Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

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VA Office of Inspector General
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Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of 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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Contents

Executive Summary

Introduction

During the week of April 25–29, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the John D. Dingell VA Medical Center Detroit, Michigan. 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 159 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of Review

The CAP review covered 16 operational activities. The medical center complied with selected standards in the following five areas:

- Agent Cashier
- Information Technology Security
- Quality Management Program
- Timekeeping for Part-Time Physicians
- Unliquidated Obligations

We identified 11 areas that needed additional management attention. To improve operations, the following recommendations were made:

- Strengthen controls over prescription drugs.
- Improve timeliness of colorectal cancer screening.
- Bill insurance carriers, where appropriate, for fee-basis care and other care provided to insured veterans.
- Keep patient and public areas of the medical center clean and sanitary and correct maintenance deficiencies.
- Improve documentation of pressure ulcer prevention and management actions.
- Continue reducing excess medical and engineering supplies.
- Require all licensed independent practitioners to have current cardiopulmonary resuscitation (CPR) certifications.
- Review and follow up on background investigations and security clearances for clinicians.

- Aggressively pursue delinquent accounts receivable and improve employee clearance procedures.
- Comply with review and documentation requirements for service contracts.
- Review and resolve outstanding Government purchase card orders.

The report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. William J. Gerow, Jr., Audit Manager, Chicago Audit Operations Division.

VISN 11 and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable implementation plans. (See Appendixes A and B, pages 18–34, 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

Medical Center Profile

Organization. Located in Detroit, MI, the medical center provides a broad range of inpatient and outpatient services. Outpatient care is also provided at two community-based outpatient clinics located in Yale and Pontiac, MI. The medical center is part of VISN 11 and serves a veteran population of about 464,000 in a primary service area that includes 4 counties in Michigan.

John D. Dingell VA Medical Center

Programs. The medical center provides medical, surgical, psychiatric, neurological, and dermatological care. The medical center has 133 acute care beds. It also operates a 109-bed nursing home care unit and a Health Care for Homeless Veterans program. Both primary and specialized outpatient services are provided. The medical center provides physical examinations for military reservists and serves as a primary receiving facility within the VA/Department of Defense contingency planning system and as a Federal Coordinating Center within the National Disaster Medical System.

Affiliations and Research. The medical center is affiliated with the Wayne State University School of Medicine and supports 74 medical residents. In addition, there are 34 other training affiliations including programs with the Department of the Army, Eastern Michigan University, City of Detroit Department of Health, and Concordia University among others. In fiscal year (FY) 2004, the medical center research program had 26 VA funded projects and a budget of $3 million. Areas of research included behavioral and neurosciences, biochemistry, cardiology, endocrinology, gastro-enterology, gerontology, hypertension, oncology, and pulmonary diseases.

Resources. The medical center's FY 2005 medical care budget was $189 million, a 2 percent increase from the FY 2004 funding of $185 million. FY 2004 staffing was 1,525 full-time equivalent employees (FTE), including 102 physician FTE and 352 nursing FTE.

Workload. In FY 2004, the medical center treated 37,702 unique patients, a 2 percent increase from FY 2003. The FY 2004 inpatient average daily census, including nursing home patients, was 158, and outpatient workload totaled 326,438 patient visits, a 7 percent increase from FY 2003.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services. On February 12, 2004, the Commission on Capital Asset Realignment for Enhanced Services (CARES) issued a report to the

Secretary of Veterans Affairs providing its recommendations for improvement or replacement of VA medical facilities. The Secretary published his decisions relative to the Commission's recommendations in May 2004. As a result of the Secretary's decisions, VA will maintain tertiary facilities at both the Ann Arbor and Detroit medical centers, with continued consolidation of services. VA will study referral patterns for patients treated in the Post Traumatic Stress Disorder and Substance Abuse Treatment Unit at the VA Medical Center Battle Creek, MI and determine whether, and what proportion of, beds should be transferred to Detroit to improve access.

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 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 16 activities.

Accounts Receivable
Agent Cashier
Background Investigations of Clinicians
Colorectal Cancer Management
Controls over Prescription Drugs
Credentialing and Privileging
Environment of Care
Government Purchase Cards
Information Technology Security
Medical Care Collections Fund
Pressure Ulcer Prevention and Management
Quality Management Program
Service Contracts
Supply Inventory Management
Timekeeping for Part-Time Physicians
Unliquidated Obligations

The review covered facility operations from FYs 2002 to 2005 through May 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees who had Internet access, and 236 employees responded. We also interviewed 30 patients during the review. Issues identified through the employee and patient surveys were discussed with medical center management.

During the review, we also presented 4 fraud and integrity awareness training sessions for 159 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.

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.

Follow-Up to Previous CAP Recommendations and Suggestions. We followed up on six recommendations and one suggestion from our prior CAP review of the medical center (*Combined Assessment Program Review of the John D. Dingell VA Medical Center*, Report No. 01-01252-37, December 20, 2001). Medical center managers adequately addressed most of the recommendations and the suggestion made in the prior CAP report. However, we make one follow-up recommendation in this report related to background investigations of clinicians.

Results of Review

Opportunities for Improvement

Controls over Prescription Drugs – Controls Needed To Be Strengthened and Inspections Completed

Conditions Needing Improvement. Veterans Health Administration (VHA) and Drug Enforcement Administration (DEA) policies intended to protect against loss and theft of prescription drugs differ based on the type of drugs involved. There are two broad categories of prescription drugs, which are referred to as controlled substances and non-controlled substances. Controlled substances are further subdivided into five "schedules." Schedule I[1] and Schedule II controlled substances require the most stringent controls. Our assessment of pharmacy controls, inspection procedures, and security identified four conditions that needed to be addressed.

Inventory Management. The medical center did not complete some physical inventories of prescription drugs and did not retain records of some physical inventories. VHA policy requires that wall-to-wall physical inventories be conducted annually for all controlled and non-controlled substances located in Pharmacy Service. VHA policy also requires that complete physical inventories be conducted for all controlled substances every 72 hours, and DEA policy requires that records of all physical inventories of controlled substances be retained for 2 years.

Records showed that, although Pharmacy Service staff conducted a wall-to-wall physical inventory of controlled and non-controlled substances in April 2005, staff inventoried only a sampling of drugs during the previous four annual physical inventories. The lack of complete wall-to-wall physical inventories prior to April 2005 prevented Pharmacy Service staff from confirming the suspected loss of two non-controlled substances, Lipitor® and Viagra®, having a combined value of over $50,000.

