# Department of Veterans Affairs
# Office of Inspector General

# Combined Assessment Program Review of the Northampton VA Medical Center Leeds, Massachusetts

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VA Office of Inspector General
Washington, DC 20420

# Office of Inspector General

# Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high-quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high-quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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# Executive Summary

## Introduction

During the week of September 26–30, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Northampton VA Medical Center, Leeds, Massachusetts. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 106 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 1.

## Results of Review

The CAP review covered 11 operational activities. The medical center complied with selected standards in the following three activities:

- All Employee Survey
- Colorectal Cancer Screening
- Quality Management

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

- Strengthen controls to improve oversight of the contracting activity and contract administration.
- Increase Medical Care Collections Fund (MCCF) collections by identifying and processing all billable patient health care services.
- Improve inventory procedures and controls over nonexpendable equipment.
- Strengthen controls to ensure purchase cardholders comply with the Federal Acquisition Regulation (FAR) and obtain competition for purchases exceeding $2,500.
- Improve controls over controlled substances inspections.
- Strengthen controls for information technology (IT) security.
- Improve radiology transcription and monitor the completion and timeliness of radiology examinations performed by fee basis radiology providers.

- Improve crash cart inspections and general housekeeping and maintenance, and secure patient information.

We also made the following observations:

- The VISN and the medical center met the requirements of the Veterans Health Administration (VHA) Executive Career Field (ECF) Performance Plan.
- The medical center met the VHA performance measure for colorectal cancer screening.

This report was prepared under the direction of Mr. Thomas L. Cargill, Jr., Director, and Mr. Philip D. McDonald, Audit Manager, Bedford Audit Operations Division.

## VISN 1 and Acting Medical Center Directors Comments

The VISN and Acting Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 18–27, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

# Introduction

## Medical Center Profile

**Organization.** The medical center is a primary and long term care facility that provides inpatient and outpatient health care services. Outpatient care is provided at three community-based outpatient clinics (CBOCs) located in Greenfield, Pittsfield, and Springfield, Massachusetts. The medical center serves a veteran population of about 180,000 in a primary service area that includes 4 counties in Massachusetts.

**Programs.** The medical center provides primary, medical, psychiatric, and long term care and rehabilitation services. The medical center has 116 general medicine, acute, and long-term psychiatric beds, and a 16-bed Psychiatric Residential Treatment Program. The medical center also operates a 65-bed Nursing Home Care Unit.

**Affiliations and Research.** The medical center is affiliated with the University of Massachusetts, University of Hartford, Springfield College, and Holyoke Community College. There is no current research activity.

**Resources.** The medical center's fiscal year (FY) 2004 medical care budget was $66.5 million, a 1 percent increase over FY 2004 funding of $65.9 million. FY 2004 staffing was 622 full-time equivalent employees (FTE), including 23 physician FTE and 97 nursing FTE.

**Workload.** In FY 2004, the medical center treated 13,398 unique patients, a 1 percent increase from FY 2003. In FY 2004, the average daily census, including nursing home patients, was 161. The outpatient workload was 150,656 visits.

## Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the

process of monitoring the quality of patient care to identify and correct 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.

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 11 activities:

- All Employee Survey
- Colorectal Cancer Screening
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Laboratory and Radiology Timeliness
- Medical Care Collections Fund
- Pharmaceutical Accountability
- Quality Management
- Service Contracts

The review covered medical center operations for FYs 2004 and 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations of our prior CAP review of the medical center (*Combined Assessment Program Review of the Northampton VA Medical Center Leeds, Massachusetts*, Report No. 04-00627-172, July 30, 2004).

As part of the review, we interviewed 30 patients. The surveys indicated high levels of patient satisfaction, and the results were shared with medical center managers.

We also presented 2 fraud and integrity awareness briefings for 106 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.

Activities needing improvement are discussed in the Opportunities for Improvement section (see pages 3–16). For these activities, we make recommendations. 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.

# Results of Review

## Opportunities for Improvement

### Service Contracts – Controls To Improve Contract Administration and Compliance with VA Policy Needed To Be Strengthened

**Conditions Needing Improvement.** Medical center management needed to improve contracting activity performance by strengthening controls to ensure that the Chief of Acquisition and Materiel Management Service (A&MMS), contracting officers (COs), and Contracting Officer's Technical Representatives (COTRs) perform their responsibilities in accordance with the FAR, the VA Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 5 contracts valued at $1,931,000 and 1 sharing agreement valued at $425,000 from a universe of 17 contracts and sharing agreements valued at $15.2 million. We also reviewed three community nursing home contracts with a combined FY 2005 value (through June 2005) of about $993,000. We identified the following issues that required management attention.

Chief, A&MMS Performance. The Chief of A&MMS is responsible for implementing and maintaining an effective and efficient contracting program and establishing controls to ensure compliance with the FAR, the VAAR, and VA policy. The Chief of A&MMS could improve oversight of the contracting activity by ensuring that thorough supervisory contract file reviews are conducted and ensuring COs and COTRs perform their duties as required.

- Contract File Reviews. There was no documentation that supervisory contract file reviews were conducted at all for two service contracts and one nursing home contract. In addition, thorough supervisory contract file reviews were not conducted for three service contracts, two nursing home contracts, and one sharing agreement. The review is intended to ensure the completeness and accuracy of the solicitations and contract documentation packages and ensure compliance with the FAR, the VAAR, and VA policy.

  Our review identified deficiencies that could have been prevented had thorough supervisory contract file reviews been conducted. Some of the deficiencies identified included not having documentation in the contract files of malpractice and general liability insurance and technician licensure/certifications.

