Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Kansas City, Missouri

Report No. 05-01654-69 **February 1, 2006**

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 1–5, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Kansas City, MO (the medical center). The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided 3 fraud and integrity awareness briefings to 176 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of Review

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

- Part-Time Physician Time and Attendance
- Primary Care for Mental Health Patients
- Purchase Card Program
- Quality Management Program

Based on our review, we noted the medical center's improvement in the Supply Processing and Distribution (SPD) area as an organizational strength.

We identified eight activities that needed management attention. To improve operations, the following recommendations were made:

- Improve Medical Care Collections Fund (MCCF) program results by billing backlogged claims, identifying all billable episodes of care, and training providers, billers, and coders.
- Reduce excess supply inventories and ensure inventory levels in the Generic Inventory Package (GIP) match the actual quantities on hand.
- Correct environmental deficiencies.
- Update and test the information technology (IT) contingency plan to ensure continuity of business operations.
- Improve timeliness of Gastroenterology (GI) evaluations, documentation of patients' diagnoses notifications, and data entries into the tumor registry.
- Improve security and inventory controls over prescription drugs.
- Protect sensitive patient information.
- Request needed background investigations on all newly hired employees.

This report was prepared under the direction of Mr. William H. Withrow, Director, and Ms. Lynn A. Scheffner, CAP Review Coordinator, Kansas City Audit Operations Division.

VISN 15 and Medical Center Directors Comments

The VISN 15 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–24, for the full text of the Directors' comments.) We consider all review issues to be resolved but will follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Kansas City, MO, the medical center is a tertiary care facility 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 Belton, Nevada, Warrensburg, and Cameron, MO; and in Paola, KS. The medical center is part of VISN 15 and serves a veteran population of about 163,000 in a primary service area that includes 14 counties in Missouri and 5 counties in Kansas.

Programs. The medical center provides medical, surgical, mental health, and advanced rehabilitation services. The medical center has 125 hospital beds and operates several regional referral and treatment programs, including substance abuse, geriatric care, oncology, and vascular and infectious diseases. In addition, the medical center has sharing agreements with the University of Kansas Medical Center and contracts with Health Midwest and the Truman Medical Center for additional medical services.

Affiliations and Research. The medical center is affiliated with both the University of Kansas and the University of Missouri at Kansas City Schools of Medicine and supports 82 medical resident positions in 22 training programs. In fiscal year (FY) 2005, the medical center research program had 128 active projects and a budget of $2.2 million. Important areas of research include visual disorders, kidney, cardiovascular, alcohol/drug addiction, and neurological diseases.

Resources. In FY 2004, medical center medical care expenditures totaled $183.4 million. The FY 2005 medical care budget was $185.5 million, 1.1 percent more than FY 2004 expenditures. FY 2005 staffing is 1,101 full-time equivalent employees (FTE), including 81.8 physician FTE and 287.9 nursing FTE.

Workload. In FY 2004, the medical center treated 46,140 unique patients, with an inpatient care workload totaling 5,660 discharges. The average daily census was 102, and the outpatient workload was 331,809 visits. For the first 6 months of FY 2005, the medical center had 3,295 inpatient discharges, an average daily census of 96, and 203,779 outpatient 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 general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or 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. We also followed up on recommendations in our previous CAP report on the medical center (*Combined Assessment Program Review Kansas City VA Medical Center*, Report No. 01-01515-40, January 2, 2002) and a follow-up report (*Report on Medical Center Sanitation and Follow-up of Combined Assessment Program Review of Kansas City VA Medical Center*, Report No. 02-02280-112, June 3, 2002).

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

Colorectal Cancer Management	Part-Time Physician Time and Attendance
Controls Over Prescription Drugs	Primary Care for Mental Health Patients
Employee Background Investigations	Purchase Card Program
Environment of Care	Quality Management Program
Information Technology Security	Supply Inventories Management
Medical Care Collections Fund	
Medical Record Privacy	

Nine of these 12 areas included follow-up of recommendations from the previous CAP and follow-up reviews. Three of the nine activities complied with selected standards. We made follow-up recommendations related to MCCF, environment of care, IT security, controls over prescription drugs, medical record privacy, and employee background investigations.

The review covered facility operations for FYs 2004 and 2005 through August 31, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we interviewed 30 patients to determine their satisfaction with the timeliness of service and the quality of care. The interview results were provided to medical center management.

During the review, we presented three fraud and integrity awareness briefings to medical center employees. These briefings, attended by 176 employees, 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.