Based on purchasing and dispensing records, Pharmacy Service staff estimated that for the period May 2004 through February 2005 there were as many as 16,859 doses of Lipitor® and 4,976 doses of Viagra® that were unaccounted for. Pharmacy Service staff could not determine beginning balances for either drug and could not calculate the exact number and value of unaccounted for drugs. Although medical center management reported the apparent missing drugs to the OIG Office of Investigations, investigative staff also were unable to confirm the loss because of the lack of adequate inventory records.

[1] The medical center did not use Schedule I controlled substances. Schedule I controlled substances are typically non-therapeutic and highly abuseable drugs, such as heroin and marijuana, that are rarely used in VA medical facilities and then only for research purposes.

Similar to annual wall-to-wall physical inventories, outpatient Pharmacy Service staff conducted 72-hour physical inventories of only a sampling of controlled substances rather than all of them. In addition, outpatient Pharmacy Service staff maintained the results of these physical inventories for only 1 month because they were not aware of the DEA requirement to maintain them for 2 years.

Lastly, VHA policy requires that Pharmacy Service staff account for the serially numbered security seals used to seal pharmacy cache containers. Pharmacy Service staff did not maintain accountability for these seals because they were not aware of the requirement. Used and unused seals were not recorded, nor were they used in sequential order.

Controlled Substances Receiving Procedures. Procedures for receiving controlled substances did not conform to VHA and DEA policies. DEA policy requires that receipts of Schedule II controlled substances be reconciled with DEA Forms 222, "Order Form – Schedule I and II Drugs," which control the ordering and receiving of drugs that are especially vulnerable to abuse and diversion. In addition, VHA and DEA policies require that a medical facility controlled substances accountable officer:

- Witness the receiving and initial opening of controlled substances.
- Certify the accuracy of receiving reports for controlled substances.
- Witness the placing of controlled substances into Pharmacy Service inventory.

The medical center's controlled substances accountable officer only certified receiving reports for Schedule II substances and did not witness controlled substances being placed into inventory. In addition, the accountable officer and Pharmacy Service staff did not reconcile receipts of Schedule II controlled substances with DEA Form 222.

Monthly Controlled Substances Inspection Procedures. Medical center staff assigned to conduct monthly controlled substances inspections needed to be better trained to ensure that they performed all of the inspection duties required by VHA policies. Based on our observation of a narcotics inspection and reviews of controlled substances inspection documentation, we found that inspectors did not:

- Note discrepancies in balances between automated Veterans Health Information Systems and Technology Architecture (VistA) "Current Stock for Inpatient Pharmacy" reports and VA Forms 10-2320, "Schedule II, Schedule III Narcotics, and Alcoholics Register."
- Note that 72-hour physical inventories of outpatient pharmacy controlled substances included only a sampling of controlled substances.
- Note that Pharmacy Service staff did not retain records of 72-hour physical inventories of outpatient pharmacy controlled substances for a 2-year period.

- Note that Pharmacy Service staff and the accountable officer did not certify receiving reports of controlled substances other than of Schedule II substances.
- Measure unsealed powders and liquids.
- Verify orders from five randomly selected dispensing activities.
- Verify the accuracy of change-of-shift counts of controlled substances conducted by staff at non-automated dispensing activities.
- Inspect controlled substances maintained in Research Service.
- Inspect controlled substances stored in the pharmacy cache.[2]
- Account for serially numbered security seals used to seal pharmacy cache containers.

Controlled Substances in Research Service. Procedures to account for receipt and dispensing of controlled substances in Research Service needed improvement. There was no uniform procedure among five Research Service investigators for requesting, receiving, and controlling controlled substances supplied by Pharmacy Service staff. Each investigator kept his or her own manual records for receipt and dispensing of controlled substances. Some investigators used the official "Controlled Substance Administration Record," but others used a variety of informal and unofficial documents. In one case, an investigator recorded the dispensing of pentobarbital on notebook paper. Analysis of those records revealed an apparent shortage of 4 ml of pentobarbital. Research Service staff should use the same procedures for controlling and dispensing controlled substances that are used by staff at other non-automated dispensing locations.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) comply with policies governing the physical inventory of controlled and non-controlled substances and maintain accountability of pharmacy cache security seals; (b) comply with policies governing the receipt of controlled substances; (c) train monthly controlled substances inspectors to ensure that they perform all the duties required of them by VHA policies; and (d) adopt receipting, dispensing, and accountability procedures for controlled substances maintained in Research Service similar to those used at other non-automated dispensing locations.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that processes were established to ensure compliance with physical inventory and inspection requirements and with receipting procedures for controlled substances. In addition, controlled substances maintained in Research Service have been brought into the controlled substances inspection process. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

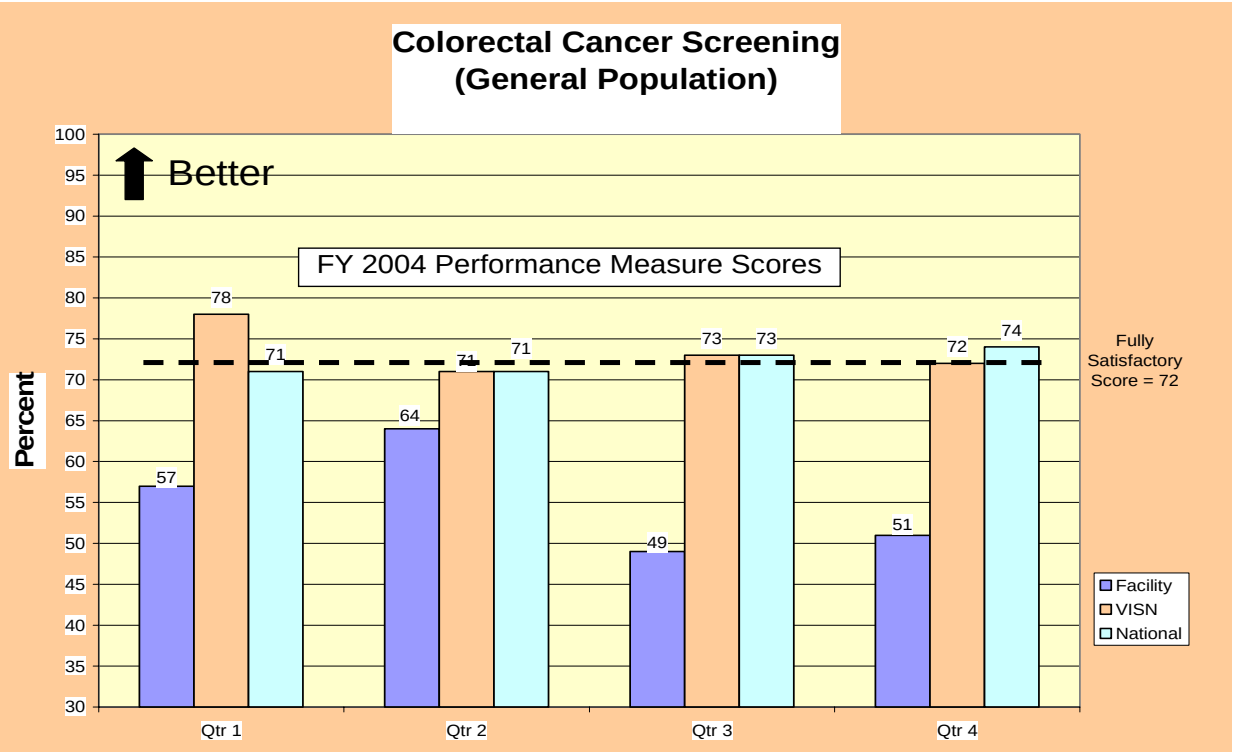
[2] Every month, inspectors should verify the physical integrity of pharmacy cache containers and the security tags used to seal them. At least quarterly, they should also open the containers to account for the controlled substances within them.

