Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the San Francisco VA Medical Center San Francisco, California

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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 August 22–26, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (VAMC). 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 145 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 21.

Results of Review

The CAP review covered 12 operational activities. The medical center complied with selected standards in the following four activities:

- Colorectal Cancer Management
- Environment of Care
- Laboratory and Radiology Services
- Part-Time Physicians Time and Attendance

We made recommendations in 8 of the 12 activities reviewed. For these activities, the medical center needed to:

- Improve the disclosure process for patients who experience adverse events, complete patient safety aggregate reviews, and provide detailed patient complaints analyses.
- Update inaccurate Generic Inventory Package (GIP) records, improve inventory controls, and reduce excess prosthetic supply inventory.
- Ensure that service contracts are properly administered and staff are trained.
- Increase Medical Care Collections Fund (MCCF) collections by improving clinical documentation.
- Reinforce pharmaceutical inventory controls, controlled substances accountability, inspector training, and physical security.
- Strengthen equipment inventory and record keeping controls.
- Improve delinquent accounts receivable collection and write-off procedures.
- Strengthen information technology (IT) security controls.

This report was prepared under the direction of Ms. Julie Watrous, Director, and Ms. Michelle Porter, CAP Team Leader, Los Angeles Healthcare Inspections Division.

VISN and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–22, 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
Deputy Inspector General

Introduction

Medical Center Profile

Organization. Based in San Francisco, California, the medical center is a tertiary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in San Bruno, Santa Rosa, Ukiah, Eureka, and downtown San Francisco, California. The medical center is part of VISN 21 and serves a veteran population of about 110,000 in a primary service area that includes San Francisco, San Mateo, Marin, Napa, Sonoma, Lake, Mendocino, and Humboldt counties in California.

Programs. The medical center provides a full range of primary and tertiary health care services. There are 112 hospital beds and 120 nursing home beds. The medical center operates several regional referral and treatment programs, including Cardiac Surgery, and has a Center for Hepatitis C Research and Education, a Mental Illness Research and Education Clinical Center, and the Western Pacemaker Surveillance Program.

Affiliations and Research. The medical center is affiliated with the University of California, San Francisco, School of Medicine. There are 133 medical residency positions in 63 training programs, covering all specialties except obstetrics, pediatrics, and family practice. In fiscal year (FY) 2004, the medical center research program had 508 projects and a budget of $65 million. Important areas of research include prostate cancer, HIV, and Hepatitis C.

Resources. In FY 2004, medical center medical care expenditures totaled $283 million. The FY 2005 medical care budget was $302 million, 6.7 percent more than FY 2004 expenditures. FY 2004 staffing was 1,636 full-time equivalent employees (FTE), including 147 physician FTE and 313 nursing FTE.

Workload. In FY 2004, the medical center treated 42,460 unique patients, a 5 percent increase from FY 2003. The inpatient care workload totaled 5,209 discharges; and the average daily census was 194, including Psychiatric Residential Rehabilitation Treatment Program patients. The outpatient care workload was 349,311 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 12 activities:

Accounts Receivable	MCCF
Colorectal Cancer Management	Part-Time Physician Time and Attendance
Environment of Care	Pharmacy Service
Equipment Accountability	QM
IT Security	Service Contracts
Laboratory and Radiology Services	Supply Inventory Management

The review covered medical center operations for FY 2004 through July 2005 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the San Francisco VA Medical Center*, Report No. 02-00987-96, May 20, 2003).

As part of the review, we used interviews to survey patient satisfaction with the quality of care. We interviewed 30 patients during the review and discussed the interview results with medical center managers.

During this review, we also presented 4 fraud and integrity awareness briefings for 145 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, 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. Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-13). For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Opportunities for Improvement

Quality Management – Disclosure Process, Patient Safety Aggregate Reviews, and Patient Complaint Analyses Needed Improvement

Conditions Needing Improvement. While the QM program was generally effective and appropriate review structures were in place for 9 of the 12 program activities reviewed, we identified 3 areas that needed improvement. We reviewed medical center policies, meeting minutes, and medical records and interviewed key staff.

Disclosure Process. In a judgment sample of seven patients who experienced adverse events during inpatient care from October 2004 – July 2005, we found that clinicians had documented the adverse events discussions with five patients (71 percent) in the progress notes. However, staff had not documented that they had advised any of the patients about their right to file claims. When adverse events occur as a result of patient care, Veterans Health Administration (VHA) policy requires staff to discuss the events with the patients and, with input from Regional Counsel, inform them of their rights to file tort or benefits claims. The Chief of Staff agreed to address this issue.

Patient Safety Aggregate Reviews. Aggregate reviews of patient falls, adverse drug events, parasuicidal behaviors, and missing patients were not done for FY 2005, as required by VHA policy. The reasons for this omission included known performance issues with the Patient Safety Officer, his retirement, and the lengthy period to fill the vacancy. The Quality Management Coordinator agreed and stated that the new Patient Safety Officer will complete the required aggregate reviews.

