Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Lebanon, Pennsylvania

Report No. 05-02502-99 **March 7, 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 September 12-16, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Lebanon, Pennsylvania, which is part of the Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected health care system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided fraud and integrity awareness training to 102 medical center employees.

Results of Review

The CAP review covered 13 operational activities. The health care system complied with selected standards in the following five activities:

- Colorectal Cancer Management
- Environment of Care
- Government Purchase Card Program
- Laboratory and Radiology Service
- Pharmacy Security

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

- Improve supply inventories controls.
- Enhance Medical Care Collections Fund (MCCF) billings and collections.
- Cancel unneeded obligations.
- Strengthen contract award and administration process.
- Improve information technology (IT) security.
- Strengthen accountability controls over controlled substances.
- Ensure patient notification of rights in adverse events and strengthen quality management of peer review.
- Develop documentation of interdisciplinary treatment plans for Colorectal Cancer patients.

VISN and Health Care System Director Comments

The VISN and Medical Center Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15-25, for the full text of the Directors' comments.) We will follow up on the

planned actions until they are completed. This report was prepared under direction of Mr. Nelson Miranda, Director, and Mr. Randall Snow, Associate Director, Washington, DC, Regional Office of Healthcare Inspections.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Facility Profile

Organization. Located in Lebanon, PA, the Lebanon VA Medical Center is a primary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based clinics located in York, Camp Hill, Pottsville, Reading, and Lancaster, PA. The medical center is part of VISN 4 and serves a veteran population of about 37,922 in a primary service area that includes 13 counties in Pennsylvania.

Programs. The medical center provides medical, surgical, mental health, geriatric, medical and surgical specialty care, substance abuse treatment, vocational rehabilitation, vision impaired services, hospice care, and primary care services. The medical center has 49 hospital beds and 101 nursing home beds and operates several regional referral and treatment programs, including Home Based Primary Care, Home Oxygen Treatment, Rehabilitation Services, Care Coordination Home Tele-Health, Respite Care, Contract Community Nursing Home Care, Community Residential Care Program, Homemaker/Home Health Aide Services, Community Adult Day Health Care Services, Purchased Skilled Home Care, Mental Health Intensive Case Management, and the Homeless Program.

Affiliations and Research. The medical center is affiliated with the Pennsylvania State University of Medicine/Hershey Medical Center, and supports 75 medical students and 27 medical resident positions in Anesthesiology, Cardiovascular Disease, Dermatology, Diagnostic Radiology, General Internal Medicine, General Surgery, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Psychiatry, Family Practice, and Urology and 237 students in 54 separate schools from allied health sciences programs. In Fiscal Year (FY) 2005, the medical center research program had seven projects and a budget of $198,757. Important areas of research include leukemia, prostate cancer, and end of life care.

Resources. In FY 2004, medical care expenditures totaled $129,544,000. The FY 2005 medical care budget is $128,986,000, (.004) percent less than FY 2004 expenditures. FY 2005 staffing was 1066 full-time equivalent employees (FTE), including 44 physician and 332 nurses.

Workload. In FY 2004, the medical center treated 37,292 unique patients, a 9.1 percent increase from FY 2003. The inpatient care workload totaled 2,197 discharges, and the average daily census, including nursing home patients, was 168.4. The outpatient workload was 269,659 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, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered healthcare system operations for FY 2004 and FY 2005 through June 30, 2005, and was done in accordance with OIG standard operating procedures for CAP Reviews.

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 13 activities:

All Employee Survey
Colorectal Cancer Management
Contract Award and Administration
Controlled Substances Accountability
Environment of Care
Government Purchase Card Program
Information Technology Security
Laboratory and Radiology Services
Medical Care Collections Fund
Pharmacy Security
QM Program
Supply Inventories Management
Unliquidated Obligations

As part of the review, we also interviewed 30 patients to survey their satisfaction with the quality of care. We discussed the interview results with medical center managers.

During this review we presented four fraud and integrity awareness briefings to 102 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Follow-Up on Prior CAP Review Recommendations

As part of this review, we also followed up on selected recommendations from our prior CAP review of the healthcare system (*Combined Assessment Program Review of the Lebanon VA Medical Center, Lebanon, Pennsylvania*, Report No. 03-02577-62, January 12, 2004). Systems managers adequately addressed most of the recommendations made in the prior CAP report; however, improvements were still needed to ensure controls to prevent physicians from engaging in conflict of interest situations, strengthen controls over prescription drugs, and correct information technology security deficiencies.

Results of Review

Organizational Strengths

VHA administers an All Employee Survey (AES) every three years to assess employee and organizational satisfaction. Each VISN is required to analyze the employee survey results and develop an action plan to identify needed improvements, actions for improvement, and establish achievement milestones.