Colorectal Cancer Management – Timeliness of Gastroenterology Evaluations and Diagnosis Notifications Needed Improvement

Condition Needing Improvement. Clinicians needed to improve the timeliness of colorectal cancer (CRC) diagnoses by reducing the time from gastroenterology (GI) consultation requests to patient evaluations. The medical center developed coordinated interdisciplinary treatment plans and provided timely surgery and hematology/oncology consultation and treatment services. However, the medical center did not meet the VHA performance measure for CRC screening, and patients were not promptly informed of diagnoses.

CRC Screening and GI Evaluations. VHA's CRC screening performance measure assesses the percent of patients screened according to prescribed timeframes. 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 CRC during FY 2004. We used the medical center's goal for accomplishing GI evaluations within 30 days from the date of the consultation request, which takes into consideration factors outside the medical center's control.

The medical center's CRC screening mean performance measure score for FY 2004 was 55 percent, compared to mean scores of 74 and 71 percent for VISN and national levels, respectively. Seven patients in our sample of 10 were referred for GI evaluations, but 5 (71 percent) of the 7 were not seen within 30 days from the date of the referral. In addition, medical records showed that 6 (60 percent) of the 10 patients were not notified of their diagnoses within 90 days from their initial clinic visits. All 10 patients were scheduled for surgery, hematology/oncology, or GI follow-up appointments.



Patients appropriately screened	Patients diagnosed within 90 days	Patients appropriately notified of diagnoses	Patients with interdisciplinary treatment plans	Patients received initial treatment within 45 days of diagnoses
7	6	4	10	8

Although GI evaluations were performed every day of the workweek, program managers told us that GI evaluations and CRC diagnoses were delayed due to limited staffing. Workload data from FYs 2002 through 2004 confirmed a steady increase in GI referrals, from 3,161 in FY 2002 to 3,506 in FY 2004. The GI clinic had one vacancy at the time of our review, and program managers were in the process of hiring a physician's assistant and a registered nurse to expedite care. Program managers reported that patients frequently did not return fecal occult blood test (FOBT) cards[3] or keep follow-up appointments, which also contributed to delays. To address this issue, QM staff implemented a procedure to telephone patients and remind them of their CRC screening and the need to return FOBT cards.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure timely patient CRC screening, GI evaluation, and notification of CRC diagnosis.

[3] These cards are provided to patients to prepare stool samples for analysis by the medical center laboratory. In February 2005, 735 FOBTs were ordered, but 492 (67 percent) were still unreturned at the time of our review.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that a task force was chartered to address performance issues related to CRC screening, that staff have been added to the GI program, and that the timeliness of diagnosis notifications will be monitored. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

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

Conditions Needing Improvement. Medical Care Collections Fund (MCCF) staff[4] could increase collections by strengthening billing procedures for care provided to patients on a fee basis and by ensuring that clinicians better document the care they provide. Federal law authorizes VA to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the medical center collected $9.4 million from insurance carriers or 79 percent of its collection goal of $11.9 million. However, there were two opportunities to improve MCCF collections.

Billing for Fee-Basis Care. Although MCCF staff billed insurance carriers for inpatient and outpatient care provided at the medical center, they did not bill for care provided on a fee basis by non-VA health care providers. From October through December 2004, the medical center paid 1,777 fee-basis claims, totaling $771,490, to private providers for care provided to veterans with medical insurance. However, MCCF staff did not bill insurance carriers for that care. This was caused by a breakdown, of unknown cause, in electronic data exchange between the medical center at Detroit and the MCCF billing function located in Saginaw, MI.

Outpatient Care. According to information provided by staff at both facilities, MCCF billing staff at Saginaw had not received any fee-basis outpatient care cases from the medical center for about 6 months prior to our review in April 2005. No one at either facility was aware of this situation until we identified it, and no one was able to explain what happened in the electronic data exchange system to cause the problem. During our review, staff at the medical center began attempts to determine the cause of the problem and to correct it.

Inpatient Care. According to information provided by staff at both facilities, MCCF billing staff at Saginaw had never received any fee-basis inpatient care cases from the medical center since the inception of VA's authorization to bill for reasonable charges in 1999. Again, no one at either facility was aware of this situation until we identified it. Staff at both facilities speculated that the cause involved a failure of the automated VistA Fee Basis system to exchange patient

[4] Medical center staff documented the care provided to veterans in electronic records, which were then electronically and automatically transmitted to MCCF staff who were, at the time of our review, located at VA Medical Center Saginaw, MI and who performed all billing and collection functions. Subsequent to our review, billing and collection functions were transferred to MCCF staff at the VA Northern Indiana Healthcare System.

encounter information with the automated "Potential Cost Recovery Report" system used by Saginaw staff to identify billable episodes of care. Staff also speculated that the problem may have been related to medical center staff not obtaining pre-admission authorizations from insurance carriers for inpatient episodes of fee-basis care.

Not billing insurance carriers for fee-basis care resulted in lost revenue. For example, in a review of eight fee-basis cases, totaling $36,241, there was one case for $4,926 that should have been billed to an insurance carrier. Although we could not project the amount of the total lost revenue, we believe the amount was significant. To illustrate, in FY 2003 the medical center paid $7 million for 1,028 episodes of fee-basis care. In FY 2004, it paid $6.3 million for 1,020 episodes of fee-basis care, and in FY 2005, through May 2005, it paid $5 million for 698 episodes of fee-basis care.

Billing for VA Care. The medical center's "Reasons Not Billable Report" dated May 2, 2005, and covering the first quarter of FY 2005 showed 1,047 cases totaling $165,786 that were not billed to insurance carriers because of insufficient documentation or because care was provided by a non-billable provider, such as a resident physician. A random sample of 50 of these cases, totaling $5,785, identified 10, totaling $2,579, that could have been billed had documentation been accurate and complete.