Patient Complaint Analyses. For FY 2004, patient complaint reports were limited to broad topic areas, such as timeliness of care and employee courtesy. Also, no reports were presented to senior managers for the second and third quarters of FY 2005. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The Customer Service Program Coordinator needed to expand data analyses in the patient complaint program to identify trends and opportunities for improvement. The Quality Management Coordinator agreed to address these issues.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) responsible clinicians fully inform patients who experience adverse events of their rights to file tort or benefits claims and document the discussions, (b) the Patient Safety Officer complete aggregate reviews as required, and (c) the Customer Service Program Coordinator perform more detailed patient complaint analyses and present trended reports to senior managers.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the local disclosure policy was revised, an education program has been initiated, and a revised review process was implemented. The process of accomplishing aggregate root cause analyses is in place. The patient complaints analysis was revised and incorporated into the Leadership Committee's agenda. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Conditions Needing Improvement. The medical center needed to manage supply stock levels more effectively and make better use of automated inventory controls. VHA policy establishes a 30-day inventory level and requires that VHA facilities use GIP for managing medical and engineering supplies and the Prosthetic Inventory Package (PIP) for managing prosthetic supplies. We selected a judgment sample of 20 medical, 10 engineering, and 10 prosthetic line items and found that improvements were needed in 3 areas.

Medical Supply Inventory. As of June 30, 2005, the medical supply inventory consisted of 2,784 line items valued at $584,830. We compared the recorded GIP quantities with our physical counts for a judgment sample of 20 medical supply items valued at $113,650. GIP inventory records were not accurate for 19 (95 percent) of the 20 items. GIP overstated 18 items by $93,976 and understated 1 item by $232. As a result, GIP records overstated the medical supply inventory by $93,744 (82 percent) for these 19 items. This occurred because Acquisition and Materiel Management Service (A&MMS) staff received or distributed supplies without making the appropriate entries into GIP. Because of the inaccuracies in the GIP data, we could not determine if the medical center maintained excess medical supply inventory.

Engineering Supply Inventory. As of June 30, 2005, GIP records for the engineering supply inventory showed 902 line items valued at $10,846. According to the Chief, Engineering Service, the service had approximately 1,100 line items on hand, but only 902 (82 percent) of the items had been entered in GIP. Based on this information, the GIP engineering supply inventory data were understated, at a minimum, by the number and value of the line items that had not yet been entered in GIP. In a judgment sample of 10 items, we found that 9 items (90 percent) did not have designated values and detailed item descriptions that allowed staff to distinguish between similar items in the service's supply inventory. The A&MMS Manager indicated that Engineering Service did not have sufficient staffing to maintain and update GIP for its supply inventory.

Prosthetic Supply Inventory. As of September 1, 2005, the prosthetic supply inventory consisted of 378 line items valued at $139,855. In a judgment sample of 10 prosthetic supply items, valued at $1,521, we compared the recorded PIP quantities on hand with

our physical counts and found that inventory records were reliable to determine the amount of stock on hand that exceeded VHA's 30-day inventory level. For the 378 line items, PIP records showed that 165 line items (44 percent), valued at $111,251, exceeded the 30-day inventory level. Of the 165 line items that exceeded the 30-day level, Prosthetics Service staff stated that 117 line items (71 percent), valued at $16,272, were maintained because the medical center required a minimum level of items on hand to meet emergent patient needs. We determined that the remaining 48 line items, valued at $94,979, exceeded the 30-day supply level. This excess prosthetic supply inventory developed because staff purchased supplies without adequately monitoring usage.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) A&MMS staff identify and update inaccurate GIP records; (b) Engineering Service staff fully utilize GIP, enter the required GIP information for all engineering supply items on hand, and update GIP records for the missing information; and (c) Prosthetics Service staff monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetics inventory.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that efforts to reduce excess inventory are ongoing. New monitors were implemented and staff roles were clarified. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts – Contract Administration and Training Requirements Should Be Followed

Conditions Needing Improvement. The VISN 21 Network Contracting Manager needs to ensure that contracting officers and Contracting Officer's Technical Representatives (COTRs) follow the Federal Acquisition Regulation (FAR). We reviewed the award and administration of 10 contracts worth an estimated $15.5 million and identified improvements needed in two areas.

Contract Monitoring. Under the FAR, only contracting officers have the authority to modify contracts. However, the COTR for a $356,000 nursing home contract approved the payment of charges to hold beds while patients were on leaves of absence, even though these charges were not part of the negotiated contract. The contracting officer was not aware of this matter until we brought it to her attention. Since June 16, 2002, the COTR had authorized payments of $16,254 for non-negotiated charges for 124 days where the nursing home held the patients' beds during leaves of absence. This occurred because the COTR thought that the nursing home was entitled to be paid for holding the patients' beds during the patients' leaves of absence. The Consolidated Contracting Activity Commodities Team Leader agreed that the nursing home was entitled to these payments for the furnished services but stated that a contract modification will be negotiated to include bed hold requirements and charges to meet future needs.

COTR Training. VA requires COTRs to receive 40 hours of training every 2 years to ensure that they effectively monitor contract performance and payments. Six of nine COTRs had not received any documented training since April 2003.