An activity that was noteworthy is recognized in the Organizational Strength section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (page 5–15). For these activities, we made recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Organizational Strength

Improvement to the Supply Processing and Distribution Section Was Noteworthy. During the prior CAP review in FY 2001, we identified serious environmental deficiencies in the SPD areas. Our follow-up inspection during this CAP review revealed that the deficiencies identified during the prior CAP review were satisfactorily resolved. SPD was relocated from the basement to the third floor of the medical center in February 2004. This move positioned SPD physically closer to the most critical patients, seen in the Surgical and Medical Intensive Care Units, Progressive Care Unit, and Emergency Room. The new SPD area had clearly defined storage for clean equipment and for decontamination functions.

SPD clean equipment room

SPD decontamination room

Opportunities for Improvement

Medical Care Collections Fund – Third Party Billing Procedures and Clinical Documentation Needed To Be Improved

Conditions Needing Improvement. MCCF managers needed to improve procedures for recovering health care costs by eliminating the billing backlog, billing fee-basis care, recording accurate provider numbers and revenue codes on billing invoices, assigning appropriate reasons not billable codes, and by training providers to improve medical record documentation. This is a repeat finding from our previous CAP review and follow-up reports. We estimated additional collections of $946,774 could have been achieved as discussed below.

The medical center did not meet its FY 2004 MCCF collection goal of $13.9 million by nearly $1 million and will not meet its FY 2005 goal of $14.8 million. In March 2005, medical center management set up an action plan to address MCCF issues identified during an internal peer review of this area.

Billing Backlog. By September 30, 2002, the billing backlog identified in our previous reports had been eliminated. However, for the 12-month period ending July 27, 2005, another backlog of approximately 9,000 cases totaling $3.7 million in unbilled care had accumulated. The medical center's action plan addressed this backlog by setting a goal of issuing all the backlogged bills by the end of September 2005. Before our onsite review, MCCF staff from two VISN 15 medical centers helped code the unbilled cases. The medical center also hired two students and two full-time temporary employees in the MCCF billing department. However, veterans' insurance carriers should have been billed before the backlog accumulated to ensure that insurance filing deadlines were met in order to maximize collections.

Fee-Basis Care. For the 3-month period ending December 31, 2004, the medical center paid 1,527 fee-basis claims totaling $405,969 to non-VA providers who provided medical care to patients with health insurance. Payments included claims for care provided to inpatients and outpatients, including ancillary services for inpatient care. We reviewed a random sample of 15 claims totaling $71,025 to determine if the medical center billed the fee-basis care to patients' insurance carriers and found that MCCF staff billed $11,717 for 2 of the 15 claims. However, bills for one case should not have been issued because the insurance carrier was a nonbillable Health Maintenance Organization (HMO). MCCF staff issued a refund to the HMO. Twelve of the remaining 13 claims were not billable because the fee-basis care was for service-connected conditions, the services provided were not covered, or reasonable charges had not been established for the care provided. The other claim was billable. MCCF staff had requested but had not received documentation from the fee-basis provider. They could have issued a bill for $26,676 with the proper documentation, but the insurance filing deadline had expired. In

January 2005, MCCF staff implemented new local procedures to identify potentially billable fee-basis care.

Provider Numbers and Revenue Codes. The MCCF billing department did not adequately ensure invoice accuracy. We reviewed MCCF accounts receivable (AR) to determine whether there were adequate controls to ensure that outstanding ARs were reconciled timely. Insurers were rejecting some of the MCCF invoices sent out by billing staff because of inaccurate provider numbers or revenue codes. AR staff reported that they spent about 3 hours per workday analyzing the rejected billings, which delayed timely reconciliations.

Reasons Not Billable Codes. The "Reasons Not Billable Report" for the period October 1–December 31, 2004, listed 827 cases totaling $173,165 that were unbilled for 1 of 3 reasons—insufficient documentation, no documentation, or care provided by a nonbillable provider (resident). We reviewed 50 of the 827 cases totaling $8,599 and found that 23 (46 percent) were billable as discussed below.

- For 16 cases totaling $2,315, medical care providers did not sufficiently document the care provided in the medical records. In 12 of the 16 cases, attending physicians failed to document resident supervision; therefore, bills for professional fees could not be issued. This documentation issue had been continually discussed in the Compliance Committee meetings. In April 2005, the Chief, Health Information Management Service, started one-on-one training for providers and had seen some improvements. MCCF staff should continue this emphasis on appropriate medical record documentation.
- For seven cases totaling $1,342, billers and coders inaccurately assigned a reason not billable of insufficient documentation. Nursing staff adequately documented care that they provided in the medical records in four cases. In the other three cases, MCCF staff determined that there was adequate documentation to bill for the care provided. Bills were issued for all seven cases while we were onsite.