The medical center AES average scores were consistently higher than all other VA medical centers. Utilizing a standard statistical analysis, the medical center scores were significantly higher than all medical centers nationwide in 13 of 34 categories; and in 3 of 34 categories the survey scores were the highest in their VISN. The medical center did not have any statistically significant scores lower than any other medical center. The medical center's AES participation rate was 84 percent, compared to 52 percent nationally.

With this information, the medical center chartered employee teams at the service line and unit level to analyze scores and develop action plans for areas identified as needing improvement. For example, the food service line developed and implemented achievable action plans that recognized the need for supervisory development and the involvement of rank and file employees in decisions that affected working conditions and processes. An assessment of employee satisfaction with work environment, communication, mission, and team diversity prior to supervisor development training showed 38 percent satisfaction rate, compared to a 76 percent satisfaction rate after the training. Turnover in food service entry level positions dropped from 21 percent to 15 percent after implementation of the food service action plan.

Veterans voiced high satisfaction with the food service line, validating the effectiveness of actions taken by the medical center in response to the AES.

Opportunities for Improvement

Supply Inventories Management – Inventory Controls Needed Improvement

Condition Needing Improvement. Inventory management staff needed to reduce excess supply inventories and improve the accuracy of Generic Inventory Package (GIP) data. VHA policy established a 30-day stock level goal, and VHA mandated that facilities use GIP to manage inventories. GIP assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand.

As of September 2005, inventory in 5 sampled supply primary control points consisted of 4,039 line items valued at $421,653. To test the reasonableness of inventory levels, we reviewed a judgment sample of 50 items valued at $28,503. For 37 of the 50 items, the stock on hand exceeded 30 days of supply, with inventory levels ranging from 35 days to 6,375 days of supply. For these 37 items, the value of stock exceeding 30 days was $16,808, or 59 percent of the total value of the 50 sampled items. Applying the 59 percent sample result to the total sampled inventories of $421,653, we estimated that the value of excess stock was $248,775.

For the 50 items inventoried, the physical count for 28 items did not match the count in the GIP. The count for 16 items valued at $7,361 was less than the count shown in the GIP, and the count for 12 items valued at $2,039 was greater than the count shown in the GIP. According to inventory management staff, these inaccuracies occurred because not all supply issues and inventory adjustments were being entered in the GIP.

Our prior CAP report in 2004 recommended that facility staff conduct a physical count of engineering supplies to obtain an accurate count of all items and include these items in the GIP system. Staff responsible for engineering primary supply areas had included all items in the GIP system.

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director requires that inventory management staff (a) reduce supply stock levels to the 30-day goal and (b) improve the accuracy of GIP data.

The VISN and Medical Center Directors agreed with the finding and recommendations, and noted that Fund Control Point (FCP) managers offer no longer needed items to other VAMCs, immediately will process all issues after the item is given to the customer, and conduct semi-annual inventories. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries

Condition Needing Improvement. Medical Care Collections Fund (MCCF) managers needed to improve procedures for recovering health care costs by billing fee-basis care and improving medical record documentation. The medical center met its FY 2004 MCCF collection goal of $11.4 million by more than $400,000 and should meet its FY 2005 goal of $13.4 million. We estimate additional collections of $40,833 could have been achieved as discussed below.

Fee-Basis Care. For the 3-month period ending December 31, 2004, the medical center paid 3,379 fee-basis claims totaling $285,951 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 22 claims to determine if the medical center billed the fee-basis care to patients' insurance carriers and found that MCCF staff billed 1 of the 22 claims. Nineteen of the remaining 21 claims were not billable because the fee-basis care was for service-connected conditions or the services provided were not covered. The other two claims were billable. MCCF staffed initiated bills for $21,602 while we were onsite. Beginning in September 2005, MCCF staff implemented new local procedures to identify potentially billable fee-basis care.

Reasons Not Billable Codes. The "Reasons Not Billable Report" for the 3-month period ending December 31, 2004, listed 818 cases (816 outpatient and 2 inpatient) totaling $151,739 that were unbilled for 1 of 3 reasons—insufficient documentation, no documentation, or care provided by a non-billable provider (resident). We reviewed 50 of the 818 cases and found in 7 cases that MCCF staff had properly billed before we began our review; 8 cases were not billable because the care was for service-connected conditions or the services provided were not covered. The remaining 35 cases were billable as discussed below.

- For 16 cases (15 outpatient and 1 inpatient), providers did not document the veterans' diagnoses or requests for laboratory services needed for the veterans' return visits. MCCF staff needed this documentation to determine the proper codes for billing.
- For 14 outpatient cases, attending physicians did not document resident supervision.
- For five outpatient cases, providers did not document the episode of care in the medical records. We found sufficient documentation in the medical records to bill two of these cases. MCCF staff reported that the providers entered the documentation late. The remaining three cases had no documentation of the clinical care provided in the medical records at the time of our review.