Recommendation 3. We recommended that the VISN Director ensure that the Network Contracting Manager requires that: (a) the contracting officer includes all of the medical center's nursing home requirements in future contracts to prevent the payment of non-negotiated charges, (b) COTRs consistently compare invoices to the contract terms and conditions to avoid payments of non-negotiated charges, and (c) COTRs receive 40 hours of relevant training every 2 years.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the contracting officer will work with VA headquarters staff to include bed holds in the contract template. A new online COTR training program will be developed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Clinical Documentation Needed Improvement

Conditions Needing Improvement. MCCF managers could increase collections by ensuring clinicians adequately document the care they provided. VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the medical center collected $8.2 million (104 percent of its FY 2004 collection goal of $7.9 million).

Clinical Documentation. VHA policy requires clinicians to enter documentation into the medical record at the time of each outpatient encounter and MCCF staff to bill insurers for the care provided. For the 3-month period October – December 2004, the medical center reported that 72 outpatient encounters had not been billed because medical record documentation did not meet the insurance carriers' billing requirements. Of the 72 encounters, we reviewed a random sample of 50 potentially billable cases, valued at $34,450, and found that 45 cases (90 percent) could have been billed.

- Bills for 22 encounters, totaling $30,703, had not been issued because clinicians did not adequately document encounters in the medical records as required by VHA policy.

- Bills for 23 encounters, totaling $3,747, were canceled because the clinicians had not sufficiently documented resident supervision; certified plans of care for physical therapy, occupational therapy, or speech pathology rehabilitation within 30 days; or recorded the duration or frequency of the provided therapy in the

treatment plans. MCCF managers stated that this occurred because at the time clinicians were still becoming familiar with the February 2003 VA billing regulations and documentation requirements for rehabilitation therapy services.

As a result of our review, MCCF personnel issued 25 bills totaling $25,646. Better clinical documentation and improved billing procedures would have resulted in increased collections. We estimated from our sample results that 65 bills (72 bills x 90 percent), totaling $49,790, could have been issued if the medical documentation had been complete. Based on the facility's FY 2004 collection rate of 17 percent, we estimated that the medical center could have increased collections by $8,464 ($49,790 x 17 percent collection rate).

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to promptly and completely document all patient encounters in the medical records.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the local policy was revised, all potentially billable encounters are reviewed, and monthly status will be reported to appropriate committees. The Chief of Staff will be responsible for taking corrective actions regarding providers who are not in compliance with documentation requirements. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Pharmacy Service – Inventory Management, Controlled Substances Accountability, Training, and Security Needed Improvement

Conditions Needing Improvement. The Chief, Pharmacy Service, Controlled Substances Coordinator (CSC), and the Police Chief needed to improve inventory management controls; controlled substances accountability, inspections, and inspector training; and physical security of controlled substances maintained in research laboratories. Controls over drugs maintained in the pharmacy vault were effective and 72-hour controlled substances inventories were performed for all areas, except the Opti-Fill machine. We identified six areas that required corrective actions.

Pharmaceutical Inventory Controls. VHA policy requires Pharmacy Service staff to perform an annual wall-to-wall inventory of all pharmaceuticals to ensure the accuracy of inventory records and to prevent and detect diversion. The Chief, Pharmacy Service, was not aware of this requirement; prior to May 2005, the Pharmacy Service staff had not performed any annual wall-to-wall inventories. In May 2005, Pharmacy Service complied with the requirement.

Controlled Substances Accountability Controls. VHA policy, in accordance with Drug Enforcement Administration (DEA) regulations, requires Pharmacy Service to develop

written procedures for the purchase and receipt of controlled substances and to designate Pharmacy Service staff responsible for ordering, receiving, posting, and verifying controlled substances orders. The Chief, Pharmacy Service, had not established the required written procedures or designated specific Pharmacy Service staff to order, receive, and verify controlled substances. Until our review, she was unaware of these requirements.

Controlled Substances Inventories and Inspections. VHA policy requires Pharmacy Service to conduct inventories of all controlled substances every 72 hours and the CSC to include all areas containing controlled substances in the monthly unannounced inspection program. The 72-hour inventories and monthly unannounced inspections were completed for the majority of the areas containing controlled substances. However, they did not include the Pharmacy's Opti-Fill machine, which contained 10,099 unit dose tablets of various controlled substances valued at about $1,278. The CSC was not aware that controlled substances were stored or dispensed from the Opti-Fill machine and did not include it in the inspection program. An inspection of the Opti-Fill machine conducted during our review indicated that Pharmacy staff could not account for 192 of the Opti-Fill machine's 10,099 controlled substance unit dose tablets.

Controlled Substances Inspector Training. VHA policy requires all controlled substances inspectors to be properly trained to conduct inspections. However, inspectors assigned to inspect research laboratories were not adequately trained before they were sent to Bio-Safety Level 2 (BSL2) areas. Because BSL2 areas may contain hazardous materials, such as gases, acids, and chemicals, inspectors needed to be trained on the health and safety measures in these areas to prevent possible injuries to themselves, other staff, and patients. The CSC had not provided this specialized training because she was not aware of the unique safety requirements of BSL2 areas.