CO Performance. COs are responsible for completing all necessary administrative actions, ensuring compliance with the terms and conditions of the contracts, and maintaining contract files containing records of preaward and postaward administrative actions. Our review of three clinical service contracts valued at about $1.6 million, three

nursing home contracts valued at $993,000, and one sharing agreement valued at $425,000 disclosed the following deficiencies.

- Required Preaward Administrative Actions. COs did not conduct required preaward administrative actions including documenting technician licensure/certification and medical liability insurance for medical technicians providing services for two clinical service contracts. General liability insurance was not documented for the sharing agreement.

- Required Postaward Administrative Actions. COs did not conduct required postaward administrative actions, including requesting the required background investigations of contractor personnel for one clinical service contract. COs did not ensure that only COTRs validated services and certified payments for two clinical service contracts and three community nursing home contracts.

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director require: (a) the Chief of A&MMS ensure that contract file reviews are conducted to comply with the FAR, the VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies; and (b) COs correct the required preaward and postaward administrative deficiencies.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that the Program Manager, Acquisition/Logistics will ensure that contract files reviews are conducted to comply with the FAR, the VAAR, and VA policy. Contract review checklists will be used to detect, correct, and prevent future contract deficiencies. Staff were re-educated on the use of checklists in January 2006. The administrative deficiencies were corrected as of October 11, 2005. Contracting staff have been re-educated about FAR and VAAR requirements. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

## Medical Care Collections Fund – Some Improvements Were Needed To Enhance Collections

**Condition Needing Improvement.** The medical center's MCCF program collected $3,112,070 between July 1, 2004, and June 30, 2005, missing its collection goal by about $57,000. Our review of samples of fee basis payments and outpatient care found documentation and billing errors. We identified opportunities to improve billing and collections from third party payers for fee basis patients. We also noted some additional improvements could be made to further enhance outpatient billing and collections by training providers on documentation requirements and following up with providers to obtain necessary medical documentation.

Fee Basis. The medical center paid 24,355 fee basis claims totaling $1,838,128 to non-VA providers who provided medical care to VA patients with insurance between July 1, 2004, and June 30, 2005. Payments to fee basis providers included 319 claims for inpatient and ancillary care at a cost of $692,799 and 24,036 claims for outpatient care at a cost of $1,145,329. Fee basis staff forwards all claims to MCCF staff after the medical center has been billed by the provider.

To determine if fee basis care was properly billed to patients' insurance carriers, we reviewed a statistical sample of 97 outpatient claims and 74 inpatient and ancillary claims. Of the 97 outpatient claims, 94 claims were not billable to third party payers because the treatments were for service-connected disabilities, Medicare supplements did not cover the services provided, or the veterans did not have the proper insurance coverage. The remaining three outpatient claims were billable to third party payers, but MCCF staff were waiting to bill until a coding issue with the vendor could be resolved.

Of the 74 inpatient and ancillary claims, 40 claims were not billable to third party payers because the treatments were for service-connected disabilities, the medical services provided were not covered by the patients' insurance, or the patients' insurance was not in effect at the time of treatments. The remaining 34 inpatient and ancillary claims were billable to third party payers for $73,887 (average bill value of $2,173), but none of the 34 were billed by MCCF staff, resulting in an error rate of 45.9 percent. A software problem was identified by MCCF staff as the cause of this deficiency.

Projecting our sample results to the universe, we estimate that an additional $318,173 could have been billed for inpatient and ancillary fee basis care (45.9 percent error rate x 319 inpatient/ancillary universe x $2,173 average bill value). Based on the medical center's FY 2005 average collection rate of 32.05 percent, we estimate that an additional $101,974 could have been collected.

"Reasons Not Billable Report". We reviewed the Nonbillable Provider (Resident), Insufficient Documentation, and No Documentation segments of the "Reasons Not Billable Report" ("RNB Report") for the period of July 1, 2004, through June 30, 2005. We selected these segments because, with proper and timely monitoring of the report, these reasons for not billing encounters are avoidable. These segments represent missed billing opportunities due to poor documentation by medical care providers. As of September 8, 2005, there were 91 encounters valued at $24,198 listed in the 3 segments of the outpatient "RNB Report" for treatment provided during the period of our review. We reviewed a sample of 11 encounters and found they were not billable because medical record documentation was inadequate.

When there is no documentation or an encounter is inadequately documented, medical center management should promptly contact providers and request that proper documentation be submitted timely. The Compliance Officer has reported that the "RNB

Reports" are now reviewed regularly and physicians are contacted when they need to complete documentation.

Outpatient Billing Review. As of September 8, 2005, there were 28,816 outpatient bills valued at $3,157,252 billed to third party payers for care delivered during the period of July 1, 2004, through June 30, 2005. We reviewed a statistical sample of 137 outpatient encounters billed at $125,317 with collections of $46,946. The review identified nine errors, of which eight encounters were underbilled by $813.41 (0.65 percent of the total billed) and one encounter was overbilled by $263 (0.21 percent of the total billed). These error rates were the lowest error rates of any medical facility within VISN 1. The medical center took action to correct these errors as a result of our review.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure that all fee basis claims for patients with insurance are billed, (b) expand compliance reviews to identify and process all billable patient health care services, and (c) provide additional training to health care providers on documentation requirements.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that fee basis claims are now being reviewed on a daily basis to identify events that have third party reimbursement potential. Compliance reviews have been expanded to include a review and approval process where MCCF staff, the Utilization Review Nurse, and Chief of Staff review all requests for fee services. Formal training by the Health Information Management Service (HIMS) and MCCF coding staff began the week of February 13, 2006, and targeted the documentation requirements based on the individual provider and clinic. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

## Equipment Accountability – Inventory Controls Needed To Be Strengthened

**Conditions Needing Improvement.** Medical center management needed to improve procedures to ensure that nonexpendable and sensitive equipment was properly accounted for and safeguarded. VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). A&MMS staff are responsible for coordinating the EIL inventories, which includes notifying all services when inventories are due and following up on incomplete or delinquent inventories.