Improved billing and coding procedures and medical record documentation would enhance revenue collections. We estimated that 380 bills (827 cases x 46 percent of cases that were billable) totaling $60,420 [($2,315 + $1,342/23 cases) x 380 bills] could have been issued with proper medical documentation or accurate assignment of reasons not billable.

Estimated Collections. Based on the medical center's FY 2004 collection rate of 25 percent, we estimate additional collections of $946,774 [($3.7 million + $26,676 + $60,420) x 25 percent] could have been achieved.

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director continues to take action to: (a) expedite billing on the backlogged claims; (b) identify all potentially billable episodes of care; (c) provide training to billers and

coders on recording accurate provider numbers, revenue codes, and assigning reasons not billable to maximize revenues; and (d) train medical care providers regarding medical record documentation.

The VISN and Medical Center Director agreed with the finding and recommendations. They planned to have other VISN 15 facilities assist in eliminating the coding and billing backlog and to actively pursue all known billables. They gave instruction to both coding and billing staff as to what constitutes proper reasons not billable. They also met with providers to review coding issues and plan to submit reports to the Compliance Committee on this issue. Auditing, education, and training are being conducted on an on-going basis. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventories Management – Inventories Should Be Reduced and Controls Strengthened

Conditions Needing Improvement. Acquisition and Materiel Management (A&MM) staff needed to reduce excess supply inventories and improve the accuracy of inventory records. Veterans Health Administration (VHA) policy establishes a 30-day stock level goal and mandates that facilities use GIP to manage inventories. Inventory managers used the GIP automated inventory control system to monitor inventory levels, analyze usage patterns, and order supply quantities necessary to meet current demand.

A&MM staff established five primary inventory supply points: total supply support (TSS), surgery, housekeeping, office, and engineering supplies. As of March 31, 2005, the medical center reported a total inventory of 87,724 items valued at $381,748. However, we could not reasonably estimate a 30-day stock level for items for 2 inventories—surgery and engineering, totaling 11,195 items at a value of $283,876—because usage data was unreliable.

The combined TSS, housekeeping, and office supply inventories consisted of 573 items valued at about $94,250. To test the accuracy of inventory balances and the reasonableness of inventory levels, we reviewed a sample of 30 items valued at $13,266. For 25 (83 percent) of the 30 items, the stock on hand exceeded 30 days of supply, with inventory levels ranging from 32 to 3,416 days of supply. For these 25 items, the value of stock exceeding 30 days was $9,348, or 75 percent of the total value of the 30 sampled items. Applying the 75 percent sample result to the combined value of the three inventories, we estimated that the value of all excess stock was $70,581.

GIP inventory balances also did not agree with our physical counts for 20 of the 30 sampled items. Twelve of the line items were over reported (less stock on hand than reported in GIP) by $932, while the other 8 were under reported (more stock on hand than reported in GIP) by $313. These inaccuracies occurred because staff did not always

record the number of line items taken out of inventory, and services had over stocked before A&MM assumed responsibility for the inventories.

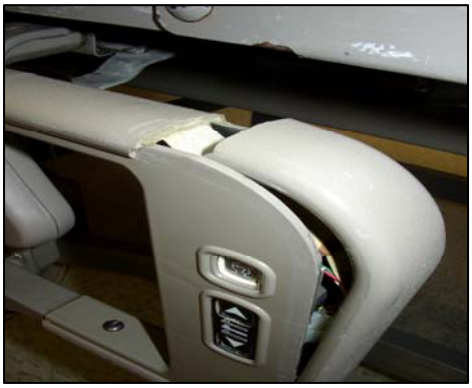
Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that supply stock levels are reduced to the 30-day goal and inventory levels in GIP match the actual quantities on hand.

The VISN and Medical Center Director agreed with the finding and recommendations. They plan to report all items in excess of a 30-day supply to the VISN 15 Logistics Supervisor and replace existing item barcode labels with usage levels printed on the labels to help track stock inventory and usage. Training was conducted focusing on managing a physical inventory and reinforcing specific accountability duties and expectations regarding the accuracy of perpetual inventories. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Conditions Needing Improvement. VHA policy requires that the medical center be safe, clean, sanitary, and maintained to optimize infection control and patient safety. We inspected four inpatient units, the Blood Drawing Laboratory, and the dialysis area. All of these areas required further management attention. While this is a repeat finding from our previous CAP review and follow-up reports, we noted significant environmental improvements in common public areas such as hallways and waiting areas near elevators and in patient care areas during this inspection. Continued management attention was needed for the following:

General Cleanliness and Maintenance. Inpatient rooms that were prepared for new patients required additional cleaning of window ledges, blinds, over-bed lights, air system vents, along baseboards, and in floor corners. Maintenance was needed to repair damaged walls, handles on patient lockers and bedside stands, and bed rails on some patient beds that were cracked or damaged.



