place. Hospital-wide awareness/refresher training on Hospital Emergency Incident Command System was conducted in April and documented in Tempo.

## Patient Sleep Studies – Results Needed To Be Interpreted, Treatment Plans Documented, and Bills Generated

**Condition Needing Improvement.** We reviewed a sample of 52 episodes of care that were not billed and found that 9 were patient sleep studies performed at the hospital. We reviewed the electronic medical records for these nine patients and were unable to locate

physician orders for the sleep studies, documentation of study results, and treatment interventions. The hospital continued to perform approximately 400 sleep studies during FY 2004 that were not interpreted and signed by a privileged physician. As a result, billing opportunities for patient sleep studies were missed.

**Recommended Improvement Action 6.** We recommended that the VISN Director ensure that the Hospital Director requires that patient sleep study results are interpreted and signed, treatment plans are documented, and bills are generated.

The VISN Director agreed with the findings and recommendations. The hospital recruited a board certified fee-basis physician to review and formally sign the sleep study interpretations.

## Accounts Receivable – Collection of Terminated Employee Debts Needed Improvement

**Condition Needing Improvement.** Accounts receivable were established, reconciled, and followed up in accordance with VA policy. However, procedures to collect debts owed by employees who had terminated their VA employment needed improvement. VA policy requires that Human Resources Management Service (HRMS) staff notify Fiscal Service staff when employees are in the process of terminating their employment. HRMS staff are also required to notify Fiscal Service staff if employees have any HRMS-related indebtedness. Fiscal Service staff then determine whether the employees have any other financial obligations to VA. However, HRMS staff did not notify Fiscal Service staff promptly of terminating employees, and as a result, debts were not collected at the time of separation.

HRMS located in Leavenworth, Kansas, provides support to all VISN 15 facilities. When notified that an employee is separating, HRMS staff are to inform Fiscal Service staff at the hospital of the employee's separation, and whether the employee has any HRMS-related indebtedness, such as lost or damaged property, recent salary overpayments, negative leave balances, or VA payments for training agreements that were not honored by the employee as a result of separation before a stipulated period of time. Upon notification from HRMS, the Accounting Section in Fiscal Service is required to determine if that employee is indebted to the Government for any other reasons and, if any indebtedness exists, immediately establish an accounts receivable for that employee. As part of the employee clearance process, the Agent Cashier is to examine accounts receivable records to determine if the employee is indebted to VA. If the employee has a debt and is unwilling to pay it, Fiscal Service staff can withhold the amount from the employee's final paycheck. Owed amounts can also be offset against any other payments due the employee at the time of separation.

Our review of 20 employee debts owed as of November 2004 included 2 debts totaling $1,212.62 owed by 2 employees separated in October 2002 and January 2004. The two

accounts receivable were established by hospital Fiscal Service staff in November 2002 and February 2004, respectively. Both debts had been referred to the Treasury Offset Program, but at the time of our CAP review neither had been collected. At separation, these two employees were paid a total of $851.56 for unused annual leave. Had the Agent Cashier been aware of their indebtedness at the time of their separations, the $851.56 could have been used to offset the debts with any balances being deducted from final paychecks. This problem occurred because HRMS staff did not communicate information on employee separations to Fiscal Service staff before employees separated, and as a result, receivables were not established timely. As a result, the Agent Cashier was unaware of employee indebtedness, and employees were permitted to clear the station without paying their debts.

**Recommended Improvement Action 7.** We recommended that the VISN Director ensure that HRMS staff timely notify hospital Fiscal Service staff of employee separations and HRMS-related indebtedness.

The VISN Director agreed with the findings and recommendations. The VISN is in the process of establishing a uniform employee clearance process with input from Network facilities.

## Information Technology Security – Controls Needed To Be Enhanced

**Condition Needing Improvement.** Information technology (IT) controls for security awareness training, virus protection, password protection, and computer room security were adequate. However, there were four areas where management could enhance IT security.

Contingency Plans Did Not Meet Requirements. VA policy requires that information systems have contingency plans, and the Federal Information Security Management Act of 2002 requires that Government information systems meet National Institute of Standards and Technology (NIST) requirements. Contingency plans for the hospital's Local Area Network (LAN) and Veterans Health Information Systems and Technology Architecture (VistA) systems did not fully comply with NIST requirements because neither plan established procedures for notifying hospital staff in the event of an emergency.