As of September 12, 2005, the medical center had 77 active EILs listing 4,966 equipment items with a total acquisition value of $10.9 million. We identified six equipment accountability issues that required corrective actions.

Inventory Controls and Procedures. VA policy requires responsible officials, such as service chiefs or their designees, to conduct annual or biennial inventories of nonexpendable equipment. These officials must evaluate the need for all equipment assigned to them and sign and date their EILs certifying that the equipment was accounted for. We found that this documentation was being maintained and responsible officials were appropriately certifying their EIL inventories. However, we identified the following equipment inventory deficiency.

- We verified that all 15 Police Service firearms were listed in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS), the property database. However, property barcode labels were not affixed to the individual lock boxes used to store the firearms. The added control of cross-referencing the serial number of each firearm to its local inventory number was not in place.

Accuracy of EILs. To assess the accuracy of equipment inventory records, we reviewed a statistical sample of 98 equipment items (combined acquisition value of $2,019,435).[1] We identified the following accountability discrepancies.

- We were unable to locate 5 (5 percent) of the 98 sampled equipment items.
  - A&MMS staff could not locate a computer server, computerized embosser, digital computer, and printer. These four items were acquired between 1995 and 2004 (total acquisition value of $24,760).
  - We were unable to physically verify a fifth item, a Pitney Bowes postal meter (acquired in 1993 for $22,282). This item was removed from the medical center by the vendor servicing it, and replaced with a new leased postal meter, which we physically verified. The lease contract and equipment replacement were done without notifying A&MMS; therefore, the "old" postal meter remained in AEMS/MERS. A "Report of Survey" ("ROS") had been completed and signed by medical center management to remove the item from AEMS/MERS.
- Thirteen items had the wrong locations listed, and 1 item had no location recorded.
- Five items had the wrong serial numbers listed, and 12 items had no serial numbers recorded.
- Six items did not have property barcode labels affixed to them.

We concluded the quality of the EIL inventories as well as the accuracy and completeness of AEMS/MERS needed to be improved. Equipment cannot be properly

[1] The 98 items were selected from the equipment list of nonexpendable property with each item having an acquisition value over $5,000.

safeguarded and accounted for without being accurately recorded on the appropriate EILs and in AEMS/MERS. Responsible officials need to do more complete inventories and physically verify all equipment listed on their EILs. Responsible officials should also review their EILs, and report incomplete or inaccurate information (i.e., serial numbers, locations) to A&MMS for correction in AEMS/MERS. The review and physical verification of all items should be completed by the responsible officials before certifying the equipment as accounted for.

Sensitive Equipment. VA policy requires that certain sensitive equipment be accounted for regardless of cost, life expectancy, or maintenance requirements. Sensitive items include computer equipment that are subject to theft, loss, or conversion to personal use.

As of September 12, 2005, the medical center had 1,724 pieces of IT-related equipment (acquisition value of $2,455,935), all of which were listed on Information Resource Management's (IRM's) EIL. Accounting for this equipment is also vital in safeguarding sensitive data.

To assess the accuracy of IT equipment inventory records, we reviewed a sample of 20 items (total acquisition value of $44,434), and we were unable to locate 1 item (5 percent). The item that we could not find was a Dell computer server that was purchased in October 2004 for $5,714. Also, of the 20 sampled items, 8 had the wrong locations, 3 did not have serial numbers, and 1 did not have acquisition information (e.g., acquisition date, cost) listed in AEMS/MERS.

Controls needed to be strengthened to safeguard and account for all sensitive IT equipment. This includes physically locating all equipment during EIL inventories, as well as adjusting information in AEMS/MERS so that it is accurate and complete.

"Out of Service" Equipment. A&MMS staff did not determine whether 322 items (estimated acquisition value of $971,750) that appeared on the current property inventory list as "out of service," were appropriately listed in this category.[2] A&MMS management stated that a concerted effort will be made to locate the items. A "ROS" should be initiated for each equipment item not located. For "ROSs" where equipment losses equal or exceed $5,000, the "ROSs" are to be forwarded to the Medical Center Director, who is responsible for establishing a Board of Survey to conduct an investigation of equipment not located.

Disposed Equipment. VA policy requires excess property to be advertised to other VA facilities for 10 days. If no VA facility is interested in acquiring the property, it is reported to the General Services Administration (GSA). If GSA is unsuccessful in locating any interested parties, GSA authorizes the agency to dispose of the property.

[2] The acquisition value was missing in the database for 51 (16 percent) of the 322 "out of service" items.

We reviewed a sample of 15 items that had been disposed of (acquisition value of $51,928) from a list of 403 disposed items (total acquisition value of $970,967) covering the period October 2003 through August 2005. A&MMS officials did not provide appropriate documentation for any of the 15 items that would allow us to verify the propriety of the disposal transactions or that they followed the mandatory disposal procedures. As a result, controls to ensure that VA excess property is properly disposed of are weak, which renders Government equipment vulnerable to misuse or theft.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director requires that:

a. Property barcode labels are affixed to all firearm lock boxes.
b. Responsible officials physically verify all equipment and correct incomplete or inaccurate information prior to signing EIL inventories and certifying equipment as accounted for.
c. Controls are strengthened to safeguard and account for sensitive IT equipment.
d. Controls are strengthened to account for property listed on the EILs as "out of service."
e. Controls are strengthened and prescribed procedures are followed covering disposal of excess property.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that property barcode labels were affixed to all firearm lock boxes on February 17, 2006. EILs have been updated and incomplete and inaccurate information corrected prior to signature by responsible officials. All sensitive equipment will be physically located and accounted for and AEMS/MERS records will be updated in March 2006. Acquisition personnel will review all items listed as "out of service" on a quarterly basis. Acquisition personnel will also monitor on a quarterly basis that procedures are followed covering the disposal of excess property. Staff were retrained on the proper disposal procedures in October 2005. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