Damaged bed rail with exposed wires

Definition of Cleaning Responsibility. Some items in patient care areas were not cleaned regularly because staff was uncertain which service (Nursing, Housekeeping, or SPD) was responsible. These items included bases of rolling patient care equipment such as intravenous pumps, blood pressure monitors, and tray tables. It also included surfaces of cardiac monitors and in kitchenettes on patient units. We observed new bar code medication administration carts on the units but found that staff

did not know who had responsibility for cleaning common surfaces such as horizontal work surfaces, bar code scanners, computers, and the bottom shelves on the carts.

Refrigerator Temperature Monitoring. Medication and nourishment refrigerator temperature monitoring was ineffective. These refrigerators required daily monitoring, and staff needed to initiate and document corrective actions if the temperatures were outside the acceptable ranges. We reviewed temperature logs for the month of July 2005 and found that:

- A nourishment refrigerator's log had no temperature recorded for 8 days.
- A medication refrigerator's temperatures were too cold on 28 days.
- A nourishment refrigerator's temperatures were outside the acceptable range on 18 days.
- A medication refrigerator's log had no temperature recorded for 5 days and the temperatures were outside the acceptable range on 11 days. We also noted that medications stored in this refrigerator in May 2005 had to be destroyed because the unit was too warm and had not been adequately repaired.

Security of Hazardous Products. Staff did not secure cleaning products at all times to prevent accidental or purposeful ingestion. A housekeeping cart with two unsecured cleaning products was unattended near the eighth floor elevators. A cleaning product was also found in a patient restroom.

Blood Drawing Laboratory. During the inspection of the Blood Drawing Laboratory, we noted the last inspection of the eyewash station was on July 15, 2004. Eyewash stations are required to be tested weekly. Dust accumulation on the eyewash station indicated that the unit had not been tested for some time. Two fans with dust buildup were also observed in the area. There was a damaged pad on the bed near the electrocardiogram room and a chair with a torn area on the backrest. Furniture with damaged surfaces created an infection control risk and should be repaired or removed from service. Additionally, we noted a lack of auditory privacy in the laboratory check-in area, as well as a lack of auditory and visual privacy for patients in the blood drawing area.

Dialysis Treatment Area. During the inspection of the dialysis area, we noted an unlocked door leading from the hallway into a storage room. An unauthorized person could enter the area and not be noticed by staff. A box cutter, which could be used as a weapon, was observed on a shelf. Supplies in the area were also vulnerable to tampering or diversion. In addition, supply carts in the hallway near the entrance to the dialysis treatment area obstructed traffic flow for patients and others.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) all patient care areas are safe, clean, sanitary, and maintained; (b) responsibility is defined for cleaning of items in the patient care areas and staff are trained on these requirements; (c) medication and nourishment refrigerator temperatures are monitored daily and employees document corrective actions taken to resolve problems when the temperatures are outside acceptable ranges; (d) all cleaning products are secured; (e) eyewash stations are tested weekly, fans in patient care areas are regularly cleaned, and furniture with compromised surfaces is repaired or removed from service; and (f) the dialysis storage area is secured and the area around the entrance to the dialysis treatment area is kept clear.

The VISN and Medical Center Director agreed with the finding and recommendations. A facility-wide plan was developed to ensure patient care areas are safe, clean, sanitary, and maintained, including clarification on the duties of cleaning laptop screens, rolling stock, horizontal surfaces, and fans. They plan to make refrigerator monitoring and the entrance to the dialysis area on-going compliance issues subject to environmental rounds and Tracer Team reviews. All cleaning products were secured, and housekeepers instructed to keep these products under direction supervision or in locked storage. The eyewash station was addressed immediately, and a new eyewash station policy was implemented in August 2005. They plan to replace damaged furniture, as funding is available. Dialysis staff was reminded to keep the entrance to the dialysis treatment area clear. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Contingency Plan Should Comply with Guidelines

Conditions Needing Improvement. The IT Local Area Network (LAN) contingency plan did not adequately ensure continuity of business operations. We reviewed the medical center's IT security to determine if controls were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Medical center staff provided annual security awareness training, established adequate system environmental and access controls, and backed up critical information regularly. However, the following areas required management attention.

The LAN contingency plan did not meet National Institute of Standards in Technology guidelines, which require that contingency planning coordinators identify an alternate facility to perform system operations in case of major disruption and test the contingency plan annually. The contingency plan did not identify an alternate processing location, and the plan had not been tested since December 13, 2003. We also determined that the IT inventory database did not include new equipment not yet placed into service. An accurate IT inventory is required in order to assess the extent of damage in the event of major service disruptions.