These documentation issues had been continually discussed in the compliance committee meetings. In March 2005, the VISN provided training on documentation of clinical services to providers. Also, MCCF staff had done follow-up one-on-one training for providers with habitual documentation difficulties and noted gradual improvement in the past few months. MCCF coders should continue this emphasis on appropriate medical documentation.

The sample review of 50 cases included 49 outpatient episodes and 1 inpatient episode of care. Applying the 69 percent (34/49) sample error rate for the outpatient cases to the universe of 816 outpatient cases, we estimated that 563 billing opportunities were missed. Based on information provided by MCCF staff, we calculated the average missed billing opportunity to be $176. We then estimated that missed billing opportunities for outpatient care totaled $99,088 (563 x $176). The one inpatient episode totaled $11, 030. Thus, the missed billing opportunities for both outpatient and inpatient cases totaled $110,118 ($99,088 + $11,030).

MCCF staff initiated bills for 14 of these cases while we were onsite. The remaining 21 cases were not billable because sufficient documentation could not be obtained or insurance filing deadlines had expired.

Potential Collections. MCCF staff can enhance revenue collections by billing fee-basis care and ensuring physicians adequately document clinical care provided and resident supervision. Based on the medical center's historical collection rate of 31 percent, MCCF staff could have increased collections by $40,833 (31 percent x ($21,602 + ($110,118)).

Recommendation 2. We recommended that the VISN Director ensure the Medical Center Director takes action to (a) identify and bill all potentially billable episodes of care and (b) continue training medical care providers regarding proper medical record and resident supervision documentation.

The VISN and Medical Center Directors agreed with the finding and recommendations, and will ensure that all fee basis care and third party claims are billed to insurance companies for possible collection. They will also ensure that MCCF performs one-on-one training with providers following monthly audits and perform periodic random audits to ensure continued compliance. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

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Unliquidated Obligations – Undelivered Orders Should Be Thoroughly Reviewed

Condition Needing Improvement. We identified two undelivered orders, valued at $6,988, that were no longer needed and should have been cancelled. VA policy requires Fiscal Service staff to analyze undelivered orders each month to identify outstanding obligations and to contact the requesting services to determine whether the obligations are still needed. If an obligation is not needed, Fiscal Service staff should cancel it and reprogram the funds.

As of August 13, 2005, the medical center had 604 undelivered orders totaling $8,951,902 million. Of these, 89 orders totaling $659,147 were delinquent (over 90 days). We reviewed a sample of 20 and found that, while Fiscal Service staff performed the required analyses and follow-up with the requesting services as to continued needs, the 2 undelivered orders were inadvertently overlooked and should have been cancelled.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director emphasizes the need to thoroughly review outstanding obligations and cancel obligations that are no longer needed.

The VISN and Medical Center Directors agreed with the finding and recommendation, and took action to ensure that Fiscal Service performs monthly reviews of all undelivered orders, verifies the accuracy of month-end reports, and incorporates these reviews as a performance measure of the Fiscal Service staff in annual performance plans. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Contract Award and Administration – Contracting Process Needed Strengthening

Condition Needing Improvement. Medical center management could improve contract award and administration in the six areas discussed below. We reviewed contract award and administration for six current contracts with an estimated total value of $16.6 million.

Pre-Award Audit of Sole Source Contracts. The medical center had awarded six sole source contracts with an estimated total value of $3.2 million. VHA policy requires that all sole source contracts valued at $500,000 or more be sent to the VA OIG Contract Review and Evaluation Division staff for pre-award audits. The primary purpose of the audits is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. One contract (Radiology Services) awarded April 1, 2004, with an estimated total value of $2.5 million, met the dollar threshold but was not submitted for a pre-award audit as required by VHA.

Legal and Technical Reviews. VA policy requires that competed contracts with an estimated value of $1.5 million or more have legal and technical reviews. The home oxygen contract was not submitted for legal and technical reviews, although it was competed and the total estimated value, including four option years, was $12 million.

Delegation of Contracting Officer's Technical Representative (COTR) Duties. VA policy prohibits COTRs from delegating authority granted by a contracting officer. The COTR assigned to monitor the Radiology Services contract (estimated value of $2.5 million) delegated his responsibility to review monthly invoices and resolve discrepancies, if any, to the radiology secretary and his responsibility to certify invoices for payment to the radiology manager.

Contract Monitoring. For each contract, the contracting officer designates a COTR who is responsible for monitoring the vendor's performance and ensuring that services are provided in accordance with the contract. This responsibility includes reviewing vendor invoices and certifying that the charges accurately reflect the work completed. The vendor for the After-Hours Pharmacy Services contract (estimated value of $521,500) provided a monthly invoice that showed the total number of prescription orders they were billing for, along with daily numbers of orders that supported the monthly total. Although the COTR totaled the daily numbers and compared the result to the monthly total, he did not verify the billed totals to an independent VA source. As a result, the COTR did not ensure the billings were accurate prior to payment.