## Government Purchase Card Program – Compliance with the Federal Acquisition Regulation Needed To Be Improved

**Conditions Needing Improvement.** Medical center management needed to strengthen controls to ensure that Government purchase cardholders seek competition for open market purchases exceeding $2,500. For the period from January 1, 2004, to July 31, 2005, the medical center had 73 cardholders and 36 approving officials processing 15,609 transactions valued at approximately $4 million. We reviewed a sample of 34 prosthetic items greater than $2,500 purchased on the open market to determine if cardholders were complying with the FAR requirement that cardholders document consideration of 3 sources for competition or document the justification for

using sole source vendor. We found that cardholders purchasing prosthetic items did not always maintain documentation to support competition or sole source purchases for purchases exceeding $2,500.

To determine if the medical center purchased items in accordance with the FAR, we reviewed 34 purchase card transactions consisting of scooter lifts, power wheelchairs, wheelchair lifts, and stair lifts valued at $145,709. Thirteen purchases (38 percent) of scooter lifts, power wheelchairs, and a stair lift, valued at $58,738, were made on the open market with no documentation of bids from 3 sources or documentation of sole source justifications. As a result, cardholders did not have reasonable assurance that the best prices were obtained or that these procurements were made in VA's best interest. The remaining 21 prosthetic purchases valued at $86,971 had documentation for 3 bids or sole source justifications.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires cardholders to consider three sources of competition for purchases over $2,500 or document the justifications for using sole source vendors.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that as of October 1, 2005, quarterly random audits of all purchases over $2,500 will be conducted to ensure three sources of competition are considered. The implementation plan is acceptable, and we will follow up on the completion of the planned action.

## Information Technology Security – Controls Needed To Be Strengthened

**Conditions Needing Improvement.** Medical center management needed to strengthen IT security. We evaluated IT security to determine whether controls and procedures were adequate to protect automated information systems (AIS) resources from unauthorized access, disclosure, modification, destruction, and misuse. We found that the medical center's Information Security Officer (ISO) ensured employees completed their annual security awareness training and periodically scanned the medical center for wireless connections to make sure that wireless devices were not being used to gain unauthorized access to the network. Also, the automatic session timeout feature was enabled on all facility workstations. The following issues required management attention.

Access to AIS Resources. VA policy requires that physical access to AIS resources be limited to only those personnel who have a legitimate need for access. Access to the medical center communication closets was controlled by a lock and key system. We found that two non-IRM Service employees without a need for access had keys to the closets. We also found that anyone who had the medical center's grand master key could access the communication closets. The listing of individuals who had grand master keys

included one separated employee. Locks on the communication closets should be re-keyed off the grand master key, and access to the closets should be limited to IRM Service employees with legitimate needs for access.

Physical Security. VA policy requires that proper safeguards be in place to protect each facility's AIS resources, including physical security of the computer room. The computer room was protected by a combination lock system, which was controlled by the Chief Information Officer (CIO). However, in the event of an emergency, the computer room can still be accessed through the use of a key. The CIO was in possession of a key, and another key was kept in a locked box behind the admissions desk. Police Service should retain possession of the key in the locked box behind the admissions desk. We also found that the computer room had no motion detection system, and the door to gain entrance to the room was not armed with an alarm system.

Hard Drive Sanitation. VA policy requires that IRM Service remove all sensitive information and data from hard drives prior to the disposal of computer equipment. The medical center used a program called Data Eraser or utilized contract services to sanitize or destroy hard drives. However, IRM Service staff did not maintain documentation when hard drives were removed from computers, and therefore they could not provide assurance that the removed hard drives of disposed computers had been properly sanitized or destroyed.

Generic User Accounts. Two computer workstations were set up in the library with generic user accounts to allow veterans access to the Internet, Microsoft Office, and other basic computer functions. However, we found that these accounts had the same options and privileges assigned to VA employees (i.e., the ability to access other network computers, access to the disk operating system prompt, etc.).

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director takes action to:

a. Re-key all communication closets off the grand master key and limit access to only IRM Service employees with legitimate needs for access.
b. Assign control of the computer room emergency key in the locked box behind the admissions desk to Police Service.
c. Install motion detection and alarm systems in the computer room.
d. Maintain documentation to provide assurance that all hard drives have been properly sanitized or destroyed prior to the disposition of computer equipment.
e. Ensure the two generic user accounts allow access only to basic computer functions.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that communication closets were re-keyed and access limited to individuals with a legitimate need. The computer room emergency key was assigned to Police Service on September 30, 2005. A request for funding will be

submitted for the purchase of the security equipment. Documentation is now maintained and tracked for hard drives that are sanitized and destroyed. The two generic user accounts have been modified to permit access to only basis computer functions. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

## Pharmaceutical Accountability – Controlled Substances Inspection Deficiencies Needed To Be Corrected

**Conditions Needing Improvement.** Medical center management needed to address weaknesses in controlled substances inspections to fully comply with VHA policy and ensure accountability of controlled substances. We identified the following issues that required management attention.

Controlled Substances Inspections. VHA policy requires medical facilities to conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate controlled substances accountability, we reviewed inspection reports for the 6-month period of March–August 2005, interviewed inspectors and the Controlled Substances Coordinator, reviewed training documentation for inspectors, and observed an unannounced inspection of selected areas where controlled substances were stored and dispensed. Our review disclosed the following deficiencies.