Controlled Substances Inventory Controls. VHA policy, in accordance with DEA regulations, requires all controlled substances to be delivered to and received by a DEA-licensed pharmacy. In one case, researchers were not aware that controlled substances purchased directly from vendors had to be received and registered in Pharmacy Service. Without the knowledge of Pharmacy Service, researchers purchased and received nine boxes of liquid Ketamine, valued at about $1,112, to euthanize research animals.[1] The researchers also did not provide to Pharmacy Service the required VA Form 10-2638, Controlled Substances Administration Record, to account for the use of the Ketamine.

Physical Security of Controlled Substances in Research Laboratories. VA policy requires research laboratories to securely store controlled substances. Proper storage of controlled substances includes, but is not limited to, anchored cabinets with key locks. Eight out of

[1] Ketamine is a non-barbiturate, rapid-acting anesthetic used on both animals and humans. However, it has the potential to be abused.

14 laboratories (57 percent) did not meet the required level of physical security for controlled substances storage. Seven laboratories did not have cabinets that were anchored in place, and three did not have key locks. In addition, one laboratory used a glass covered cabinet to store controlled substances. The controlled substances were not properly secured in these research laboratories because the Police Chief was not aware that these security requirements applied to research laboratories containing controlled substances.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that:

a. The Chief, Pharmacy Service conducts a wall-to-wall physical inventory of all pharmaceuticals annually.
b. The Chief, Pharmacy Service establishes written procedures for ordering and receiving controlled substances.
c. The CSC includes in the inspection program all areas where controlled substances are stored, including the Opti-Fill machine.
d. The Chief, Pharmacy Service provides a complete accounting of all controlled substances.
e. The CSC provides and documents BSL2 training for all inspectors.
f. Researchers have all controlled substances received and registered in the Pharmacy and use VA Form 10-2638 to record the use of controlled substances.
g. The Police Chief ensures that the required level of physical security over controlled substances in research laboratories is implemented and maintained.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that full inventories will be conducted annually, the controlled substances policy was revised, and an education program was initiated. Pharmacy staff will follow up with each researcher to ensure that controlled substances are incorporated into the pharmacy inventory. All controlled substances were removed from Opti-Fill machines, and all narcotic areas of use will be subject to unannounced inspections. BSL2 training was provided to current inspectors and will be incorporated into annual inspector training. The research controlled substances policy was revised. All controlled substances are now properly secured. The improvement plans are acceptable.

Equipment Accountability – Inventory and Accounting Controls Needed To Be Strengthened

Conditions Needing Improvement. A&MMS managers needed to improve procedures to properly account for capitalized nonexpendable equipment (items acquired for $5,000 or more with an expected useful life of 2 years or more) and equipment sensitive in nature (susceptible to theft or conversion to personal use). VA policy requires the completion of physical inventories to ensure equipment is properly accounted for and

recorded on Equipment Inventory Lists (EILs). The engineering management system[2] further requires A&MMS staff to enter specific information, including the acquisition date, asset value, and location in the Fixed Asset Package (FAP) to manage all equipment inventories and to provide information, such as capitalized asset values, for financial statement reporting. As of June 2005, the medical center had 223 EILs containing 6,408 items valued at $55,650,885. We identified three areas that needed improvement.

Equipment Accountability. VA policy requires A&MMS staff to ensure that all capitalized and sensitive nonexpendable equipment, including VA-owned, leased, loaned, or donated property, on EILs are present and accounted for. In a judgment sample of 25 capitalized and sensitive nonexpendable equipment items valued at $390,685, A&MMS staff could not locate 11 items (44 percent) valued at $31,594. Ten of the items (91 percent), valued at under $5,000, were sensitive in nature (such as cellular telephones, laptop computers, and a video projector) but were not listed on EILs, as required. For the remaining item, the responsible service was not aware that a digital computer, valued at $5,196, was missing until our review.

The Chief, A&MMS stated that they were not required to account for equipment valued under $5,000 and that they were unclear about the definition of sensitive items discussed in a January 11, 2005, VA Central Office memorandum. However, the memorandum cited a Government Accountability Office (GAO) report[3] that identified similar equipment accountability deficiencies at five VHA sites, including the medical center. The GAO report provided examples of sensitive items, such as computers, printers, monitors, and copier machines.

Equipment Information. The engineering management system user guide requires medical facilities to enter specific information, such as the acquisition date, asset value, and location in FAP for inventory and capitalization purposes. For the 2,058 capitalized equipment items valued at $5,000 or more, totaling $54.6 million in the engineering management system, information for 326 items (16 percent) was incomplete. Of these, 166 items (51 percent) did not have location information, 114 items (35 percent) did not have EIL numbers, and 46 items (14 percent) lacked acquisition dates. Without complete information, A&MMS cannot properly account for equipment items. In addition, 7,532 items, including computers and vehicles, had no dollar values listed, which prevented the medical center from accurately reporting capitalized nonexpendable equipment for financial statement purposes.

Reports of Survey. VA policy requires medical facility staff to prepare Reports of Survey (ROS) for lost, damaged, or destroyed Government property. For ROS where equipment losses equal or exceed $5,000, the ROS are to be forwarded to the Medical

[2] Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS).
[3] *VA Medical Centers: Internal Control over Selected Operating Functions Needs Improvement* (GAO-04-755, July 21, 2004).