Contract Documentation. The Federal Acquisition Regulation (FAR) requires that contract files contain sufficient documentation to constitute a complete history of contractual actions. A Price Negotiation Memorandum used to describe important elements of the contract negotiation process, including an explanation of how the prices were determined to be reasonable, was not prepared for the After-Hours Pharmacy Services contract (estimated value of $521,500). A similar issue was also reported in the prior CAP report.

Conflict of Interest Documentation. VA policy requires that all physicians, allied health supervisors, or managers have a signed Acknowledgment Form in their personnel folders. The signed form shows that a physician, allied health supervisor, or manager has received, read, and agrees to abide by guidance for avoiding conflict of interest problems associated with Scarce Medical Specialist Service contracts. Our review of the personnel folders of a sample of 11 physicians, allied health supervisors, or managers found that 5 individuals did not have the required Acknowledgment Form.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) all sole source contracts valued at $500,000 or more be submitted to the VA OIG for pre-award audits; (b) all contracts that require legal and technical reviews are submitted; (c) COTRs do not delegate responsibilities granted by the contracting officer; (d) a process is established to ensure the monthly invoices for the

After-Hours Pharmacy Service contract are accurate prior to payment; (e) the contracting process is adequately documented as required by the FAR; and (f) all personnel folders of physicians, allied health supervisors, or managers contain a signed Acknowledgment Form.

The VISN and Medical Center Directors agreed with the finding and recommendations and noted that all sole source affiliate contracts, valued at $500,000 or more, will be sent to the VA OIG Contract Review and Evaluation Division staff for pre-award audits and that contracting staff will determine if solicitations require legal/technical reviews before issuing the contract. All COTRs received training on delegation of duties and verifying invoices. Contracting Office employees will ensure that all information listed on the contract checklist is included in the contract folder before awarding the contract. Acknowledgment Forms were obtained for all physicians, allied health supervisors, and managers as needed. The improvement actions taken are acceptable, and we will follow up with the planned actions until they are completed.

Information Technology Security – Improvements Were Needed To Comply with Guidelines and VA Policy

Condition Needing Improvement. The Information Security Officer and Information Resource Management Service management needed to improve some aspects of IT security. We found adequate segregation of duties, risk assessments, virus protection, computer room security, and critical data backups. However, we identified two areas that required management attention.

Contingency Plan Documentation. The consolidated contingency plan did not include all information outlined in the National Institute of Standards and Technology (NIST) guidelines. Contingency planning refers to interim measures to recover IT services following an emergency or system disruption. The consolidated plan did not include equipment and system requirements, including lists of servers, personal computers, printers, and software required to support system operations. The lists should include details including model or version number, specifications, and quantity.

Security Plan Documentation. The Local Area Network/Work Area Network security plan did not include all information outlined in the NIST guidelines. Security planning provides an overview of the security requirements of the system and describes the controls in place or planned for meeting those requirements. Our review of the operational control portion of the plan found that four (Personnel Security, Physical and Environmental Protection, Integrity Controls, and Incident Response Capability) of the nine operational controls were not addressed in the plan. Operational controls address security mechanisms that focus on methods that primarily are implemented and executed by individuals.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) the consolidated contingency plan contains information necessary to comply with NIST guidelines and (b) the security plan contains all security requirements of the system.

The VISN and Medical Center Directors agreed with the finding and recommendations, and noted that the Information Security Officer and the Chief Technical Officer will establish a team of subject matter experts, who will schedule weekly meetings to incorporate the current consolidated contingency plan into the VHA Facility Contingency Plan template. They also completed a Security Plan that contained all security requirements of the system. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Controls Over Prescription Drugs – Controls Should Be Strengthened

Condition Needing Improvement. VA policy requires Pharmacy Service staff to have effective controls to safeguard and account for prescription drugs, to maintain accountability over all pharmaceuticals, and to comply with DEA regulations for controlled substances. Our review identified three concerns.

Annual Wall-to-Wall Physical Inventories. The VHA Inventory Management Handbook requires annual wall-to-wall physical inventories of pharmaceuticals in order to maintain accuracy. These inventories were not conducted prior to April 2005. The Pharmacy Service Chief stated that he conducted them in April 2005, when he determined that annual wall-to-wall inventories of pharmaceuticals were required. Until then, he was unaware that the inventories were required.

Segregation of Duties. One Pharmacy Service employee had the responsibility of both ordering and receiving non-controlled pharmaceuticals from the prime vendor. As a result, there was no control to prevent the employee from destroying the invoices and diverting pharmaceuticals without recording them into pharmacy inventory records. Proper segregation of duties for the ordering and receiving of all pharmaceuticals should be implemented.