- In four cases, MCCF staff did not issue bills totaling $1,258 because clinicians did not adequately document the care provided. Clinician progress notes were not present or did not include information such as the reason for the visit, the diagnosis, or evidence of an examination. In addition, medical record technicians did not follow up with clinicians to obtain the necessary documentation.
- In four cases, MCCF staff did not issue bills totaling $949 because medical record technicians had incorrectly coded the treatment provided.
- In one case, MCCF staff did not issue a bill for $331 for care provided by a resident physician because the attending physician had not documented his or her supervision.
- In one case, MCCF staff did not issue a bill for $41 for physical therapy because the physician's order for physical therapy had expired before the therapy was given.

The sample of 50 episodes of care showed that 10 (20 percent) episodes of care could have been billed in the amount of $2,579, an average of $258 per episode. Based on the sample results, we estimated that the universe of 1,047 unbilled episodes of care during the first quarter of FY 2005 contained 209 (1,047 x 20 percent) that could have been billed. If projected to the entire fiscal year, there would be about 836 episodes of care (209 first quarter episodes x 4 quarters) totaling $215,688 (836 episodes x $258 per episode) that will not have been billed but could be.

Summary – Potential Collections. Improved billing procedures for fee-basis care and better clinical documentation would improve collections. We estimated that additional billings totaling $220,614 ($4,926 for 1 fee-basis case + $215,688 for an estimated 836 non-fee-basis cases) could have been achieved. Based on the medical center's collection rate of 18.9 percent per amount billed, we estimated that the medical center could have increased collections by $41,696 ($220,614 x 18.9 percent).

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) identify and correct the cause of the problems preventing the billing of inpatient and outpatient episodes of fee-basis care and establish procedures to obtain pre-admission authorizations for inpatient episodes of fee-basis care, (b) review episodes of inpatient and outpatient fee-basis care occurring within the preceding 12 months and bill insurance carriers where appropriate, (c) review the 10 cases of unbilled episodes of care cited above and bill insurance carriers where appropriate, and (d) ensure the completeness and accuracy of medical record information necessary to bill insurance carriers.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that the cause of the problem preventing billings for fee-basis care has been identified and corrected, that a procedure has been established to obtain pre-admission authorizations for fee-basis inpatient care, that episodes of fee-basis care occurring over the preceding 24 months have been reviewed and billings initiated where appropriate, that billings have been initiated for cases reviewed during the CAP review, and that controls have been established to ensure complete and accurate medical record documentation. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Environment of Care – Patient Care Areas and Public Restrooms Should Be Cleaned and Maintenance Deficiencies Corrected

Condition Needing Improvement. VA policy requires that medical facilities be clean, sanitary, and maintained to optimize infection control and patient safety. Because pre-CAP electronic survey results showed that employees were concerned about cleanliness, we inspected patient rooms and restrooms on four inpatient units and public restrooms throughout the medical center. Many of the patient rooms and restrooms inspected required cleaning and maintenance. We observed:

- Accumulation of debris and dust on floors along baseboards, in corners, and on horizontal surfaces in patient rooms.
- Soiled bedside stands and tray tables in patient rooms.
- Missing covers on lights over patient beds.
- Soiled grout in patient and public restrooms.

- Accumulation of dust on air vents.
- Food debris in drawers, trash in patient lockers, and dirty sinks in rooms that were ready for new patient admissions.
- Soiled floor tiles, commodes, and sinks in public restrooms.
- Inaccessible emergency call system cords in some public restroom stalls.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that all patient care areas and public restrooms be kept clean and sanitary and that maintenance deficiencies be corrected.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that Environmental Management Service (EMS) has been realigned under the Associate Director, that an assessment is underway to assess staffing and training needs with a report due by October 1, 2005, that patient room cleaning inspection sheets have been developed for use by EMS supervisors, that EMS staff have received refresher training, and that the Associate Director has initiated weekly administrative rounds to validate the effectiveness of those process changes. In addition, weekly interdisciplinary hazardous surveillance rounds have been initiated to identify and report on trends involving hazardous conditions. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Pressure Ulcer Prevention and Management – Documentation Needed To Be Improved

Condition Needing Improvement. Medical center policy requires that a patient's skin integrity be assessed within 24 hours of admission and when a patient transfers between nursing units. To evaluate the medical center's controls over the prevention and management of pressure ulcers, we reviewed a judgment sample of 10 medical records of patients who had pressure ulcers (8 inpatients and 2 outpatients) and found 3 deficiencies:

- There was no documentation of skin integrity assessments by accepting nursing units in 12 patient transfers involving 9 of the 10 patients. (Some patients in our sample transferred between nursing units multiple times.)
- There were inconsistencies in documentation, such as improper description of the ulcer location and condition, in eight patient records.
- Documentation of completed pressure ulcer treatments was missing from four patient records.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) skin integrity assessments for patients transferring between nursing units be performed and documented, (b) pressure ulcer documentation correctly reflects the pressure ulcer location and condition, and

(c) pressure ulcer treatments are completed as ordered and are documented in medical records.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that nursing policy is being updated to include standardized medical record templates to outline skin assessment and treatment expectations; that training will be conducted by September 2005 to address this new policy; and that a performance indicator will be established effective October 1, 2005, to monitor compliance and outcomes, which will be reported to nursing leadership monthly. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Supply Inventory Management – Excess Stock Needed To Be Reduced

Condition Needing Improvement. VHA policy requires medical facilities to establish stock levels that do not exceed 30 days of stock on hand. Medical facilities are required to use the Generic Inventory Package (GIP) for most types of supplies. Prosthetics supplies are managed using the Prosthetics Inventory Package (PIP). Both systems were fully implemented, and tests revealed that data recorded in both systems was accurate. However, engineering and medical supplies exceeded 30-days of stock on hand.