Recommendation 4. We recommended that the VISN Director ensure the Medical Center Director requires that: (a) an alternative processing facility is documented in the contingency plan, (b) the contingency plan be tested annually, and (c) the IT inventory listing be updated as new equipment arrives.

The VISN and Medical Center Directors agreed with the finding and recommendations. They tested the LAN contingency plan, recorded the IT inventory database, and plan to revise the LAN contingency plan to ensure continuity of business operations with VISN 15's Eastern Orbit and the St. Louis VA Medical Center as the back up and alternate processing sites. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Colorectal Cancer Management – Timeliness of GI Evaluation, Patient Diagnosis Notification, and Tumor Registry Needed Improvement

Conditions Needing Improvement. The medical center provided effective colorectal cancer (CRC) screening and developed coordinated interdisciplinary treatment plans. However, 4 of 10 medical records we reviewed showed delays of at least 2 months in completing GI evaluations after the initial dates of referral. Providers needed to improve documentation in the medical records of informing patients of their diagnoses. Also, medical center staff did not enter data into the tumor registry promptly.

Timeliness of GI Evaluations. Screening, timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items—including timeliness of evaluations by specialists (such as GI, Surgery, and Oncology) after the initial referral dates—in a random sample of 10 patients who were diagnosed with CRC during FY 2004. All 10 patients received appropriate CRC screening. Providers referred 8 of the 10 patients to GI Service, but 4 (50 percent) of the 8 were not evaluated by specialists within 2 months of the initial referral requests.

Medical center staff planned to address delays in evaluating patients by prioritizing referrals and hiring a registered nurse to assist in coordinating GI cases. The GI Service was also testing a template for use in the electronic medical record that will identify patients who are at high risk for CRC. VHA standards for FY 2006 will require that patients be seen within 30 days of referral to a specialty clinic.

Patient Diagnosis Notification. In 2 (20 percent) of the 10 cases reviewed, we were unable to find documentation in the electronic medical records that the patients were notified of their CRC diagnoses. All 10 patients were either scheduled for surgery, oncology interventions, and/or follow-up appointments with GI Service within acceptable timeframes after their CRC was confirmed.

Tumor Registry. The medical center had established a Tumor Registry Program. Data entry into the tumor registry database was backlogged 6 months due to staffing issues. The Commission on Cancer standards requires that for each year between its surveys of a facility's Tumor Registry Program, staff should enter 90 percent of cancer cases into the registry database within 6 months of the dates of first contact. Prompt entry into the tumor registry database is essential for accurate data collection, evaluation, and reporting of outcomes. At the time of our review, the medical center had resolved the staffing issues and was making efforts to eliminate the backlog of cases.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure: (a) timely GI evaluations, (b) medical record documentation reflects the patients' timely notifications of diagnoses, and (c) prompt data entries into the tumor registry.

The VISN and Medical Center Directors agreed with the finding and recommendations. They were in the process of hiring a registered nurse to coordinate GI cases, creating the template for identifying high-risk patients, and using additional staff to update the tumor registry. They had been monitoring medical records to see that patients were notified of diagnoses, and stated that in cases where documentation may not have said "told of diagnosis," there was evidence in the medical records that the patients had been informed as treatments were initiated. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Controls Over Prescription Drugs – Security and Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. VHA and Drug Enforcement Administration 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: controlled and noncontrolled substances. Controlled substances are subdivided into five "schedules." Schedule I[1] and Schedule II substances require the most stringent controls. Noncontrolled substances are drugs that are not included in the five "schedules"; however, they do include High Alert Medications.[2] The VA National Council for Patient Safety has established guidelines for controls and security of these medications. In the operating room (OR) area, there were controlled substances that were not double locked, and High Alert Medications that were not secured. The High Alert Medications that were not secured in the OR were neuromuscular-blocking agents. Specifically, these drugs have the potential to cause harm and possibly death due to their paralyzing action, which impedes all skeletal muscle movement and will cause a cessation of breathing. In

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

[2] High Alert Medications (also known as high risk or high hazard) present a substantial risk of causing injury if abused.

addition, the Post Anesthesia Care Unit (PACU) inventory discrepancy reports located in the medication area were maintained in a haphazard manner.