- Twelve (43 percent) of 28 inspectors did not receive required refresher training in FYs 2004 or 2005.
- Inspectors did not review the audit trail of 10 drugs held for destruction each month. This condition was also reported in our prior CAP review. Also, inspectors did not determine whether Pharmacy Service had completed drug destructions quarterly.
- Inspectors did not randomly select and verify hard copy prescriptions for a minimum of 10 percent or a maximum of 50 Schedule II drugs dispensed from the outpatient pharmacy. Inspectors only verified prescriptions for three drugs dispensed on the day of the inspection.
- Inspectors did not review the monthly "Prime Vendor Inventory Summary Report" or the "Drug Receipt History Report," as required. These reports should be reviewed to ensure all controlled substances were received and placed into inventory.
- The August 2005 controlled substances inspection forms for the medical center and the Springfield CBOC pharmacy vaults were not completed, as required.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that controlled substances inspectors conduct inspections in accordance with VHA policy.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that controlled substances inspectors will conduct inspections as required. Inspectors will review drugs held for destruction each month and also verify hard copy prescriptions dispensed from the outpatient pharmacy. In addition, inspectors will review the "Prime Vendor Inventory Summary Report" and "Drug Receipt History Report" to ensure all controlled substances are received and placed into inventory. The implementation plans are acceptable, and we will follow up on the completion of planned actions.

## Laboratory and Radiology Timeliness – Radiology Transcription Needed To Be Improved and Fee Basis Radiology Studies Needed To Be Monitored

**Conditions Needing Improvement.** VISN 1 and medical center policies defined timeliness standards for laboratory and radiology examinations. The turnaround times for laboratory tests generally met the standards set by the policies and there was documentation to support reasons for scheduling routine laboratory tests beyond the designated timeframes. However, medical center managers needed to develop and implement processes to ensure that radiology studies performed at the medical center were appropriately transcribed and accurately reported, and fee basis studies were monitored for timeliness.

Transcribing Radiology Studies. QM managers identified delays in transcribing radiology studies performed at the medical center as "precluding successful attainment" of the verification goal (2 days). QM managers also identified transcription errors (for example, the wrong radiologist was identified on some radiology reports) prior to the CAP review. These conditions occurred because the medical center was unable to retain a full-time transcriptionist. At the time of our review, the medical center assigned collateral transcription responsibilities to a primary care clinic clerk 2 hours per day. While this action helped improve timeliness and reduce errors, the transcriptionist position was considered a full-time position. VISN managers approved a transcription FTE position, and the medical center was in the process of recruiting. Until the position is filled, medical center managers need to ensure that radiology studies are correctly transcribed and accurately reported to providers.

Fee Basis Radiology Services. Fee basis radiology services were approved by the Chief of Primary Care. Once approved, studies were scheduled by clinic clerks, patients were notified of their appointments, and results of the studies were to be returned to the medical center's ordering provider and Radiology Department. At the time of the CAP review, a comprehensive monitoring process was not in place to ensure that providers and the Radiology Department received study results timely. The only tracking of fee basis studies that occurred was when a request for payment from the fee basis provider arrived in the Radiology Department. The Radiology Department Manager then verified the date

the study was performed and the date it was received in the department. This information was recorded in a log book. A review of the log book for the last quarter of FY 2005 showed that two abnormal radiology reports had turnaround times of 10 days and 15 days, respectively, and one report documenting a malignancy had a turnaround time of 22 days. Since there was no comprehensive monitoring process to ensure that studies were completed and reported to providers timely, delays in provider notification and patient treatment could occur.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) radiology studies performed at the medical center are accurately transcribed and reported and (b) processes are developed to monitor radiology studies performed by fee basis providers to ensure that they are completed and the results are timely reported to providers.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that a transcriptionist was recently hired to work exclusively for radiology transcription 5 days per week. Monitors have been established to track turnaround times. In addition, a system will be developed and implemented to track radiology studies performed by fee basis providers to ensure that they are completed and results are timely reported. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

## Environment of Care – Crash Cart Inspections and General Housekeeping and Maintenance Needed To Be Improved and Patient Information Needed To Be Secured

**Conditions Needing Improvement.** We inspected inpatient units and found the environment of care to be generally clean and safe. However, medical center managers needed to ensure that crash carts were inspected according to medical center policy, general housekeeping and maintenance standards were followed, and patient information was secured.[3]

Crash Carts. The crash cart inspection log on a geriatric psychiatry unit showed that the cart had not been inspected on three shifts during September 2005. Also, the inspection log on the acute psychiatry unit showed that the crash cart had not been inspected on two shifts during the same month. The medical center policy requires carts to be inspected each shift and inspections to be documented in the inspection log. The inspections are necessary to ensure the integrity of equipment and supplies in the event of a cardio-pulmonary emergency.

[3] Crash carts are portable carts located in patient care areas that contain emergency equipment, supplies, and medications used to stabilize a person who experiences a cardio-pulmonary emergency.

General Housekeeping and Maintenance. On the geriatric psychiatry unit mentioned above, we found that floors in the two patient bathrooms were soiled. Blackened floor tiles were also found in these areas. One bathroom had a radiator cover missing, exposing electrical wires, and an electrical cord from a fan was draped over a bathroom sink. In the laundry room, the clothes dryer vent was disconnected and an extensive accumulation of lint (a potential fire hazard) was found. Additionally, there were unsecured sharp objects (for example, scissors and a razor) found in one of the bathrooms. VHA policy requires that the medical center environment present minimal risk to patients, employees, and visitors. All of these conditions posed safety risks.

Patient Information. The door to a room across from the patient waiting area in the Radiology Department, which contained several computers, was open and computers had patient information visible on the screens. Because the door was open, patients and the public had access to the room. Federal law requires that patient information be secured and protected from people who do not have a legitimate need to know that information.