Center Director, who is responsible for establishing a Board of Survey to conduct an investigation. Under no circumstances are ROS to be delayed longer than the time required to search the immediate area and question persons who might have knowledge of the item. A&MMS did not follow the prescribed process to ensure ROS were promptly forwarded to the Medical Center Director. In November 2004, A&MMS could not locate three equipment items, valued at about $38,000, and notified Research Service to initiate the ROS for the missing equipment. As of August 26, 2005, the A&MMS manager still had not forwarded the three ROS to the Medical Center Director, as required, because Research Service was conducting physical inventories to verify that the equipment was missing. The Acting Associate Director agreed the three ROS for the missing equipment items should have been processed more promptly.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires A&MMS staff to: (a) ensure all capitalized nonexpendable and sensitive equipment items are included on EILs; (b) ensure nonexpendable and sensitive property recorded in the engineering management system includes complete and accurate equipment information, including the asset value, acquisition date, EIL number, and location; and (c) ensure that required ROS forms are promptly forwarded to the Medical Center Director and the ROS process is completed for the three missing equipment items in Research Service.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that all capitalized nonexpendable items and sensitive equipment are now recorded on EILs, and files will be screened for completion. ROS for the three missing items were completed, and all ROS will be processed promptly. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Delinquent Accounts Receivable Controls Needed To Be Improved

Conditions Needing Improvement. Fiscal Service managers needed to improve the management of delinquent accounts receivable. VA policy requires the termination of collection actions on a claim when it becomes clear that VA cannot collect any significant amount from the debtor. VHA uses the Gross Days Revenue Outstanding (GDRO) measure to assess the pace of collections relative to the amount of a medical facility's accounts receivable.[4] We found that the medical center had not properly monitored delinquent accounts, implemented automated software write-off features, or made timely write-offs. For the period October 2003 – July 2004, the medical center's average GDRO value of 176 exceeded VHA's standard value of 100.

[4] Based on industry standards, the GDRO performance value is calculated by determining the gross revenue during a given period (in this case, a rolling 3-month period) divided by the number of days in that period. This figure is then divided into the total accounts receivable. GDRO specifically defines the age of outstanding receivables and the number of accounts receivables liquidation days. VHA's GDRO standard is 100.

To improve the monitoring of delinquent accounts receivable and the medical center's GDRO value, Fiscal Service implemented software program features 1 week before our CAP review that automated the write-off process for eligible delinquent accounts receivable. This resulted in the write-off of 7,345 delinquent accounts receivable, valued at $371,763, which had been outstanding for over 3 years. As a result, the medical center's accounts receivable write-offs increased from $232,832 in FY 2004 to $880,278 in FY 2005. Although the GDRO value subsequently improved to 127 in August 2005, further monitoring improvements were needed, including writing-off uncollectible accounts receivable that remain in the accounting system for an extended period.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that the Fiscal Service Manager monitors and promptly writes-off uncollectible, delinquent accounts receivable.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that monitoring processes are in place. The improvement plan is acceptable.

Information Technology Security – Controls Needed To Be Strengthened

Condition Needing Improvement. Information Resources Management (IRM) managers needed to strengthen IT security controls. VA policy requires the implementation of physical devices and control measures to protect IT assets and sensitive information from misuse and damage. Accordingly, VA has implemented controls related to IT access, data security, and computer virus protection.

We found that IRM staff had adequate controls to ensure IT users' levels of access were appropriate to their needs; password controls, virus protections, and safeguards were in place to protect the equipment and computer room; critical information was backed up and stored at a secure offsite location; and policies were in place to ensure sensitive information was removed from computers prior to disposal. However, we identified one area where IRM managers could improve IT security.

The Information Security Officer (ISO) had not established a process for recording automated information system security incidents. VA policy requires the ISO to establish a log of reported incidents. Examples of security incidents include unauthorized access to data and IT resources, criminal activity committed with the aid of IT resources, and unauthorized downloading of VA information. The ISO was not aware of the requirement and was unable to provide any log of reported incidents to show the monitoring of incidents.