VistA Information Needed To Be Sent to VHA. The Information Security Officer had not submitted site-specific information such as key personnel, backup and restore capabilities, and security processes to the VHA VistA Imaging Program Office and had not incorporated information in the program office's security plan. Because VA's Assistant Secretary for Information and Technology has issued a full authority to VHA facilities to operate VistA Imaging without interim status or any other limitations on a national, rather than site-specific basis, the program office requires site-specific information to support current and future authorities to operate VistA Imaging nationally.

Storage of Backup Files Needed To Be Addressed. VA policy requires that backup files be secured in a remote location. Information Resources Management staff maintained LAN and VistA backup files in two locked safes in an unsecured area of the warehouse. In addition, the files were located within 200 yards of the primary processing facility. Hospital staff had performed a risk assessment to evaluate the risks associated with storage of the backup files in the warehouse and decided to store them there despite the problems the location presented. However, because the backup files were maintained in a location that presented security concerns and was not remotely located, hospital management needed to document its acceptance of the risk associated with the location of the files in the hospital IT security plan.

Plans for An Alternate Processing Site Needed to Be Documented. An alternate processing site is a location that computer operations can be transferred to if a disaster causes the primary processing facility to become inoperable. Hospital management had identified an alternate processing site but had not documented the plans in the LAN and VistA contingency plans.

**Recommended Improvement Action 8.** We recommended that the VISN Director ensure that the Hospital Director requires that IT staff: (a) develop LAN and VistA contingency plans that fully comply with NIST requirements, (b) submit site-specific information to the VHA VistA Imaging Program Office, (c) document hospital management's acceptance of risks associated with the storage of LAN and VistA backup files, and (d) document designation of the alternate processing site.

The VISN Director agreed with the findings and recommendations. Hospital managers are currently rewriting the LAN and VistA contingency plans based on the templates provided by the Office of Cyber and Information Security. The contingency plans will contain all the elements outlined in NIST Special Publication 800-34. The hospital VistA Imaging Security Plan was submitted to the VISN Information Security Officer to be forwarded to the VistA Imaging Program Office. The hospital's IT security plan will be updated to document management's acceptance of the risk associated with the location of back up files in the data safe. The hospital's LAN contingency plan will be updated to document alternate processing site designation.

## Supply Inventory Management – Controls Needed To Be Strengthened

**Condition Needing Improvement.** In FY 2004, the hospital spent approximately $9.4 million for medical/surgical, prosthetics, engineering, and environmental management supplies. VHA policy requires that hospital staff use the Generic Inventory Package (GIP) and the Prosthetics Inventory Package to manage most supply inventories, and also requires that staff conduct an annual inventory of all supplies. Our review of a judgment sample of 20 medical/surgical and prosthetics items with a value of $40,453 showed that inventory records were accurate. However, Logistics Service staff did not fully utilize GIP to manage engineering supplies or conduct annual inventories in all areas.

GIP Was Not Fully Utilized for Engineering Supplies. VHA policy requires that GIP be used to manage supplies in six primary inventory areas (medical/surgical, dental, laboratory, imaging, environmental management, and engineering). While GIP was fully utilized to manage supplies in five of the six areas, it was only utilized for those engineering supplies that Logistics Service considered to be recurring. Descriptions and some usage information for non-recurring engineering supplies were included in GIP, but GIP was not fully utilized to manage these supplies.

Annual Inventories Were Not Performed. VHA policy requires annual inventories of all supplies. The Supervisory Inventory Management Specialist in Logistics Service was responsible for conducting the inventories, but the specialist did not conduct annual inventories for surgical, prosthetics, and engineering supplies. The specialist stated that inventories were not needed because supply levels in these areas were constantly monitored by visual inspection, bar coding, and logs. Inventories had not been conducted over an extended period of time, and the specialist was unable to tell us when inventories in these areas had last been conducted.