**Recommendation 8.** We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) all crash carts are inspected according to medical center policy; (b) patient care areas are cleaned and maintained and sharp objects are secured; and (c) patient information is secured.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that Nursing Service initiated random monthly audits of crash carts and logs in February 2006. Other areas with crash carts will also begin monthly audits of crash carts and logs. A verification of crash carts has been added to the Patient Safety Officer's check list and the scheduled weekly environmental rounds activity. All showers and bathing units are cleaned each day, and in some instances, more often as needs dictate. Patients on the ward in question have been relocated to a newly renovated unit. The unit in question is undergoing a renovation project that was started in February 2006. A review of sharps has been added to the scheduled weekly environmental rounds activity. Computer screens throughout the facility have been reoriented and shielded so that patient data cannot be viewed. Regularly scheduled privacy rounds are conducted by the CIO, ISO, and Compliance Officer to ensure privacy. The implementation plans are acceptable, and we will follow up on the completion of the planned actions.

# Other Observations

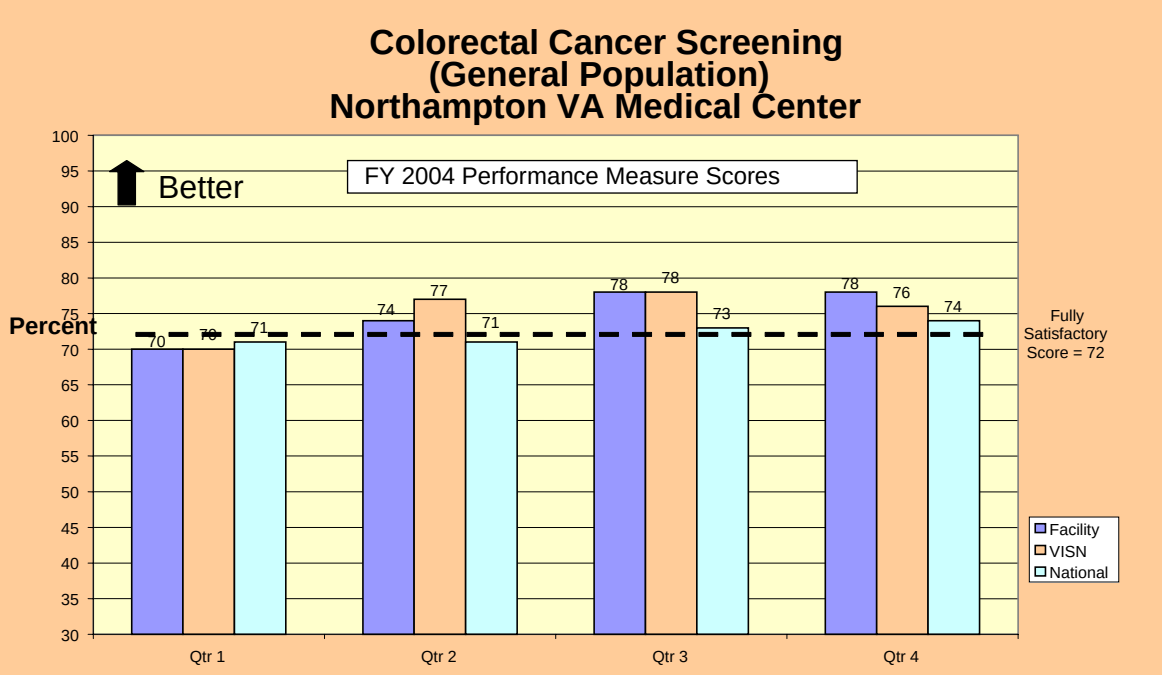
## All Employee Survey – Improvement Plans Were Developed and Implemented

The VHA ECF Performance Plan for FY 2005 required that VISN Directors ensure that the results of the 2004 All Employee Survey (AES) were disseminated throughout their networks during the FY 2005 rating period. Also, VISNs were required to analyze the 2004 AES results and help facilities formulate improvement plans to address deficient areas. These plans were to include timelines and milestones that would effectively measure improvements, and the plans were to be in place by September 30, 2004.

The VISN and the medical center met the requirements of the VHA ECF Performance Plan. The medical center's AES coordinator distributed survey results throughout the medical center by electronic mail, and managers conducted service meetings and town hall meetings. Medical center managers also analyzed the survey results and developed improvement plans. In addition, based on the AES job satisfaction index data, the Federal Executive Association of Western Massachusetts testified before the Federal Salary Council and successfully negotiated a 10 percent locality pay raise for Title 5 VA employees in Western Massachusetts. VISN 1 managers conducted an interim AES in March 2005 and the medical center's results generally mirrored the 2004 national results. Consequently, medical center managers established an agreement with the VA National Center for Organizational Development in an effort to improve employee satisfaction.

## Colorectal Cancer – Screening Processes Were Timely

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. Following initial screening, the medical center referred patients who required further diagnostic studies and treatments to surrounding facilities, including other VA facilities; and the patients were monitored by the accepting facility. We reviewed the medical center's colorectal cancer screening performance measure and found that it met or exceeded VISN and national statistics for the last three quarters of FY 2004.


Colorectal Cancer Screening
(General Population)
Northampton VA Medical Center
FY 2004 Performance Measure Scores
Better
Percent
100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
70
70
71
74
77
71
78
78
73
78
76
74
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Fully Satisfactory Score = 72
Facility
VISN
National

**Appendix A**

# VISN 1 Director Comments

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

**Date:** March 20, 2006

**From:** VISN 1 Director

**Subject:** **Northampton VA Medical Center, Leeds, Massachusetts**

**To:** Office of Inspector General (50)

1. Attached is the response to the Northampton VA Medical Center Combined Assessment Review conducted at that facility on September 26-30, 2005.

2. If you have any questions or need additional information, please contact Ms. Joanne Carney, Acting Director, VAMC Northampton by calling (413) 582-3000.