Reorder Points and Minimum Inventory Stock Levels. Although Pharmacy Service staff was ordering pharmaceuticals using the prime vendor inventory management system, Pharmacy Service management had not implemented the inventory management segment of the system to establish reorder points to maintain minimum inventory stock levels. The Pharmacy Service Chief stated that the prime vendor was to provide reorder points, but had not yet done so. As a result, the Chief said he would determine the reorder points himself and input them on the shelf labels.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) Pharmacy Service staff perform annual wall-to-wall

physical inventories of pharmaceuticals, (b) the responsibilities for ordering and receiving all pharmaceuticals are properly segregated, and (c) Pharmacy Service staff establish reorder points for the pharmaceutical inventories and input this information on the shelf labels.

The VISN and Medical Center Directors agreed with the finding and recommendation, and noted that Pharmacy Service staff will perform annual wall-to-wall physical inventories of pharmaceuticals, as needed, and that responsibilities for ordering and receiving all pharmaceuticals are in compliance with Medication Manual, Section 27 – Pharmacy Inventory Management. Pharmacy Service staff established reorder points and quantities and implemented inventory shelf labels for all pharmacy products. The improvement actions taken are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management – Adverse Outcome Discussions and Peer Review Needed improvement.

Conditions Needing Improvement. The QM program was generally effective but certain QM reviews and processes needed to be strengthened. Appropriate review structures were in place for 10 of the 12 program areas reviewed, but the 2 other areas needed improvement.

Adverse Outcome Discussions. When clinical managers discussed adverse outcomes with patients and their families, they needed to notify the patients of their right to file claims and document these notifications in the patients' medical records. VHA and medical center policy requires staff to discuss adverse outcomes with patients and to inform them of the right to file tort or benefit claims. During FY 2004-2005, responsible clinicians documented adverse outcome discussions with three patients but did not advise these patients of their right to file claims.

Peer Review. Medical center management needed to ensure that peer reviews for specialty providers are performed and adequately documented. Peer review is the process of critical review performed by a peer of an episode of care provided by another professional. Formal peer review includes an evaluation of appropriateness and quality of care. VISN 4 policy requires that medical centers establish and maintain a peer review program in support of clinical care programs and professional services. If an appropriate peer reviewer cannot be identified within a medical center, assistance will be obtained from a practitioner in another VA medical center.

We reviewed Credentialing & Privileging files for 10 physicians who had been granted independent practice privileges in the last 12 months and found appropriate peer review completed for 9 of the physicians. One physician, the sole provider at the medical center practicing in a particular specialty, had not been peer reviewed. The Chief of Staff

identified the need for heightened surveillance and monitoring of this provider's care when the provider joined the staff in 2004. While the Chief of Staff monitored patient complaints, there was no quarterly monitoring by the Care Line Managers and no peer review performed.

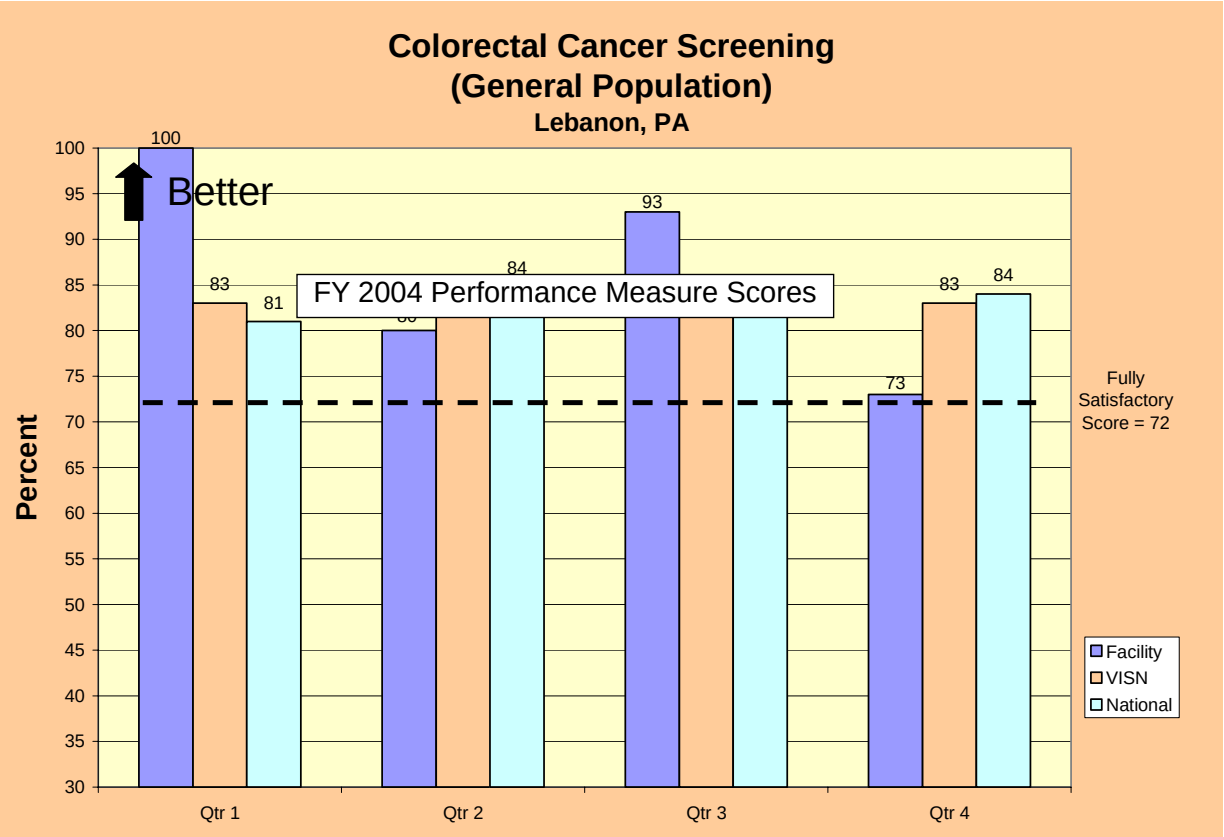
Recommendation 7. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) clinical Staff advise all patients who experience adverse outcomes of their rights to file claims and document the notification in the patients' medical record, and (b) ensures proper peer review for physicians of all specialties.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the Chief of Staff will advise patients and their families of the right to file claims and document these discussions when there are adverse outcomes and that they will ensure that proper peer review for physicians of all specialties will be completed.