**Recommended Improvement Action 9.** We recommended that the VISN Director ensure that the Hospital Director requires that: (a) GIP be utilized to include manage non-recurring engineering supplies in addition to the recurring supplies already managed by GIP and (b) the Supervisory Inventory Management Specialist in Logistics Service conduct required annual inventories of supplies.

The VISN Director agreed with the findings and recommendations. Logistics will continue to implement secondary inventory points for engineering in accordance with the 10/28/04 memorandum from the Deputy Under Secretary for Health for Operations and Management. Wall to wall inventories of supplies will be conducted as required.

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 17, 2005

**From:** VISN Director

**Subject:** **Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri**

**To:** Director, Chicago Regional Office of Healthcare Inspections, Office of Inspector General

**THRU:** **Director, Management Review Service (10B5)**

Enclosed are comments regarding the draft report for the Combined Assessment Program (CAP) Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri - Project Number 2005-00082-HI-0014.

Peter L. Almenoff, M.D., FCCP

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

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

**OIG Recommendations**

**Recommended Improvement Action** 1. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) 72-hour inventories are performed timely;

Concur **Target Completion Date:** Implemented and Ongoing

Prior to the arrival of the OIG team, gaps in the 72-hour inventory records had been identified. A process improvement and SOP update had been completed. All updated processes are in place and operational.

(b) staff perform inventories annually and at other times when required by VHA policy;

Concur **Target Completion Date:** Completed

The Truman VA pharmacy inventory was completed on March 3, 2005.

(c) drug destructions are performed quarterly and drug destructions are witnessed by the Accountable Officer;

Concur **Target Completion Date:** Implemented and Ongoing

VISN 15 contracts for destruction of controlled substances. When the VISN contractor changed in mid-2004, the previous contractor canceled a scheduled destruction just before the end of the contract. The new contractor was slightly over the 90-day limit by the time they arrived in Columbia for the first available destruction. The Accountable Officer, a VISN employee, is now in full compliance with the witnessing requirements. No controlled substances were unaccounted for, no problems in diversion were noted and the new contractor was in place and fully compliant for more than six months prior to the OIG visit.

and (d) controlled substances inspectors review 72-hour inventories and destructions of controlled substances.

Concur **Target Completion Date:** Implemented and Ongoing

In January 2005, the controlled substances inspectors began reviewing the 72 hour inventory records in the mail pharmacy vault and the Missouri Veterans Home pharmacy vault. They review and stamp the records back to the inspection of the previous month. The results of the inventory reviews are included in the monthly report to the facility director. The Controlled Substance Officer documents that the Accountable Officer (Supervisory Inventory Management Specialist in Logistics) witnesses the release of drugs eligible for destruction to the contract vendor that destroys them.

**Recommended Improvement Action** 2. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) managers conduct a risk assessment of the 3 East outdoor patio;

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

A risk assessment has been completed. Identified vulnerabilities are being corrected.

(b) sharp items, staff work rooms, patient care storage rooms, and auxiliary doors leading into clinical areas are secured, and pictures are attached securely to walls in the locked mental health unit;

Concur **Target Completion Date:** Implemented and Ongoing

General safety to include sharps, security, storage, etc. are included in the Environmental Safety Rounds conducted on a regular schedule. Findings are shared with staff and monitored for appropriate corrective action. Auxiliary doors to the clinical areas are secured. Picture frames in the mental health unit have been caulked to the wall.

(c) the emergency call system is accessible, functional, and promptly answered;

Concur **Target Completion Date:** Implemented and Ongoing

As part of the National Patient Safety Goal for alarm audibility, monitors are in place, data are trended and feedback is provided to appropriate staff. This is part of the medical center's JCAHO readiness activity.

(d) medication and nourishment refrigerators are monitored and maintained within an acceptable temperature range;

Concur **Target Completion Date:** 6/15/05

Digital thermometers were purchased for each refrigerator in areas with 24/7 operation. Digital thermometers with memory for other areas are being installed. The refrigerator temperature log has been standardized to include documentation of action taken if the temperature is not within range.

and (e) emergency crash carts are checked according to hospital policy.

Concur **Target Completion Date:** Completed

Crash cart audits are performed on an unannounced, ongoing basis with feedback to appropriate service line managers for corrective actions.