Although medical center inventory management staff had made progress in reducing excess stocks of engineering and medical supplies by transferring stock to other VA facilities and to other Government agencies, at the time of our review, there was still excess stock valued at $1,026,606. Most of this stock represented supplies that had been transferred to the John D. Dingell VA Medical Center when the former VA Medical Center Allen Park, MI was closed in 1996. Use of this stock at the new medical center was precluded because it was not compatible with new building service equipment and medical equipment. According to the Chief of Facilities Management Service, about 6 months prior to our review, the value of the excess stock was approximately $2 million. Continuing efforts to transfer this excess stock to other VA facilities and other Government agencies will allow better use of Federal funds by reducing acquisition costs at those other facilities.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director continues efforts to reduce supply stock levels to a 30-day supply.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the medical center will continue to reduce stock levels to achieve a 30-day supply by January 31, 2006, that Materiel Management Service staff will concentrate on inactive and long supply items, and items will be reviewed to determine appropriate stock levels and identify areas for improvement. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Credentialing and Privileging – Verification of Cardiopulmonary Resuscitation Certification Was Needed

Condition Needing Improvement. VHA regulations require that clinically active staff maintain current CPR certification. Among credentialing and privileging files for five licensed independent practitioners, there was one for an advanced practice nurse and one for an ophthalmology fellow that did not show evidence of CPR certification. Proof of this training should be presented by practitioners at the time of initial privileging, and subsequent re-privileging documentation should reflect that the practitioners' CPR certifications remain current.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires that all licensed independent practitioners have current CPR certifications and that they are documented in credentialing and privileging files.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that by August 15, 2005, all licensed independent practitioners will be reviewed for compliance with CPR certification, that credentialing and privileging records will be updated to reflect certifications, and that staff identified as not having current certifications will have until August 31, 2005, to complete an acceptable CPR certification course. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Background Investigations of Clinicians – Results of Background Investigations Needed To Be Monitored for Timeliness

Condition Needing Improvement. Newly appointed clinicians are subject to background investigations conducted by the Office of Personnel Management (OPM). Human Resources Management Service (HRMS) staff are required to request an investigation within 14 workdays of each employee's appointment and to follow up if results are not received within 2 months. In response to a suggested improvement action made in our prior CAP review, HRMS staff developed a procedure to track and follow up with OPM when new clinicians' background investigation results were not returned within 2 months of submission.

However, among a judgment sample of Official Personnel Folders (OPFs) for eight clinicians, one OPF did not contain evidence that an initial background investigation had been performed. This physician began employment at another VA medical center prior to transferring to the John D. Dingell VA Medical Center and had worked for VA for more than 18 years continuously. At our request, the Chief of HRMS contacted OPM to determine if it had records to confirm that a background investigation had been performed. OPM officials were unable to provide confirmation because they do not retain those records longer than 15 years.

Because the physician was recently promoted to a sensitive high-risk position, a Public Trust clearance was requested on February 4, 2005, and received from OPM on April 27, 2005. However, the physician was not covered under any documented security clearance during the 17 years prior to the promotion.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director requires HRMS staff to review all clinicians' OPFs and follow up on background investigation and security clearance discrepancies.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that, by August 1, 2005, HRMS staff will complete a review to confirm evidence of initial background investigations and appropriate security clearances for all clinicians and will establish a tracking system to ensure follow-up on past due investigations. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Accounts Receivable – Follow-Up and Collection Procedures Needed To Be Improved

Condition Needing Improvement. Accounts receivable were established and reconciled according to VA policy. However, there were two areas where Fiscal Service staff could improve accounts receivable collections. Some delinquent accounts receivable needed additional follow-up, and procedures for employees who terminate their employment needed to be improved.

Follow-Up of Delinquent Receivables. VA policy requires prompt and aggressive follow-up collection action on accounts receivable and establishes the use of uniform collection procedures. Among accounts receivable records, there was no documentation of follow-up beyond three automatically generated demand letters for nine delinquent vendor accounts totaling $90,926.

In addition, there were two other delinquent accounts receivable, with a total value of $1,388, that represented debts owed by former employees. Although Fiscal Service staff had referred both debts to the U.S. Department of Treasury's Treasury Offset Program (TOP), collection actions through TOP were subsequently suspended at the medical center's request. Although Fiscal Service staff speculated that collection actions had been suspended because these former employees submitted waiver requests, we were unable to locate any evidence of pending waivers.

Clearance Procedures. VA policy requires that 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 an employee's termination creates a debt to VA. Among a sample of 30 delinquent accounts receivable, there were 9 for former employees totaling $18,313. Two of these could have been prevented or substantially

offset. Two employees cleared station with debts of $10,988 and $2,057, respectively. In both cases, the debts represented special pay the employees had received but were not entitled to because they had not remained in VA service long enough to satisfy their contractual requirements. At the time of their separation, these employees were paid for unused annual leave, $4,904 and $5,697, respectively, despite their outstanding indebtedness. Accounts receivable were not established timely to offset the debts because HRMS staff had not notified Fiscal Service staff of the employees' debts.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) aggressively pursue delinquent accounts receivable and document follow-up and (b) ensure that HRMS staff notify Fiscal Service staff if an employee's termination creates an employee debt.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that Fiscal Service has established a process to follow up with telephone calls to ensure that open accounts receivable are paid and established an electronic follow-up system which will be reviewed monthly. In addition, HRMS and Fiscal Service staff initiated a process that creates a bill of collection before an employee clears station upon termination. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Service Contracts – Contract Administration Needed To Be Strengthened

Condition Needing Improvement. To determine the reasonableness of negotiated prices, VA policy requires preparation of Price Negotiation Memorandums (PNMs) for noncompetitive contracts. PNMs contain significant facts and considerations that control the negotiated agreement and include any significant differences between a contractor's position and a VA contracting officer's position during negotiations. VA policy also requires that legal and technical reviews be conducted for certain types of contracts and that market research be conducted for other types of contracts.

Among records for 15 service contracts, with a total value of $32 million, there were 5 that did not contain 1 or more types of required documentation. Four service contracts, with a total value of about $9 million, did not contain PNMs. A legal and technical review was not performed on one contract valued at $735,000, and market research was not documented on two contracts with a total value of $1 million. Not preparing required documentation and not conducting required reviews and market research could result in VA not obtaining the best price or receiving services that do not represent good value to the Government.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Medical Center Director ensures that contracting officers fully document contracting records and conduct required reviews and market research.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that, effective August 5, 2005, contracting officers will use checklists to ensure that contracting actions are fully documented; that higher level contracting officers will review each contract; and that training will be provided on market research, technical reviews, and PNMs. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Government Purchase Cards – Outstanding Purchase Orders Needed To Be Researched and Corrected

Condition Needing Improvement. Cardholders performed reconciliations of purchase card bills and receipts timely, and approving officials approved purchase card transactions timely. The Purchase Card Coordinator reviewed transactions every other day and sent e-mails to cardholders and approving officials to notify them of unreconciled and unapproved transactions. As of March 2005, the medical center had 68 Government purchase cardholders, 29 approving officials, and 251 purchase card accounts. During FY 2004, cardholders executed 19,984 purchase card transactions totaling $1.2 million. There was one area where management needed to strengthen controls over the purchase card program.