Security. We inspected three OR suites and found the following:

- An unlocked OR suite with an unlocked anesthesia cart containing Schedule II substances. The key to lock the cart was hanging from the lock. An employee who was responsible for cleaning the OR, but was not responsible for controlled substances, was in the suite.
- An unlocked, unoccupied OR suite with an unlocked, empty anesthesia cart with drawers left open. The medication cart that belonged in the suite had been moved into the hallway. This cart was unlocked and contained neuromuscular-blocking agents for use during surgery. OR staff reported that the lock on this cart was malfunctioning, but they had not submitted a work order for repair.
- An unlocked, unoccupied OR suite with a locked anesthesia cart and an unlocked medication cart, which had neuromuscular-blocking agents in the drawer and filled and labeled syringes lying on top of the cart.
- A locked medication room with an unlocked cart containing neuromuscular-blocking agents. Staff reported that the lock on this cart was malfunctioning also, but they had not submitted a work order for repair.

To eliminate the possibility for tampering with or diversion of controlled substances and High Alert Medications, OR suites should remain locked when not in use and anesthesia and medication carts should have working locks and remain locked, with the keys stored separately, or in the possession of the responsible staff. Medical center management took immediate action to secure the OR area while we were onsite.

Inventory Controls. In the PACU, there was a computerized controlled substances inventory system (PYXIS®) in use. To verify the inventory amounts, PACU staff obtained electronic discrepancy reports from PYXIS®. The reports consisted of slips of paper that were stapled to stenography pad sheets. Two PACU staff members reviewed and signed the sheets. The sheets were maintained in a haphazard manner that made it difficult to authenticate the inventories and determine if there were any irregularities.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) all medications in the OR suites be secured appropriately according to policies and (b) controlled substances inventory documentation is well organized.

The VISN and Medical Center Directors agreed with the finding and recommendations. They met with all OR staff to inform them to monitor medication carts, lock the medication rooms and anesthesia medication carts when not in use, and called Facility Service to fix or replace the double lock drawers and account for all keys for the

anesthesia medication carts. Pharmacy Service included six new anesthesia PYXIS® carts in their FY 2006 budget. They also placed a notebook with the PYXIS® machines to keep inventory sheets with the signatures of nurses who conducted the inventories. Oversight of these processes will be conducted through regular pharmacy rounds and Tracer Team reviews as well as attention to this by the service chief and nurse co-leader. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Medical Record Privacy – Sensitive Patient Information Should Be Protected

Condition Needing Improvement. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that sensitive patient information be protected at all times. On August 3, 2005, we were leaving the medical center and noticed two open doors leading to the staff work area in the Silver Clinic on the first floor. There were a number of unsecured medical records in the room, but no staff member was present for approximately 10 minutes, leaving the medical records vulnerable to unauthorized access.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that sensitive patient information be protected at all times, in accordance with HIPAA regulations.

The VISN and Medical Center Directors agreed with the finding and recommendation, and noted that the medical records were no longer brought to the Silver Clinic. The improvement action taken is acceptable, and we will follow up on the planned actions until they are completed.

Employee Background Investigations and Security Clearances – Documentation Of Requests Needed To Be Improved

Condition Needing Improvement. VA policy requires that Human Resources Management Service (HRMS) staff request that the Office of Personnel Management or VA Security Service conduct appropriate background investigations for security clearances within 14 workdays of new employee appointments. We reviewed a sample of 12 Official Personnel Files of clinical and administrative employees to determine if timely and appropriate background investigations were completed. Eight files contained completed investigations and three files had investigation requests pending results. One file had no documentation that a required higher-level background investigation had ever been requested.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that HRMS document all background investigation requests in Official Personnel Files for all newly hired employees as required by VA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. The VISN HRMS required that all facilities establish and maintain a log to track background investigations and that all facilities submit documentation verifying that background investigations have been requested on all new hires to the Network Business Office (NBO). The medical center now forwards copies of all documentation pertaining to the initiation and completion of background investigations to the NBO for inclusion in the Official Personnel Folder. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 9, 2005

From: Network Director, VA Heartland Network, VISN 15 (10N15)

Subject: **CAP Review of the VA Medical Center Kansas City, Missouri**

To: Assistant Inspector General for Audit

1. In response to the Draft Report of the Combined Assessment Program review of the Kansas City MO VA Medical Center, attached please find comments, corrective action plans, and completion dates for each recommendation as provided by the Medical Center Director.

2. I have reviewed the document and concur with it.

Peter L. Almenoff, M.D., FCCP

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 6, 2005

From: Medical Center Director, VA Medical Center Kansas City, Missouri (589/00)

Subject: **CAP Review of the VA Medical Center Kansas City, Missouri**

To: Attached is the medical center's response and recommended actions to the opportunities for improvement identified in the review conducted by the Office of Inspector General (OIG), August 1-5, 2005.