**Recommended Improvement Action** 3. We recommend that the VISN Director ensure that the Hospital Director requires that MCCF staff:

(a) reduce the time taken for initiating MCCF bills;

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

A national revenue performance measure on days to bill was instituted in FY 2003 and continued in FY 2004. The facility significantly reduced its days to bill throughout FY 2003 and into FY 2004. Unfortunately, a backlog built up due to staff turnover and shortages in the facility's coding staff. The facility's corrective action included approved use of overtime for billing staff, use of a contractor to assist with billing, and implementation of a process that assured that billable outpatient episodes were to be coded within seven days. At the present time, the facility's mean days to bill is 60 days. The new approach has led to significant improvements. For example, in July 2004, the backlog was in excess of $5 million. In April 2005, the billing backlog was less than $1 million.

(b) aggressively follow-up on insurance receivables;

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

A national revenue performance measure for accounts receivable greater than 90 days was instituted in FY 2003 and continued in FY 2004 and FY 2005. The facility's measure was 42% in FY 2003, 36% in FY 2004, and is currently 37% in FY 2005 to date, which is within the 40% met level. MCCF collections were performance measures for the same time periods. The facility exceeded its collection target for FY 2003 by 7% and FY 2004 by 10%.

(c) pursue collection on the six receivables that needed additional follow-up;

Concur **Target Completion Date:** 7/15/05

Appropriate action will be taken.

(d) improve medical record documentation for potentially billable cases;

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

Medical record documentation issues have been identified as an ongoing focus area for improvement. Part of that continuing effort is to bring in an outside vendor, who is a physician, to provide training to facility providers on medical record documentation practices. As previously noted, this facility exceeded assigned collection targets during the past two fiscal years at a significant level. Based on its size and the number of unique patients, this collection rate was very favorable in comparison to many larger VAMCs throughout the country.

and (e) review all cases on the "Reasons Not Billable" report and initiate bills where appropriate.

Concur **Target Completion Date:** Completed

The Reasons Not Billable report is reviewed on a regular basis. The cases cited by the OIG report were part of the previously mentioned backlog, which has been addressed by the facility.

**Recommended Improvement Action** 4. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) pressure ulcer location and status are correctly described by clinical staff;

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

A wound/skin assessment template revision has been completed. Program committee members continue to educate nursing staff on the guidelines for completing the template. Staff education includes correct staging of an ulcer, description of location, and status of the ulcer. Training will be completed and all staff will use the wound/skin template to document skin care by 7/1/05.

(b) pressure ulcer treatments are completed as required and are easily identifiable in records;

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

The facility's Skin/Wound Committee is developing a monitor to assess if treatment measures are properly documented either on treatment sheets or in BCMA. The committee will review results of the monitor on a monthly basis and take appropriate action to correct deficiencies.

and (c) pressure ulcer education is provided to patients, external caregivers, and clinical staff.

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

Patient/caregiver education is documented on the wound/skin assessment template. This section has been revised to include check boxes to identify the specific items taught. In addition, a statement was added to indicate that the patient/caregiver verbalized understanding of education related to pressure ulcers and the patient's wound care treatment plan.

Also, Skin/Wound Committee members are providing pressure ulcer education to nursing staff. This education will be completed by 7/1/05. Skin/wound continued competency education will be included in nursing mandatory reviews beginning 10/1/05. Pressure ulcer program and education will be incorporated into nursing orientation by 7/1/05.

**Recommended Improvement Action** 5. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) physical security access vulnerabilities are corrected

Concur **Target Completion Date:** Implemented and ongoing

Concrete planters were relocated to serve as barriers. Two options have been identified to control building access via the smoking shelter entrance. The feasibility of these two options will be reconsidered in the context of risk assessments and the lack of any reported security problems.

The tunnel access has been previously evaluated for risk of after hours access. The tunnel leads to the University of Missouri Hospital and Clinics and serves as a 'life safety' route in the event of fire. The tunnel access doors are locked when all access to the facility would be restricted.

and (b) the hospital emergency plan defines employee disaster and EP training, including job-specific training expectations, and the training is completed and documented in employee training records.