Colorectal Cancer Management – Interdisciplinary Treatment Planning Documentation Needed Improvement

Condition Needing Improvement: The medical center met the VHA performance measure for colorectal cancer screening by providing timely Gastroenterology (GI), Surgery and Hematology/Oncology services, and promptly informing patients of diagnoses and treatment options. Regular telephonic discussions about pathologic findings and further treatment between the medical center surgeons and the Philadelphia VAMC pathologist were reported; however, there were no documented interdisciplinary treatment plans.

The VHA colorectal cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of 10 patients who were diagnosed with colorectal cancer during fiscal year 2004. To determine reasonableness, we used a 90-day goal for GI evaluation (taking into consideration factors outside the facility's control).



Patients appropriately screened	Patients diagnosed within 90 days	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatment
7/10	**5/10***	**7/10**	**0/10**	**10/10**

*5/10 patients had a delay in getting a colonoscopy scheduled. The medical center is actively recruiting a GI specialist, and colonoscopies are performed by the Surgical Service and fee-based out to the private sector as needed.

Recommendation 8. We recommend that the VISN Director ensure that the Medical Center Director takes action to develop a consistent method for documentation of interdisciplinary treatment plans for Colorectal Cancer patients.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a multidisciplinary team met and have developed a consistent method for documentation of interdisciplinary treatment plans for Colorectal Cancer patients.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 1, 2005

From: Director VISN 4 (10N4)

Subject: **VA Medical Center Lebanon, Pennsylvania**

To: Office of Inspector General

The Lebanon VA Medical Center carefully reviewed the recommendations and suggestions from their September 2005 Office of Inspector General Combined Assessment Program review.

As you will see in the attached report, several of the Lebanon VA Medical Center's corrective actions have been completed, are near completion, or are in the developmental phase.

VISN 4 appreciated the opportunity to have the Office of Inspector General once again visit one of our ten facilities. What they saw and heard from the Lebanon VA Medical Center staff again emphasizes their local strategic principle of "Putting Veterans First".

(original signed by:)

CHARLEEN R. SZABO, FACHE

Network Director

Appendix B

Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 28, 2005

From: Lebanon, Pennsylvania VA Medical Center Director

Subject: **VA Medical Center Lebanon, Pennsylvania**

To: Office of Inspector General

Network Director, VISN 4

Network Director, VISN 4

I have reviewed the findings within the report of the Combined Assessment Program Review of the VA Medical Center, Lebanon Pennsylvania. I am in agreement with the findings.

Lebanon VA Medical Center staff recognize this review as an integral part of our performance improvement program.

Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)

TERRY GERIGK

Director, Lebanon VA Medical Center

Director's 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:

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure the Medical Center Director requires that inventory management staff (a) reduce supply stock levels to the 30-day goal and (b) improve the accuracy of GIP data.

Concur

Target Completion Date: June 30, 2006

(a) The Lebanon VA Medical Center has 15 primary inventories with a total of 6,725 line items of managed stock. To provide direction toward the Central Office established goals, a meeting with the Fund Control Point Managers was held. The meeting reviewed Fund Control Points (FCPs) and provided direction on how to improve 30 day stock levels. Inventories will be processed to verify on hand quantities and reports will be run to identify the items that are causing excess conditions. Reduction goals (reduce excess stock and make necessary level adjustments) along with their proposed timelines will be established for the FCP Managers. To ensure items are required for future use, FCP Managers will coordinate their efforts with their assigned areas. Items no longer necessary will be offered to other VAMCs on a free basis, as long as shipping is paid for by the receiving facility.