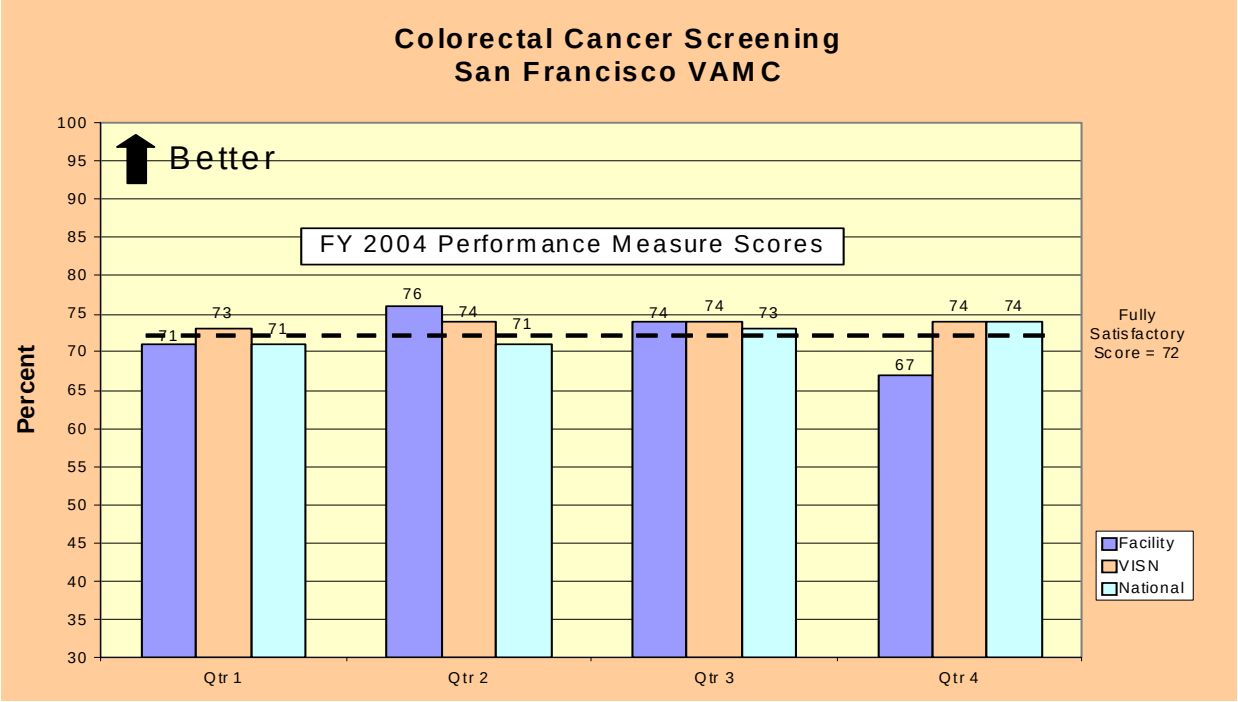
Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that the ISO establishes a log of reported incidents.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a log was established. The improvement plan is acceptable.

Other Observation

Colorectal Cancer Management – Processes were Timely and Appropriate

The medical center provided timely gastroenterology, surgery, and hematology/oncology services; promptly informed patients of diagnoses and treatment options; and developed coordinated interdisciplinary treatment plans. The VHA colorectal cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes, and the medical center achieved the fully successful level for 2 of 4 quarters in FY 2004 (see graph below). Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a random sample of 10 patients who were diagnosed with colorectal cancer during FY 2004.



Patients appropriately screened	Patients diagnosed within reasonable timeframes	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatments
9/10*	9/10*	10/10	10/10	10/10

***One patient did not comply with scheduled interventions.**

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 22, 2005

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

Subject: **San Francisco VA Medical Center, San Francisco, California**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Ms. Margaret Seleski, Director, Management Review Service (10B5)

I appreciate the opportunity to provide comments to the report of the Combined Assessment Program (CAP) review of VAMC San Francisco. I carefully reviewed the report, as well as my notes from the exit briefing I attended (via videoconference) on August 26, 2005. In addition, I discussed the findings and recommendations with senior leadership at VAMC San Francisco and the VISN 21 office.

In brief, I concur with all of the conditions needing improvement and recommendations. The implementation plan showing specific corrective actions and timelines is provided in Appendix B. As you will note, several actions have already been completed and the remainder are well underway.

I am pleased that you noted the colorectal cancer management processes were timely and appropriate. I am very proud that the questionnaires and patient interviews documented an impressive level of patient satisfaction with care at this facility.

In closing, I would like to express my appreciation to CAP review team. The team members were thorough and professional. In addition to audit and oversight activities, the CAP team provided several educational sessions (e.g., fraud and abuse awareness) that were helpful. The collective efforts and insights of the CAP review team have helped to improve our clinical activities and business practices at VAMC San Francisco.

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

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 22, 2005

From: Medical Center Director

Subject: **San Francisco VA Medical Center, San Francisco, California**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Ms. Margaret Seleski, Director, Management Review Service (10B5).

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the San Francisco VA Medical Center. I carefully reviewed the report, as well as my notes from the exit briefing on August 26, 2005.

2. In brief, I concur with all of the findings and suggested improvement actions. As you will note, the vast majority of the actions have already been completed. The remaining proposed remedies will be completed in the next few months.

3. I am pleased that there are no suggested improvement actions and no "negative" findings related to environment of care nor part-time physicians time and attendance. I was also pleased that patient interviews indicated a high level of patient satisfaction and that clinical processes were found to be timely and appropriate in colorectal cancer management.

4. In closing, I would like to express my thanks to the CAP review team. The team members were professional, comprehensive, and focused. I appreciated that the survey team discussed issues. The educational sessions regarding fraud and abuse awareness were also helpful and well received. The collective interest and efforts of the CAP review team have helped improve our clinical and business practices at VAMC San Francisco

(original signed by:)

Sheila M. Cullen

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

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

SAN FRANCISCO VA MEDICAL CENTER (662)
Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Quality Management - Disclosure Process, Patient Safety Aggregate Reviews, and Patient Complaint Analysis Needed Improvement.

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) responsible clinicians fully inform patients who experience adverse events of their rights to file tort or benefits claims and document the discussions, (b) the Patient Safety Officer complete aggregate reviews as required, and (c) the Customer Service Program Coordinator perform more detailed patient complaint analyses and present trended reports to senior managers.