Reports generated by the automated Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system for FYs 2002 through 2004, showed that there were 356 outstanding purchase card-related purchase orders (purchase orders that had not been closed[5]) valued at $66,836. In each of the 3 fiscal years, the reports showed outstanding purchase orders with either negative, zero, or positive balances. Although the Purchase Card Coordinator believed that some actions by either cardholders or approving officials had not been completed, neither Fiscal Service staff nor we were able to determine the causes of these outstanding balances.

Recommended Improvement Action 11. We recommended that the VISN Director ensure that the Medical Center Director takes action to determine why IFCAP reports continued to show outstanding purchase card-related purchase orders after 3 years and take appropriate corrective actions.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that outstanding purchase card-related purchase orders were caused by staff not following proper closure procedures. Action to address the outstanding purchase orders will be completed by September 1, 2005. In addition, purchase card holders will be provided bi-annual refresher training. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

[5] Normally, a purchase order is closed when purchasing or receiving staff input information into the IFCAP system showing that an order has been received in full.

Appendix A

VISN 11 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 1, 2005

From: Director, VISN 11 (10N11)

Subject: Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

To: Director, Chicago Audit Operations Division, Office of Inspector General (52CH)

1. I have reviewed all findings, discussed issues with the Medical Center Director and concur with their findings and action plans.

2. Thank you for your comprehensive review and identification of areas for improvement for the John D. Dingell VA Medical Center Detroit, Michigan.

(original signed by:)
Linda Belton

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2005

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

To: Director, Chicago Audit Operations Division, Office of Inspector General (52CH)

1. We have reviewed the recommendations of the Office of the Inspector General resulting from our recent Combined Assessment Program Review. We recognize the importance of this review and the value that it can add to our day-to-day operations here at the medical center and to the care that we provide to our veterans.

2. We continually strive to provide the best care possible, yet we are ever mindful that there are always opportunities to improve. Our staff at the John D. Dingell VA Medical Center are dedicated, conscientious and talented professionals who strive to provide quality, compassionate and state-of-the-art care to our patient population. We embrace the OIG's objective to ensure that our Nation's veteran receive high quality health care. In doing so, we make every effort to evaluate findings within this report and to implement action plans in an expeditious manner.

3. On behalf of the staff at the JDDVAMC we appreciate the assistance that the survey team provided us throughout this process.

(original signed by:)
Michael K. Wheeler

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) comply with policies governing the physical inventory of controlled and non-controlled substances and maintain accountability of pharmacy cache security seals; (b) comply with policies governing the receipt of controlled substances; (c) train monthly controlled substances inspectors to ensure that they perform all the duties required of them by VHA policies; and (d) adopt receipting, dispensing, and accountability procedures for controlled substances maintained in Research Service similar to those used at other non-automated dispensing locations.

Concur **Target Completion Date:** 8/31/05

ACTION PLAN:

A. Comply with policies governing the physical inventory of controlled and non-controlled substances and maintain accountability of pharmacy cache security seals.

1. The process of conducting full 72-hour inventories and annual wall to wall inventories was implemented on May 2, 2005, upon identification of a deficiency related to performance and national directive. The required reporting of findings will be maintained in both the inpatient and outpatient pharmacies effective August 1, 2005, and will be included in the monthly unannounced substance controlled inspector's duties and findings reported in the monthly Controlled Substances Coordinator (CSC) reports to leadership.

2. Balancing of VistA medication stock on hand reports and actual unit stock on hand will be validated through pharmacy review and discrepancies requiring follow-up until resolution. The specific issue related to methadone is being addressed by eliminating the use of methadone diskettes, with conversion to methadone liquid. The facility will complete conversion through utilization of diskette stock on hand and all new orders will be methadone liquid. Pharmacy to monitor conversion to ensure that appropriate documentation and balancing of stock against reports.

3. Effective August 2005, the Controlled Substance Program will initiate the following actions to ensure compliance with national directives:

a. CSC will randomly select and verify five dispensing activities and will include findings of review in their reporting to leadership.

b. The controlled substances inspectors will verify accuracy of change in shift counts for controlled substances in units where non-automated processes exist. The CSC will identify these areas and ensure they are included in the monthly inspections.

c. The findings of activities listed above will become part of the CSC's report to leadership for the month of August and monthly thereafter.

4. A spreadsheet log has been developed to account for all of the seals used in the cache. Additionally, during the middle month of each quarter, the sealed containers will be opened, contents verified, and new seals put into place.

B. Comply with policies governing the receipt of controlled substances.

1. The facility redesigned the process for receiving and witnessing the opening of controlled substances (Scheduled II thru V) by our CSC when identified during CAP review. Effective August 1, 2005, the CSC will complete reconciliation utilizing the DEA 222 order form with the contents, ensuring documentation of any discrepancies and initiating report to vendor.

a. This process will include the measuring and validation of contents of all liquid controlled substances.

2. Effective August 1, 2005, the CSC will comply with the witnessing of the placement of controlled substances into the pharmacy inventory. Documentation of the witnessing will be verified by both the CSO and the pharmacy representative.

C. Train monthly controlled substance inspectors to ensure they perform all duties required of them by VHA policies.

1. Effective August 15, 2005, re-education of all controlled substance inspectors will be initiated immediately with completion within 90 days. Training will include duties, expectations, and reporting requirements.

2. To further strengthen the program, we will work to include these duties within the employees' position description, performance expectations, and competency assessments within the next year based upon their anniversary date (Title 38 and/or date of reviews Title 5).

3. The CSC will initiate immediately precepting for all controlled substance inspectors by:

a. Having all new inspectors be precepted by an existing inspector who has validated competencies or by the CSC before granting full independent inspection authority.

b. The CSC will accompany all inspectors at least once annually to validate competency and provide constructive feedback.

D. Adopt receipting, dispensing, and accountability procedures for controlled substances maintained in Research Service similar to those used at other non-automated dispensing locations

1. Research Policy draft has been written to identify process, identify responsibilities and to establish reporting mechanisms and frequency to bring program in alignment with VHA Directives. The policy is presently being routed for concurrance with a target date of August 15, 2005, for full implementation.

2. Identified staff will receive training on new policy through discussion in staff meetings and confirmation by signature of knowledge and understanding of new policy on or before full implementation on August 15, 2005.

3. The research program will be added to the unannounced controlled substance inspection program effective August 2005. Results of findings will be included in the CSC's reports to leadership as identified in Medical Center Memorandum # 118-302, Inspection of Controlled Substances, Precious Metals and VA form 10-25-77F Controlled Substance Prescription Pads.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to ensure timely patient CRC screening, GI evaluation, and notification of CRC diagnosis.