(b) FCP managers will be instructed to ensure the processing of issues immediately after the item is given to the customer. In order to ensure inventory data accuracy, semi-annual inventories will be conducted on all primary FCPs. More frequent inventories will be directed as recurring problems are noted.

Recommendation 2. We recommend that the VISN Director ensure the Medical Center Director takes action to (a) identify and bill all potentially billable episodes of care and (b) continue

training medical care providers regarding proper medical record and resident supervision documentation.

Concur

Target Completion Date: Completed

(a) MCCF staff has taken action by reviewing the "Potential Cost Recovery Report" on a monthly basis. Upon review of this report, the first-party co-payments are established for both medical care and prescriptions. The third-party claims are created from scratch and distributed to insurance companies for possible collections. Few fee-basis claims are found to be billable due to service-connected care.

(b) The Medical Record Specialist performs regular one-on-one training with providers following monthly audits. Following the training session, random audits are performed on that provider periodically to ensure continued compliance.
Additionally, the Medical Record Specialist provides generalized training on a regular basis at Primary Care Staff Meetings and General Medical Staff Meetings. We plan to do the same throughout the year, which is targeting those providers that continue to fall out on the audits.

On a yearly basis, the Lebanon VA Medical Center contacts the VISN to provide education to the providers regarding documentation and coding. This year's training is scheduled for November 30 – December 2, 2005.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director emphasizes the need to thoroughly review outstanding obligations and cancel obligations that are no longer needed.

Concur

Target Completion Date: Completed

Fiscal Service is ensuring that a 100% review is done for all Undelivered Orders. Fiscal Service verifies the accuracy of the month-end report (889B- Analysis of Open Docs) that is utilized for this review and utilizes other month-end reports i.e. F851 (used by OIG reviewers) in conjunction with the 889B report. Completion of these items will be a performance measure of the Fiscal Service staff in annual performance plans.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) all sole source contracts valued at $500,000 or more be submitted to the VA OIG for pre-award audits, (b) all contracts that require legal and technical reviews are submitted, (c) COTRs do not delegate responsibilities granted by the contracting officer, (d) a process is established to ensure the monthly invoices for the After-Hours Pharmacy Service contract are accurate prior to payment, (e) the contracting process is adequately documented as required by the FAR, and (f) all personnel folders of physicians, allied health supervisors, or managers contain a signed Acknowledgment Form.

Concur

Target Completion Date: Completed

(a) Contracting Office employees were reminded and provided with the VHA Policy which requires all sole source affiliate contracts, valued at $500,000 or more, to be sent to the VA OIG Contract Review and Evaluation Division staff for pre-award audits. Pre-award audit of sole source contracts was added to the contract checklist used for contract file documentation to remind contracting employees of this requirement for certain contracts. This requirement will be incorporated into the annual performance plans of the contracting staff.

(b) The Home Oxygen contract was close to award when it was determined it required legal and technical review. This issue was discussed with Central Office. Central Office advised the Lebanon VA Medical Center to proceed without legal and technical review. In the future, contracting staff will comply with VHA policy that requires them to check the legal/technical review chart to determine if a solicitation requires review before it is issued. Legal and technical review has been added to the contract checklist used for contract file documentation. Compliance with this requirement will be a performance expectations of the Contracting Office staff in their annual performance plans.

(c) All COTRs have been trained on their duties and responsibilities. This training emphasized the delegation issue to ensure all COTRs are aware that they can not delegate authority granted by the contracting officer. Annual performance standards for individuals serving in a COTR role will clearly delineate these requirements and expectations.

(d) All COTR's have been trained on their duties and responsibilities. Contracting has emphasized the importance of verifying invoices, as well as provided several verification methods for their utilization. These performance expectations of the COTRs will be incorporated into their annual performance plans.

(e) Contracting Office staff are currently using a contract checklist to ensure that all of the appropriate information is contained in the contract folder. Contracting Office employees were reminded to ensure that all of the information listed on the contract checklist is included in the contract folder and to do a final review before awarding the contract. This expectation of the Contracting Office staff will be incorporated into their annual performance plans.

(f) The Acknowledgment Form has been obtained for the 5 individuals identified to be lacking during the OIG review. Additionally, all personnel folders of physicians, allied health supervisors, and managers were reviewed to verify the presence of the Acknowledgement Form. Periodic audits will be conducted to ensure compliance with this requirement.

Recommendation 5. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) the consolidated contingency plan contains information necessary to comply with NIST guidelines and (b) the security plan contains all security requirements of the system.

(a) Concur

Target Completion Date: May 31, 2006

The Information Security Officer and the Chief Technical Officer will establish a team of subject matter experts and will schedule weekly meetings. This team will be tasked with reviewing the current Consolidated Information Systems Contingency Plan dated February 2005, and incorporating this plan into the VHA Facility Contingency Plan template, Version 1.0 dated March 22, 2005. The results will provide a comprehensive facility contingency plan that will adhere to NIST guidelines.