*(original signed by:)*

Jeannette A. Chirico-Post, MD

**Appendix B**

# Acting Medical Center Director Comments

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

**Date:** February 14, 2006

**From:** Acting Medical Center Director

**Subject:** **Northampton VA Medical Center, Leeds, Massachusetts**

**To:** VISN 1 Network Director (10N1)

1. Attached, please find the responses to the recommendations provided in the above cited OIG/CAP report.

2. Questions may be directed to Mr. Michael Walsh, RN, Acting Quality Manger at (413) 582-3016.

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

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

**OIG Recommendation(s)**

**Recommendation 1.** We recommend that the VISN Director ensure that the Medical Center Director requires: (a) the Chief, A&MMS ensure that contract file reviews are conducted to comply with the FAR, VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies; and (b) COs correct the required preaward and postaward administrative deficiencies.

Concur **Target Completion Date:** Completed

(a) The Program Manager, Acquisition/Logistics will ensure that contract files reviews are conducted to comply with the FAR, VAAR, and VA policy. Contract review checklists will be used to detect, correct, and prevent future contract deficiencies. Staff were re-educated on the use of checklists in January 2006.

(b) The cited deficiencies have all been corrected. Contracting staff have been re-educated about FAR and VAAR requirements. The deficiencies were corrected as of October 11, 2005.

**Recommendation 2.** We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure that all fee basis claims for patients with insurance are billed, (b) expand compliance reviews to identify and process all billable patient health care services, and (c) provide additional training to health care providers on documentation requirements.

Concur **Target Completion Date:** Completed

(a) Fee basis claims are manually reviewed in batches on a daily basis (after the fee payments have been released to Austin, TX by accounting staff) to identify events which have third party reimbursement potential and applicable copayment charges. Since the implementation of this process on October 3, 2006, this facility established $246,575 fee basis/third party claims and have manually added $4,793 in Means Test inpatient and outpatient copayments as a result of the fee care provided. Completed October 15, 2005.

(b) The process has been expanded to include a review and approval process "up-front" where MCCF staff (coders and billers), the Utilization Review Nurse and the Chief of Staff review all requests for fee services at a regularly scheduled three-day-per-week meeting.

All fee claims paid are then manually reviewed by MCCF staff for reimbursable insurance and applicable copayment charges. As of February 28, 2006, $150,038 has been billed to insurance providers on events paid via the fee system. Completed October 15, 2006, and is ongoing.

(c) MCCF, Compliance Officer and HIMS staff are collaboratively working on providing education to providers. MCCF biller/coders identify any deficiencies on the Reason Not Billed (RNB) report (via QuadraMed software). Providers are notified to correct the documentation deficiency. When the Compliance Officer reviews the RNB report, that information is sent to the appropriate clinical staff for correction of documentation. HIMS staff identify any documentation concerns at the time of record coding and contact the provider for correction. Formal training by both HIMS and MCCF coding staff began the week of February 13, 2006, and is structured as a 1:1 training opportunity and targets the documentation requirements based on the individual provider and associated clinic. Additionally, the VISN CIO (a physician) provided a recent Continuing Education Class to all providers on the necessity of proper and accurate documentation. There are also plans to have a VISN representative target Mental Health providers and the unique documentation requirement for that group.

**Recommendation 3.** We recommend that the VISN Director ensure that the Medical Center Director requires that:

a. Property barcode labels are affixed to all firearm lock boxes.
b. Responsible officials physically verify all equipment and correct incomplete or inaccurate information prior to signing EIL inventories and certifying equipment as accounted for.
c. Controls are strengthened to safeguard and account for sensitive IT equipment.
d. Controls are strengthened to account for property listed on the EILs as "out of service."
e. Controls are strengthened and prescribed procedures are followed covering disposal of excess property.

Concur **Target Completion Date:** Completed

(a) Barcode labels were affixed to all firearm lock boxes on February 17, 2006.

(b) EILs have been updated and all incomplete and inaccurate information was corrected prior to signature by responsible officials. Further follow up will be in March 2006, with the annual physical inventory.

(c) VA Directive 7125.1 dated April 5, 1996, Appendix A, lists the "Standardized EIL Department Numbers". EIL Number 78 is identified as Information Resource Management. Having the CIO responsible for the management and life cycle of all IT equipment is consistent with VA policy and is reinforced with the establishment of a separate appropriation in FY 2006 for all IT resources. All sensitive equipment will be physically located and accounted for and AEMS/MERS records updated so that they are accurate and complete during the annual inventory. This will be completed in March 2006.

(d) To strengthen controls, access to the database allowing equipment to be placed out of service will only be given to designated Acquisition personnel. Access to the database was restricted as of February 28, 2006.

Acquisition personnel will review all items listed as out of service on a quarterly basis to assure that they are accounted for.

(e) Excess property disposal procedures have been reviewed with appropriate staff and are now being done in compliance with regulations. Acquisition staff will monitor this quarterly to assure continued compliance. Staff were retrained about proper disposal processes for excess equipment in October 2005.

**Recommendation 4.** We recommend that the VISN Director ensure that the Medical Center Director requires cardholders to consider three sources of competition for purchases over $2,500 or document the justification for using a sole source vendor.

Concur **Target Completion Date:** Completed October 1, 2005, with ongoing monitoring.

To insure that three sources of competition are considered, Sensory & Physical Rehabilitation Service has begun quarterly random audits of all purchases over $2,500, beginning October 1, 2005. Random audits will continue to be done on a quarterly basis on all purchases over $2,500.