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

ACTION PLAN:

1. A task force was chartered by Medical Center Leadership on May 4, 2005, to address performance issues related to CRC screening. The following actions have been implemented:

a. Implemented posters to increase awareness and flyers to hand out to the patients.

b. Development of new patient instruction sheet to enhance patient understanding of process.

c. Implemented firm assignment sheet of patient's who receive FOBT cards that is communicated weekly.

d. Patient's now receive education on FOBT directly from nursing staff in each firm.

e. Patients receive phone call follow up within 14 days if they have not returned FOBT cards.

f. Medicine doctors to obtain one FOBT when performing a history and physical on inpatients to increase colorectal screening and discharge instruction template created to inform patients of next steps to take.

2. GI evaluation and diagnosis actions:

   a. A new GI section chief was named with the task of increasing the number of procedures performed and increasing the number of procedural clinics.

   b. Added a nurse to the GI clinic increasing staffing to a total of three nurses.

   c. An additional fellow from the affiliate, Wayne State University Medical School, has been added to the GI department which will increase the number of procedures preformed.

   d. Providers in the GI clinic receive a daily list of the encounters that have not been satisfied to ensure compliance.

   e. Phoning patients in the GI clinic one week before colonoscopy to remind patients of the procedure and to decrease the no-show rate.

   f. Made transportation available for patients without appropriate transportation assistance to accompany them to their colonoscopy appointment.

3. Results/Monitoring to date:

   a. External Pier Review Program scores related to CRC screening have improved from 46 percent to 61 percent compliance within the past 3 months demonstrating the effectiveness of our process changes.

   b. Timeliness of diagnosis will be an area that we will monitor through our Tumor Board to determine early detection and staging of CRC.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director take action to: (a) identify and correct the cause of the problems preventing the billing of inpatient and outpatient episodes of fee-basis care and establish procedures to obtain pre-admission authorization for inpatient episodes of fee-basis care, (b) review episodes of inpatient and outpatient fee-basis care occurring within the preceding 12 months and bill insurance carriers where appropriate, (c) review the 10 cases of unbilled episodes of care cited above and bill insurance carriers where appropriate, and (d) ensure the completeness and accuracy of medical record information necessary to bill insurance carriers.

Concur **Target Completion Date:** Ongoing

ACTION PLAN:

A. Identify and correct the cause of the problems preventing the billing of inpatient and outpatient episodes of fee-basis care and establish procedures to obtain pre-admission authorization for inpatient episodes of fee-basis care.

1. A review was conducted to identify problems preventing the billing of fee basis care. The last step in the software package "finalizing the batch" was found to be malfunctioning. The function has been fixed and staff trained on proper procedure for completing the batch to accurately create the Potential Cost Recovery Report. The reports are now being generated and follow-up on pending cases in progress.

2. VAMC Detroit will contact all fee basis providers of care by September 30, 2005, providing instructions to notify the VAMC related to any patient presenting with the VA identified as the payor source the next administrative work day. This process will initiate discussions and identify the need for utilzation review of the case. A clinical review and authorization by the Chief of Staff or his designee will be initiated for all cases that are referred to an outside fee-basis provider. Fee basis staff will forward to MCCF staff any cases that are potential cases for billing after initial review of priority status. Any case found to not have been appropriately authorized will be forwarded to the Medical Center Director for follow up and appropriate action.

B. Review episodes of inpatient and outpatient fee-basis care occuring within the preceding 12 months and bill insurance carriers where appropriate.

1. The medical center has initiated a review of the last 24 months of potential cost recovery cases and is in process of initiating appropriate actions to bill, including a review of the adequacy of the medical record documentation. Tracking has been initiated to validate amounts recovered.

C. Review the 10 cases of unbilled episodes of care cited and bill carriers where appropriate.

1. The review of the 10 identified cases has been completed, including a review of the medical record documentation. A total of 3 of the 10 cases were found to be billable for a total collection of $317.64. The remaining 7 cases were found to be unbillable cases.

D. Ensure the completeness and accuracy of medical record information necessary to bill insurance carriers.

1. The medical center implemented corrective actions in advance of the CAP review to ensure the completeness and accuracy of medical record documentation that includes:

a. Coders now notify the lead coder of any missing signatures or documentation. The lead coder then contacts the provider of care to ensure that all documentation is completed in a timely manner. E-mail tracking system is in place to allow for identification of non-compliance.

b. Provider education has been completed to train provider staff in proper process for creating patient encounters to avoid duplication of "duplicate - non-billable encounters."

c. Process of electronically generated alerts and flags to the providers of care has been implemented to ensure that occupational therapy and physical therapy orders are updated and signed timely by the providers. This action is improving the timeliness of billing and collection of these patient encounters.

d. Coders have received education on the durable medical equipment and supply distribution process that is positively impacting their ability to identify items that have been released to the patient and is now a billable item.

e. Compliance Officer continues to conduct audits to provide feedback to both coding and provider staff through the Chief of Staff and Medical Center Director.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that all patient care areas and public restrooms be kept clean and sanitary and that maintenance deficiencies be corrected.

Concur **Target Completion Date:** Ongoing

ACTION PLAN:

1. The following processes and reporting mechanisms have been put into place to assist in improving the overall environment of care related to actions stated above:

a. The Medical Center Director has realigned Environmental Management Service under the Associate Medical Center Director (AD) who is designated as the responsible official for the environment of care functions within the Medical Center.

b. An organizational assessment is in progress by an independent subject matter expert to give leadership feedback on the adequacy of staffing levels, training, supplies and equipment to determine resources required to effectively maintain the environment on a daily basis. The report is expected within 45 days of initiation with a target date of October 1, 2005, for implementation of actions to address findings.

c. Continuous monitoring activities that have been initiated include:

1. Inspection sheets for patient care areas and public restrooms have been developed and are being utilized by Environmental Management Service (EMS) supervisors to note deficiencies and to take corrective actions as needed. Information is being aggregated and reported to the Chief of EMS that will be shared with the Environment of Care Committee.

2. EMS staff have received refresher training related to proper technique for cleaning patient rooms and restrooms.

3. An assessment has been conducted and high use/problem prone areas have been identified for increased cleaning frequency.

4. Re-structuring of cleaning schedules has taken place to complete major project work on the midnight shift rather than the day shift to better utilize human resources.

5. The AD has initiated Administrative Rounds weekly to validate effectiveness of process changes and to identify areas for continued improvement. Actions are delegated to the Chief of EMS for follow up and resolution.

6. The Chief of EMS has initiated rounds with the Clinical Nurse Manager to identify and correct deficiencies. Reports from the rounds are forwarded to the AD for review.