Concur **Target Completion Date:** Implemented and ongoing

An emergency management plan that describes the approach to emergencies within the hospital, as well as, the community is in place. The plan follows the elements of performance as outlined in JCAHO Environment of Care standard EC.4.10. Staff emergency preparedness training has been ongoing. Hospital-wide awareness/refresher training on HEICS was conducted in April and documented in Tempo. Action has been taken to easily extract emergency preparedness training from Tempo records. Online training modules for managing specific emergency conditions are being developed for use as training tools for staff.

**Recommended Improvement Action** 6. We recommend that the VISN Director ensure that the Hospital Director requires that patient sleep study results are interpreted and signed, treatment plans are documented, and bills are generated.

Concur **Target Completion Date:** 10/31/05

The backlog in documentation associated with sleep study interpretation (reasons not billed) occurred because of staff vacancies and a shortage of trained providers. To help address the backlog, the facility recruited a board certified fee basis physician to review and formally sign the interpretations. The technical staff that reviews the sleep study results does include a VAMC pulmonary physician (Dr. Hofmann), who does make a treatment plan to ensure timely care pending a review by a sleep study certified physician. Dr. Hofmann is scheduled for formal training in October 2005. This issue has been fully remedied and will be optimal when Dr. Hofmann completes training in sleep study interpretation in October 2005. A fee basis board certified physician is available to review and make official interpretations until Dr. Hofmann is formally trained.

**Recommended Improvement Action** 7. We recommend that the VISN Director ensure that HRMS staff timely notify hospital Fiscal Service staff of employee separations and HRMS-related indebtedness.

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

The VISN is in the process of establishing a uniform employee clearance process with input from Network facilities.

**Recommended Improvement Action** 8. We recommend that the VISN Director ensure that the Hospital Director requires that IT staff:

(a) develop LAN and VistA contingency plans that fully comply with NIST requirements;

Concur **Target Completion Date**: 08/31/05

All VA information systems must be certified and accredited by 8/31/05. The facility is currently rewriting the LAN and VistA contingency plans based on the templates provided by the Office of Cyber and Information Security (OCIS). The contingency plans will contain all the elements outlined in NIST Special Publication 800-34 ("Contingency Planning Guide for Information Technology Systems") and will be completed.

(b) submit site-specific information to the VHA VistA Imaging Program Office;

Concur **Target Completion Date:** Completed

The facility VistA Imaging Security Plan was submitted to the VISN Information Security Officer to be forwarded to the VistA Imaging Program Office.

(c) document hospital management's acceptance of risks associated with the storage of LAN and VistA backup files;

Concur **Target Completion Date:** 8/1/05

The facility's IT security plan will be updated to document management's acceptance of the risk associated with the location of back up files in the data safe and in accordance with established requirements/policy.

and (d) document designation of the alternate processing site.

Concur **Target Completion Date:** 8/1/05

The facility's LAN contingency plan will be updated to document alternate processing site designation.

**Recommended Improvement Action** 9. We recommend that the VISN Director ensure that the Hospital Director requires that:

(a) GIP be utilized to manage non-recurring engineering supplies in addition to the recurring supplies already managed by GIP

Concur **Target Completion Date:** 10/1/05

GIP is used to manage recurring engineering supplies, which was accomplished by the 8/31/04 deadline. Because GIP is not currently used to manage all non-recurring engineering supplies, logistics will continue to implement secondary inventory points for engineering in accordance with the 10/28/04 memorandum from the Deputy Under Secretary for Health for Operations and Management. Also, VHA is currently in the process of developing policy on the use of GIP for non-recurring engineering supplies and has assembled a national workgroup for this purpose.

and (b) The Supervisory Inventory Management Specialist in Logistics Service conduct required annual inventories of supplies.

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

Wall to-wall inventories will be conducted as required.

**Appendix B**

# Monetary Benefits in Accordance with IG Act Amendments

| Recommendation | Explanation of Benefit(s) | Better Use of Funds |
|---|---|---|
| 3 | Accounts Receivable Should Be Pursued Aggressively. | 20,465 |
| 3 | Medical Record Documentation for Billable Insurance Cases Should Be Improved. | 9,233 |
| | Total | $29,698 |

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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**Appendix D**

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