Concur

Planned Action:

(a) Medical Center Memorandum (MCM) 11-72 Informing Patients about Adverse Events Disclosure dated November 17, 2005, has been revised to comply with newly issued VHA directive 2005-049, Disclosure of Adverse Events to Patients. An education program has been initiated to inform appropriate staff of this new requirement through the Medical Executive and Clinical Chiefs Meeting. The education program will also ensure written notification to all employees through our bi-monthly newsletter and our daily bulletin.

During our normal review after each incident, the reviewer will evaluate the clinical record to determine if the clinician should inform the patient of the adverse event. If no documentation can be found in the record, the reviewer will notify the clinician to have the discussion and to document it in the record. After the clinician has documented the discussion with the patient, a second meeting with the Regional Counsel or Quality Management will occur with the patient to discuss the compensation and tort claim process.

Completion/Target Date: February 2006

(b) Aggregate root cause analyses for medication and falls reviews for FY 05 have been completed. No missing patient occurrences happened during FY 05. Only one para-suicide/suicide occurred during FY 05, and a substantial peer review was accomplished and reviewed in the Peer Review Committee. No further delays will occur now that the new Patient Safety Manager is on board.

Completion/Target Date: Completed

(c) A new graphic display system of complaints/compliments by service as well as types and volume of complaints has been incorporated into the Leadership Committee agenda for presentation on a quarterly basis. Additionally, the same information will be available by service and provided to the respective service chief for inclusion into service level quality improvement functions.

Completion/Target Date: January 2006

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

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) A&MMS staff identify and update inaccurate GIP records; (b) Engineering Service staff fully utilize GIP, enter the required GIP information for all engineering supply items on hand, and update GIP records for the missing information; and (c) Prosthetics Service staff monitor item usage rates, adjust PIP stock levels, and reduce excess prosthetics inventory.

Concur

Planned Action:

(a) Continued emphasis on updating GIP records will include a new QA monitor and an additional supply clerk for the GIP Unit.

Monthly Stock Status Report is required by the Network CLO and will be monitored by the Medical Center to insure that stock levels are appropriate. The Medical Center will also ensure stock levels are within the 30-day limit where possible.

Completion/Target Date: January 2006

(b) Weekly meetings are taking place to incorporate appropriate Engineering items within the GIP program. An inventory manager will be identified to oversee the Engineering GIP inventory.

Completion/Target Date: January 2006

(c) Consignment agreements have been awarded which will reduce on-hand inventory.

Completion/Target Date: Completed

3. Service Contracts – Contract Administration and Training Requirements Should Be Followed

Recommendation 3. We recommend that the VISN Director ensure that the Network Contracting Manager requires that: (a) the contracting officer includes all of the medical center's nursing home requirements in future contracts to prevent the payment of non-negotiated charges, (b) COTRs consistently compare invoices to the contract terms and conditions to avoid payments of non-negotiated charges, and (c) COTRs receive 40 hours of relevant training every 2 years.

Concur

Planned Action:

(a) The contracting officer will work with the VA Community Care Program Office (114) in VA Headquarters to amend the national community nursing home contract template to include a requirement for "bed hold" pricing in all future Community Nursing Home contracts. Upon receiving the updated national contract template, all future Community Nursing Home contracts will include negotiated "bed hold" charges.

Completion/Target Date: January 2006

(b) The COTR currently monitors all Community Nursing Home invoices on a monthly basis to compare actual charges against contract negotiated terms to prevent non-negotiated charges. Discrepancies are addressed in the nursing home budget meetings by the COTR.

Completion/Target Date: Completed

(c) The VHA Chief Logistics Office has addressed our agency's COTR requirement by developing an online COTR training course, which will insure all new and refresher COTR training is conducted. This will ensure COTR training is provided in a timely manner.

Completion/Target Date: January 2006

4. Medical Care Collections Fund – Clinical Documentation Needed Improvement

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires clinicians to promptly and completely document all patient encounters in the medical records.

Concur

Planned Action:

MCM 136-31, Standards for Medical Records dated September 20, 2005, requires clinicians to promptly and completely document all patient encounters in the medical record. All potentially billable encounters are already being reviewed. The Compliance Officer will provide monthly reports of findings to the Medical Record and Compliance committees. The Chief of Staff will be notified of providers who are not in compliance with documentation requirements (to include not replying to requests for documentation), and will be responsible for taking appropriate corrective action.

Completion/Target Date: January 2006

5. Pharmacy Service – Inventory Management, Controlled Substances Accountability, Training, and Security Needed Improvement

Recommendation 5. We recommend that the VISN Director ensure that the Medical Center Director requires that:
(a) The Chief, Pharmacy Service conducts a wall-to-wall physical inventory of all pharmaceuticals annually.
(b) The Chief, Pharmacy Service establishes written procedures for ordering and receiving controlled substances.
(c) The CSC includes in the inspection program all areas where controlled substances are stored, including the Opti-Fill machine.
(d) The Chief, Pharmacy Service provides a complete accounting of all controlled substances.
(e) The CSC provides and documents BSL2 training for all inspectors.
(f) Researchers have all controlled substances received and registered in the Pharmacy and use VA Form 10-2638 to record the use of controlled substances.
(g) The Police Chief ensures that the required level of physical security over controlled substances in research laboratories is implemented and maintained.