7. Interdisciplinary hazardous surveillance rounds are conducted weekly. The aggregate findings are reported to the Environment of Care Committee with identified corrective actions to be completed within 30 days. Analysis of information is completed at the committee level to determine trends and effectiveness of corrective actions.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) skin integrity assessments for patients transferring between nursing units be performed and documented, (b) pressure ulcer documentation correctly reflects the pressure ulcer location and condition, and (c) pressure ulcer treatments are completed as ordered and are documented in medical records.

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

ACTION PLAN:

A. Skin integrity assessments for patients transferring between nursing units be performed and documented.

1. Nursing leadership has identified the Braden Scale as a standardized communication mechanism for skin integrity.

a. Nursing policy is being updated to include the development of standardized Computerized Patient Record System (CPRS) templates to outline expectations related to skin assessment, preventative treatment, and, when indicated, wound care.

b. Education program is planned for September 2005 to address the new policy, staff expectations, documentation requirements, use of the template.

c. Upon completion of training, the Nurse Manager or designee on each unit will validate the competency of the nursing staff related to risk assessment (Braden Scale), proper staging of ulcers, use of clinical note templates, and contingency plans for documentation in the case of computer failure.

B. Pressure ulcer documentation correctly reflects the pressure ulcer location and condition.

1. Training and confirmation of staff competency will be completed as stated in A. In process monitoring will be established that will include concurrent chart reviews to demonstrate the effectiveness of the training that will include all nurses for a period of 3 months and will be part of the clinical pertienence reviews for nursing staff to support continued competency.

C. Pressure ulcer treatments are completed as ordered and are documented in medical records.

1. Nursing Service will initiate a review of all orders per shift to validate that all pressure ulcer treatments are completed and documented in the medical record as part of the monitoring of the redesigned process. A performance indicator will be established effective October 1, 2005, to monitor compliance and outcomes and will be reported to Nursing Leadership on a monthly basis.

Recommended Improvement Action 6. We recommend that the VISN Director ensures that the Medical Center Director continues efforts to reduce supply stock levels to a 30-day supply.

Concur **Target Completion Date:** 1/31/06

ACTION PLAN:

1. The medical center will demonstrate continuous improvement in the reduction of stock levels to a 30 day supply by January 31, 2006, by:

a. Continuing efforts to transfer items to other government agencies that were transferred from Allen Park site.

b. Materiel Management will run reports on inactive and long supply monthly to identify areas for concentration and improvement.

c. Twenty percent of all items will be reviewed and feedback provided to the user to determine appropriate stock levels and identify areas for improvement.

d. Inventory that has been identified as excess will be turned over to Materiel Management for completing the process of excessing the items in a timely manner.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires that all licensed independent practitioners have current CPR certifications and that it is documented in credentialing and privileging files.

Concur **Target Completion Date:** 8/31/05

ACTION PLAN:

1. By August 15, 2005, all licensed independent practitioners records will be reviewed for compliance with CPR certification.

a. Provider files that validate the existence of Advanced Cardiac Life Support or Basic Life Support (or equivalent) certification will be updated to reflect current certification and expiration dates.

b. Credentialing and Privileging process has been redesigned to include this verification at the time of privileging or reprivileging.

c. Those staff identified as not having current certification will be notified in writing and will have to demonstrate completion of an acceptable course by no later than August 31, 2005.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires HRMS staff to review all clinicians' OPFs and follow up on background investigation and security clearance discrepancies.

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

ACTION PLAN:

1. HRMS to review the OPF of all clinicians and confirm evidence of an initial background investigation and documented security clearance. Follow-up investigations will be initiated on any discrepancies found.

2. HRMS will establish a tracking mechanism to ensure follow-up is completed on any past due investigations that are outside the control of the medical center and document actions taken to resolve any issues.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) aggressively pursue delinquent receivables and document follow-up and (b) ensure that HRMS staff notify Fiscal Service staff if an employee's termination creates an employee debt.

Concur **Target Completion Date:** Ongoing

ACTION PLAN:

A. Aggressively pursue delinquent receivables and document follow-up.

1. Fiscal Service has defined a process for follow-up with identified hospital accounts payable offices by telephone to ensure open accounts are paid. Although these open receivables were annotated with follow-up annotation, an electronic follow up system has been established and will be reviewed monthly.

B. Ensure that HRMS staff notify Fiscal Service staff if an employee's termination creates an employee debt.

1. HRMS and Fiscal initiated a new process that creates a bill for collection before the employee officially clears station, if required waivers are identified by HRMS and appropriate action taken as needed.

2. Tracking of the effectiveness of the process redesign will continue for at least 12 months to ensure stability in the process.

Recommended Improvement Action 10. We recommend that the VISN Director ensure that the Medical Center Director ensures that contracting officers fully document contracting records and conduct required reviews and market research.

Concur **Target Completion Date:** 8/5/2005

ACTION PLAN:

1. Effective immediately, each contracting officer shall use the Business Review Checklist as a guide to ensure that proper documentation has been placed in the contract file. The list shall be maintained in the contract file and action completed as the procurement actions take place.

2. Effective immediately, each contract specialist shall have the contract reviewed by a higher level contract specialist or their equal. Both contract specialist shall initial the review and sign and and date the tracking sheet.

3. Effective immediately, each contract specialist must ensure that the contract file is organized as outlined in FAR 4.803.

4. Training shall be completed on market research, legal and technical reviews, and price negotiation memorandum utilizing the appropriate FAR reference.

Recommended Improvement Action 11. We recommend that the VISN Director ensure that the Medical Center Director takes action to determine why IFCAP reports continued to show outstanding purchase card-related purchase orders after 3 years and take appropriate corrective action.

Concur **Target Completion Date:** 9/1/2005

ACTION PLAN:

1. Root cause has been determined to be related to compliance following proper procedures related to the credit card program. Fiscal Service has initiated actions to address the orders that are not in transaction complete status including notification of responsible supervisory staff and offering assistance of purchasing agents to assist cardholders in one-to-one instruction.

2. Fiscal and Logistics will continue to provide refresher training at least bi-annually to all card holders related to proper procedures for follow-up of delinquent purchase card holders which will be documented and reported to the identified supervisor for action.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Billing for fee-basis care and preventing lost opportunities for billing for care provided in the medical center will increase collections from insurance carriers.	$ 41,696
6	Continuing to transfer excess engineering and medical supplies to other VA facilities and other Government agencies will allow better use of Federal funds.	1,026,606
	Total	$1,068,302

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr. (708) 202-2667
Acknowledgments	Verena Briley-Hudson Donald Bunce Paula Chapman Larry Chinn Mary Ann Fitzgerald William J. Gerow, Jr. Kevin Gibbons Wachita Haywood Richard Horansky Gavin McClaren Dana Martin Cynnde Nielsen Annette Robinson Leslie Rogers William Wells

Appendix E

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