Kent D. Hill

Attachment

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

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

OIG Recommendation(s)

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director takes action to: (a) expedite billing on the backlogged claims; (b) identify all potentially billable episodes of care; (c) provide training to billers and coders on recording accurate provider numbers, revenue codes, and assigning reasons not billable to maximize revenues; and (d) train medical care providers regarding medical record documentation.

Concur **Target Completion Date:** August 2005

(a) We had already established an agreement with other Western Orbit facilities to assist us in eliminating coding and billing backlog prior to the OIG Audit. This is ongoing.

(b) We were actively pursuing all known potential billables. Previously we had requested a site visit from another VISN to review our systems, etc. This was completed and we had moved quickly to address any areas to improve.

(c) We had already identified these training opportunities prior to the OIG Audit and instruction was given to both coding and billing staff. We identified that the reasons not billable was too generic, and we had provided instruction to both coding and billing as to what constitutes reason not billable.

(d) Train medical care providers: We have been meeting with providers to review coding issues and reports are submitted to Compliance; this process remains in place and it was in place prior to the OIG Audit. Medical record documentation and coding has been an area of emphasis along with appropriate resident supervision guidelines for billing. Auditing, education and training is being conducted on an on-going basis.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director ensures that supply stock levels are reduced to the 30-day goal and inventory levels in GIP match the actual quantities on hand.

Concur **Target Completion Date:** December 2005

(a) Each Inventory Management Specialist is justifying all items in excess of a 30-day supply on a monthly basis until reduced. This is reported to the VISN 15 Logistics Supervisor.

(b) Supply Technicians are replacing existing item barcode labels with usage levels printed on the labels. This action will assist in reducing overstocking in secondary inventory points as Supply Technicians are required to rely on established levels and information obtained from their barcode scanning activities rather than visual replenishment of stock. The KC VAMC Logistics Supervisor is monitoring this action.

(c) The VISN 15 Logistics Supervisor conducted refresher Inventory Management Training on October 12 and 13 for KC VAMC Logistics Inventory Management Specialists. This training focused on managing a physical inventory.

(d) The KC VAMC Logistics Supervisor reviewed position descriptions of Inventory Management Specialists and reinforced specific duties. He will continue to reinforce accountability and expectations regarding the accuracy of perpetual inventories for all Logistics employees. Failure to comply in these areas will lead to corrective action.

(e) An accountability system to record the line items removed from inventory by the Nursing Supervisor will be implemented by December 15, 2005.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) all patient care areas are safe, clean, sanitary, and maintained; (b) responsibility is defined for cleaning of items in the patient care areas and staff are trained on these requirements; (c) medication and nourishment refrigerator temperatures are monitored daily and employees document corrective actions taken to resolve problems when the temperatures are outside acceptable ranges; (d) all cleaning products are secured; (e) eyewash stations are tested weekly, fans in patient care areas are regularly cleaned, and furniture with compromised surfaces is repaired or removed from service; and (f) the dialysis storage area is secured and the area around the entrance to the dialysis treatment area is kept clear.

Concur **Target Completion Date:** September 2005

(a) Significant overall improvements have been made and we have a facility-wide Plan to assure patient care areas are safe, clean, sanitary, and maintained.

(b) The only area that required clarification was cleaning of laptop screens which has been corrected. All nursing wards have an assigned night shift staff member who is responsible for cleaning rolling stock and cleaning horizontal surfaces.

(c) Ensuring compliance with refrigerator monitoring is an on-going compliance issue. Areas with noncompliant temperature logs have received memos advising staff to ensure temperature logs are up-to-date. Additionally, to assure compliance, review of these logs is conducted with environmental rounds and with Tracer Team reviews. This was also a high priority for us during the past year as we prepared for compliance with JCAHO. We received no recommendations in this area from the JCAHO survey team in October 2005. To further refine this process, the refrigerator temperature log has been revised to include an "action taken" column.

(d) Ensuring all cleaning products are secured is ongoing. Housekeepers are instructed to "lock/secure" cleaning products if they are not under direction supervision. This requirement has been re-emphasized. Again, review of this

procedure is conducted with environmental rounds and Tracer Team reviews which are held monthly.

(e) The testing of the Eyewash station was addressed immediately. The Annual Workplace Evaluation cited the facility's eyewash policy in May. A policy was drafted in June and was in the concurrence process during the CAP review in August. Compliance with the new eyewash policy has been selected as a performance standard for FY 06 and the practice will be aggressively addressed. This was being addressed prior to the OIG CAP visit. Fans: Fans are included in the rolling stock cleaning procedures and this particular area was addressed at the time of the visit. Furniture: Furniture identified as needing replacement has been prioritized and replacement will occur as funding is available. Again, these issues were being addressed prior to the OIG CAP visit.