**Recommendation 5.** We recommend that the VISN Director ensure that the Medical Center Director takes action to:

a. Re-key all communication closets off the grand master key and limit access to only IRM employees with a legitimate need for access.
b. Assign control of the computer room emergency key to Police Service.
c Install motion detection and alarm systems in the computer room.
d. Maintain necessary documentation to provide assurance that all hard drives have been properly sanitized or destroyed prior to the disposition of computer equipment.
e. Ensure the two generic accounts allow access only to basic computer functions.

Concur **Target Completion Date:** Completed

(a) Locks changed to IRM keys on closets that are not shared-use. Two electricians have keys to closets that also have electrical panels. Locks were changed on September 30, 2005.

(b) Assignment and control of the computer room emergency key to the Police was accomplished at the time of the IG visit on September 30, 2005.

(c) The project to purchase security equipment will be re-submitted through the IT Tracking system to acquire approval and funding from VHA Central Office. Alternative funding will be sought locally if denied by IT Tracking, and will be resubmitted October 1, 2006, for next FY funding.

(d) All computers or hard drives are shipped out for sanitization and/or destruction via the National contract with Intelligent Decisions or with Dell. These shipments are tracked via spread sheets of scanned serial numbers accepted by both parties and a returned spreadsheet listing the final disposition of the hardware. This was accomplished after the site visit on July 25, 2005.

(e) Access to the two generic use computers has been modified by placing these computers into a "locked down" Organizational Unit in Active Directory. This will permit access to only the most basic of computer functions. This change was accomplished shortly after the site visit on June 12, 2005.

**Recommendation 6.** We recommend that the VISN Director ensure that the Medical Center Director requires that controlled substances inspectors conduct inspections in accordance with VHA policy.

Concur **Target Completion Date:** March 2006

The Medical Center will adhere to all aspects of VHA Handbook 1108.2, "Inspection of Controlled Substances." All inspectors will complete the Controlled Substance/Drug Diversion Inspection Certification Program for FY 2006. Completed on March 15, 2006.

Inspectors will review the audit trail of 10 drugs held for destruction each month, and will determine that Pharmacy Service had completed drug destructions quarterly. These components will be added to the monthly checklist. Completed on March 1, 2006.

Inspectors will select and verify hard copy prescriptions for a minimum of 10 percent or a maximum of 50 Schedule II drugs dispensed from the outpatient pharmacy. This task will be added to the monthly checklist. Completed on March 1, 2006.

Inspectors will review the monthly Prime Vendor Inventory Summary Report and Drug Receipt History Report, as required to ensure all controlled substances are received and placed into inventory. This task will be added to the monthly checklist. Completed on March 1, 2006.

**Recommendation 7.** We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) radiology studies performed at the medical center are accurately transcribed and reported and (b) processes are developed to monitor radiology studies performed by fee basis providers to ensure that they are completed and the results are timely reported to providers.

Concur **Target Completion Date:** Completed or as noted below.

(a) A transcriptionist was hired November 13, 2005, and currently works exclusively for radiology transcription 5 days per week, 3 hours per day. Monitors have been established to track turn around times.

Verification of radiology reports within 2 days is a national performance measure and is tracked nationally, at the VISN, and locally.

(b) Radiology will develop and implement a system to track all radiology studies performed by fee basis providers to ensure that they are completed as ordered and that reports are received and reported to providers timely. Target Date: May 1, 2006.

**Recommendation 8.** We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) all crash carts are inspected according to medical center policy; (b) patient care areas are cleaned and maintained, and sharp objects are secured; and (c) patient information is secured.

Concur **Target Completion Date:** Completed

(a) Medical Center Policy 006-01 "Medical Emergency Response and Review Team" outlines the procedures for checking the crash carts.

Additionally, nursing has initiated random monthly audits of crash carts and logs on the patient care units, beginning in February 2006. These will be submitted to the "Medical Emergency Response and Review Team" committee by the 10th of the following month.

Other areas with crash carts will also model the audit and begin monthly audits of their crash carts and logs and submit these to the Medical Emergency Committee by the 10th of the following month. Performance Management will conduct random audits on a quarterly basis. A verification of crash cart checks has been added to the scheduled weekly environmental rounds activity. Additionally, a check of crash carts has been added to the Patient Safety Officer's check list.

(b) All shower/bathing areas are on a routine cleaning schedule, based on the particular needs of the unit and the patient population. This is accomplished at least once per day, and in some cases, more often as the needs dictate. Patients on the ward in question have been relocated to a newly renovated unit. The vacated unit is now undergoing a renovation project (previously scheduled) and was started the first week of February 2006.

During the scheduled weekly environmental rounds activity, a review of sharps has been added as an activity. Sharps have also been added to the Patient Safety Officer's check list.

(c) As a part of their annual cyber security training, all staff are made aware of the need for locking down computer screens before they leave their respective work areas. Computer screens throughout the facility have been re-oriented and shielded as appropriate to the environment, such that patient data can not be viewed. Regularly scheduled "Privacy Rounds" are done by the Chief Information Officer, Information Security Officer and Compliance Officer to insure privacy is maintained. Completed January 24, 2006.

**Appendix D**

# Monetary Benefits in Accordance with IG Act Amendments

| Recommendation | Explanation of Benefit(s) | Better Use of Funds |
|---|---|---|
| 2a | Better use of funds by increasing MCCF revenues by identifying and processing all billable patient health care services. | $101,974 |

**Appendix E**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Philip D. McDonald 781-687-3140 |
| Acknowledgments | Annette Acosta<br>Maureen Barry<br>Stephen Bracci<br>Michael Cannata<br>John Cintolo<br>Nicholas Dahl<br>Mathew Kidd<br>Jeanne Martin<br>James McCarthy<br>Patricia McGauley<br>Amy Mosman<br>Katherine Owens<br>Steven Rosenthal<br>Jackie Stumbris<br>Joseph Vivolo<br>Hope Watt |

**Appendix F**

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Acting Director, Northampton VA Medical Center (631/00)

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