(b) Concur

Target Completion Date: Completed

As a result of the VHA Certification and Accreditation initiative, a new consolidated Site Security Plan was created. When the OIG team requested the Site Security Plan, this plan was in the process of being graded by the Data Review Team and results of the review were unknown. The results of the review have since been received and the Lebanon VA Medical Center Site Security Plan, Final Version dated June 27, 2005, is available for review.

Recommendation 6. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) Pharmacy Service staff perform annual wall-to-wall physical inventories of pharmaceuticals, (b) the responsibilities for ordering and receiving all pharmaceuticals are properly segregated, and (c) Pharmacy Service staff establish reorder points for the pharmaceutical inventories and input this information on the shelf labels.

Concur

Target Completion Date: Completed

(a) Pharmacy staff performed the annual wall-to-wall inventory beginning in 2005 as directed. Our annual inventory for 2006 is scheduled to occur on January 21, 2006. The inventory will be done by RGIS as it was in 2005.

(b) The Lebanon VA Medical Center complies with the Medication Manual, Section 27 – Pharmacy Inventory Management; which requires that:

1) Orders arrive from the wholesaler in full cases, sealed totes, or special packaging. Employee assigned to receipt for orders acknowledges receipt of "X" number of totes and/or cases.

2) Tote is to be opened by designated employee (employee other than the one who placed the order) and compared to the invoice and purchase order.

3) If order is for controlled substances, order is received by pharmacy vault technician.

4) Accountable officer from A&MM must verify receipt of controlled substance orders.

Periodic audits will be conducted to ensure compliance.

(c) Inventory labels have been implemented for all pharmacy products indicating reorder point and reorder quantity. The quantity levels are utilized when placing our daily order with our prime vendor. Compliance is measured by monitoring projected annual pharmacy inventory turns utilizing a report provided as part of the pharmacy prime vendor software package, and will be reported to the Chief of Staff quarterly.

Recommendation 7. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) clinical Staff advise all patients who experience adverse outcomes of their rights to file claims and document the notification in the patients' medical record, and (b) ensures proper peer review for physicians of all specialties.

Concur

Target Completion Date: Completed

(a) The Risk Manager ensures that all patients who experience adverse outcomes are notified of their right to file a claim for compensation and/or a tort claim. The patient's provider shares the outcome, explains the impact on the patient's condition, and the resulting changes in treatment, if any, with the patient or surrogate.

The Risk Manager contacts the Regional Office Veterans Benefits Counselor and requests their involvement in the case by explaining the process to the veteran or family member. The notification is documented on a template form.
Modifications to medical staff bylaws, incorporating the above processes, will be accomplished as necessary.

(b) The Chief of Staff has met with all clinical leaders and Care Line Managers and reviewed the requirements for on-going quality assurance reviews for all providers. Each Care Line has reviewed and revised, as appropriate, current procedures for ensuring consistent and routine clinical record reviews that feed into the re-credentialing cycle. Documentation of results are maintained in each provider's personnel file, both at the Care Line level and with the medical center's Credentialing and Privileging Coordinator.

For those medical specialties where no more than one specialist is employed by the medical center, we have obtained agreement from providers at other VA medical centers to complete quality assurance reviews (Orthopedics, Neurology, Urology). We provide access for providers from other VA Medical Centers to our medical records for the purpose of peer reviews. Our Information Resource Management department provides the necessary passwords for these providers. This access is closely monitored by our Information Security Officer and access is terminated when the need no longer exists.

Recommendation 8. We recommend that the VISN Director ensure that the Medical Center Director takes action to develop a consistent method for documentation of interdisciplinary treatment plans for Colorectal Cancer patients.

Concur

Target Completion Date: December 16, 2005

A multidisciplinary team comprised of nursing, laboratory, and surgery met immediately after the OIG visit to address the above issue. Lebanon has two progress notes available for noting pathology notification. One note is the "nurse pathology notification note" and the other is the "physician pathology notification note." Both notes are activated after the provider/nurse team receives the pathology view alert from the laboratory. The initial pathology notification note is the "parent" note to which surgery, oncology, and other clinical progress note entries are attached, thus creating one note that outlines all communication and treatment planning for the veteran. We are also exploring further enhancements of the process by implementing a retrospective linkage by Informatics to the initial pathology note that will include the initial consultation from primary care, the surgical Gastroenterology Clinic note, the scope note, etc.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Reducing supply inventories to 30-day levels.	$248,775
2	Enhancing MCCF billings and collections.	40,833
3	Canceling unneeded obligations.	6,988
	Total	$296,596

Appendix D

OIG Contact and Staff Acknowledgments

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Acknowledgments	Robert C. Zabel Audit Team Leader Jeffrey Hughes Robin Frazier Dennis Capps Henry Mendala Oscar Williams Lynn Scheffner Carol Torczon Donna Giroux Gail Bozzelli

Appendix E

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