(f) Dialysis Storage Area: Although the National Fire Protection Association does not require a lock, a combination lock has been installed. Staff are reminded and expected to keep the entrance to the dialysis treatment area clear. Again, this will continue to be a part of the environmental rounds and Tracer Team reviews.

Recommendation 4. We recommended that the VISN Director ensure the Medical Center Director ensures that: (a) an alternative processing facility is documented in the contingency plan, (b) the contingency plan be tested annually, and (c) the IT inventory listing be updated as new equipment arrives.

Concur **Target Completion Date:** November 2005

(a) The Contingency plan is in the revision process and will ensure continuity of business operations with the Eastern Orbit as our back up site. The LAN contingency plan will be updated to reflect St. Louis as the alternate processing site.

(b) The LAN contingency plan has been tested and the write-up of the LAN contingency test is in process.

(c) The IT inventory data base was burned to a CD and sent to the alternate STORAGE site (VISN OFFICE) to be stored with the contingency plan.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure: (a) timely GI evaluations, (b) that medical record documentation reflects the patients' timely notifications of diagnoses, and (c) timely data entries into the tumor registry.

Concur **Target Completion Date:** April 2006

(a) This issue had been identified prior to the OIG visit and we had a plan in process, which is noted in the report. The RN position was posted and interviews are in process. The template has been through review by key staff and made available for use in the pilot phase, and now refinements are being made. We anticipate being in compliance with the VHA Directive timeliness goals for FY06 outlined in (2001-006 2/7/01).

(b) Notification of diagnoses so documented in the medical record: this is an area we have addressed by monitoring activities over the past two years with significant improvement such that we limited our monitoring to semi-annual. While the documentation may not have said "told of diagnosis," there was evidence in the medical record that the patient had been informed as there was treatment initiated.

(c) Tumor Registry: As you know, we had identified previous to the OIG CAP visit problems with abstracting of cases timely. Aggressive efforts were underway to resolve this issue. At this time, the Tumor Registry is approximately 5 months behind, with 1.5 FTE currently working to resolve this issue. Anticipated date of currency by March/April 2006.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) all medications in the OR are secured appropriately according to policies and (b) controlled substances inventory documentation is well organized.

Concur **Target Completion Date:** August 2005

(a) Interventions were taken immediately: A staff meeting with all OR staff was conducted that evening and the OIG's findings were discussed. Facility Service was called immediately, locks on all carts were fixed, and all keys for anesthesia medication carts were accounted for that evening. Double lock drawers were ordered and mounted to anesthesia medication cart within 72 hrs of incident. During the transition of waiting for the new double lock cart, RN staff was instructed to monitor medication carts when anesthesia left the room and to lock the rooms when not in use. Chief, Anesthesia has also instructed anesthesia personnel when storing their carts for the day they must double check to make sure they are locked. Pharmacy has included six anesthesia PYXIS® carts in their FY06 budget.

(b) PACU: A notebook placed (with PYXIS® machine) for keeping all weekly inventory sheets with specific inventory day and with nurses signatures of who conducted the inventory. Controls of prescription drugs have been an area of focus in the past year. Pharmacy has worked with the OR on a regular basis to work out procedures to improve our processes. Our recent JCAHO survey of October 2004 found our facility in compliance. Oversight of these processes will be conducted through regular Pharmacy rounds and Tracer Team reviews as well as attention to this by the Service Chief and Nurse Co-Leader.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that sensitive patient information be protected at all times, in accordance with HIPAA regulations.

Concur **Target Completion Date:** August 2005

Issue is resolved as medical records are no longer being brought to the Silver clinic. The area in question is locked also when the clerk leaves at 4:30 p.m.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that appropriate background investigations are requested and completed on all newly hired employees as required by VA policy.

Concur **Target Completion Date:** August 2005

To ensure that we are in compliance with the VA's policy on background investigations the VISN HRMS has required that all facilities establish and maintain a log to track background investigations and that all facilities submit documentation verifying that background investigations have been requested on all new hires to the Network Business Office (NBO).

The log to track background investigations has been established since 2001, with minor modifications being made from time to time. Since August 2005, this facility has been forwarding copies of all documentation pertaining to the initiation and completion of background investigations to the NBO for inclusion in the Official Personnel Folder.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Improve MCCF collections.	$ 946,774
2	Reduce supply inventories to 30-day levels.	70,581
	Total	$1,017,355

OIG Contact and Staff Acknowledgments

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Acknowledgments	Verena Briley-Hudson Dennis Capps Paula Chapman Joseph Duffey David Griffith Wachita Haywood Henry Mendala Jennifer Reed Leslie Rogers Lynn Scheffner Scott Severns Raymond Tuenge Oscar Williams

Appendix E

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