Concur

Planned Action:

(a) A wall-to-wall physical inventory of all pharmaceuticals was conducted May 2005 and will be conducted annually by May 30.

Completion/Target Date: Completed

(b) The Medical Center has revised Medical Center Memorandum (MCM) 119-11, Controlled Substances, to incorporate written procedures for the purchase and receipt of controlled substances and to designate Pharmacy Service staff responsible for ordering, receiving, posting, and verifying controlled substances orders. An education program has been initiated to inform all staff including researchers and research employees of the requirement to have all controlled substances received through the Pharmacy. Failure to

follow procedures will result in appropriate disciplinary action. We have asked our Research foundation to provide copies of all current controlled substance purchase orders to Pharmacy. Pharmacy will then follow-up with each Researcher to ensure that these drugs are incorporated into the pharmacy inventory and green control sheets are completed.

Completion/Target Date: Completed

(c) Since the inspection all controlled substances have been removed from the Opti-Fill, and prescriptions are now manually filled by a pharmacist. All dispensing records will be subject to monthly unannounced controlled substance inspections.

Completion/Target Date: Completed

(d) The facility is complying by performing 72-hour inventory of all controlled substance working stock. In addition, all narcotic areas of use will be subject to an unannounced monthly controlled substance inspection.

Completion/Target Date: Completed

(e) August 23, 2005, the Medical Center Research Safety Officer and Radiation Safety Officer presented BSL2 training to the inspectors currently assigned to inspect research laboratories. Training was documented in Tempo. BSL2 training will be provided to inspectors assigned to inspect research laboratories during annual controlled substance inspector training and orientation as well as when new inspectors are appointed and will be documented in Tempo.

Completion/Target Date: Completed

(f) The Medical Center revised Research Policy No. 151-5, Research Laboratory Controlled Substances Policy (dated September 7, 2005), to incorporate procedures for investigators to order and receive controlled substances from the Pharmacy.

Completion/Target Date: Completed

(g) The Chief, Police Service conducted a comprehensive inspection of the laboratories maintaining inventories of controlled substances, using inspection criteria from VAHB 0730/1, Appendix B, Item "L." Those areas identified as having improperly stored controlled substances were directed to move the substances to locations meeting the requirements of VAHB 0730/1. All controlled substances are now properly secured in key locked, anchored cabinets or work stations.

Completion/Target Date: Completed

6. Equipment Accountability – Inventory and Accounting Controls Needed To Be Strengthened

Recommendation 6. We recommend that the VISN Director ensure that the Medical Center Director requires A&MMS staff to: (a) ensure all capitalized nonexpendable and sensitive equipment items are included on EILs; (b) ensure nonexpendable and sensitive property recorded in the engineering management system includes complete and accurate equipment information, including the asset value, acquisition date, EIL number, and location; and (c) ensure that required ROS forms are promptly forwarded to the Medical Center Director and the ROS process is completed for the three missing equipment items in Research Service.

Concur

Planned Action:

(a) All capitalized nonexpendable items are recorded on EILs. All sensitive equipment, as identified in VA Handbook change dated 10-11-05 and purchased in the past 2 years are recorded on EILs.

Completion/Target Date: Completed

(b) Engineering and A&MMS have identified a plan to populate incomplete fields for each nonexpendable and sensitive EIL item. The plan includes screening equipment inventory files for incomplete entries and entering correct data. The Bio-Medical Engineer Trainee will be leading this project for the facility with the cooperation and input from A&MMS and IRMS.

Completion/Target Date: April 2006

(c) All Reports of Survey will be processed promptly and the three Research Reports of Survey for the three missing Research items have been completed.

Completion/Target Date: Completed

7. Accounts Receivable – Delinquent Accounts Receivable Controls Needed To Be Improved

Recommendation 7. We recommend that the VISN Director ensure that the Medical Center Director requires that the Fiscal Service Manager monitors and promptly writes-off uncollectible, delinquent accounts receivable.

Concur

Planned Action:

The Medical Center continues to monitor and promptly write-off uncollectible, delinquent accounts with assistance from the new software program, Automatic First Party Write-off Routine, implemented in August 05. Quarterly, staff will review the items identified and take appropriate action based on the regulations.

Completion/Target Date: Completed

8. Information Technology Security – Controls Needed to Be Strengthened

Recommendation 8. We recommend that the VISN Director ensure that the Medical Center Director requires that the ISO establishes a log of reported incidents.

Concur

Planned Action:

Log/spreadsheet was implemented during the audit. The ISO will present to the Leadership Committee on a bi-annual basis a summary of the previous incidents.

Completion/Target Date: Completed

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Better use of funds by reducing excess prosthetic supply inventory.	$94,979
4	Better use of funds through improved MCCF billing and documentation procedures.	8,464
	Total	$103,443

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous (310) 268-3005
Acknowledgments	Julio Arias Daisy Arugay Frank Giancola Tae Kim Andrea Lui Pauline Murano Michelle Porter Maurice Smith Vishala Sridhar Wilma K. Wong

Appendix E

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