Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Tomah, Wisconsin

Report No. 06-00511-131 **April 17, 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 January 9–13, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Tomah, WI, which is part of Veterans Integrated Service Network (VISN) 12. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided 3 fraud and integrity awareness training sessions to approximately 60 medical center employees.

Results of Review

The CAP review covered 14 areas. The medical center complied with selected standards in the following six areas:

- Accounts Receivable
- All Employee Survey
- Breast Cancer Management
- General Post Funds
- Government Purchase Card Program
- Supply Inventory Management

Based on our review, the following organizational strength was identified:

- The Falls Prevention program reduced major injuries.

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

- Improve monitoring and timeliness of payments for construction and service contracts.
- Reduce Medical Care Collections Fund (MCCF) billing backlog.
- Improve the peer review process and invasive procedures reviews.
- Improve monitoring of diabetic patients' laboratory values.
- Strengthen controlled substances inspection procedures.
- Complete follow-up screenings of volunteer drivers.
- Improve Personal Funds of Patients (PFOP) controls.
- Correct environmental deficiencies.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Mark Collins, Audit Manager, Chicago Audit Operations Division.

VISN 12 and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in Tomah, WI, the medical center is a primary and long-term care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at community-based outpatient clinics in LaCrosse, Loyal, Wausau, and Wisconsin Rapids, WI. The medical center operates the Troop Medical Center at Fort McCoy and provides dental services to soldiers and airmen stationed in the area. The medical center is part of VISN 12 and serves a veteran population of about 62,000 in a primary service area that includes 14 counties in Wisconsin and 1 county in Minnesota.

Programs. The medical center's inpatient programs include acute medicine, acute and long-term psychiatry, vocational and social rehabilitation, psycho-geriatric, Alzheimer's assessment and management, residential substance abuse treatment, and post-traumatic stress disorder. Outpatient programs include the mental hygiene clinic, a community support program, and a variety of social and recreational activities supporting the local community residency homes.

Affiliations and Research. The medical center is not affiliated with a school of medicine, but has affiliations with Viterbo University, Western Wisconsin Technical College, University of Wisconsin-LaCrosse, Marquette University, and Winona State University for nursing, social work, psychology, and other programs.

Resources. The medical center has 26 acute care beds, 45 residential care beds, and 200 nursing home beds. In fiscal year (FY) 2005, the medical center's expenditures were $77.8 million. The budget for FY 2006 is $78.8 million. Staffing for FY 2005 was 711 full-time equivalent employees (FTE), including 30 physician FTE and 279 nursing FTE.

Workload. In FY 2005, the medical center treated 21,460 unique patients, a 4 percent increase from FY 2004. The FY 2005 average daily census was 10 inpatients, 35 residential care patients, and 174 nursing home patients. Outpatient workload in FY 2005 totaled 149,638 visits.

Objectives and Scope of the CAP Review

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

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

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

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

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 14 activities:

Accounts Receivable	General Post Funds
All Employee Survey	Government Purchase Card Program
Breast Cancer Management	Medical Care Collections Fund
Contract Administration	Patient Transportation Services
Controlled Substances Accountability	Personal Funds of Patients
Diabetes and Atypical Antipsychotic Medications	Quality Management Program
Environment of Care	Supply Inventory Management

The review covered facility operations from FYs 2001 to 2006 through December 2005 and was done in accordance with OIG standard operating procedures for CAP reviews.

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

During the review, we also presented 3 fraud and integrity awareness training sessions for approximately 60 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 5–11). 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.

Follow-Up to Previous CAP Review Recommendations and Suggestions. We followed up on six recommendations and two suggestions from our previous CAP review report of the medical center (*Combined Assessment Program Review of the VA Medical Center, Tomah, Wisconsin*, Report No. 03-02067-29, November 21, 2003). Medical center managers adequately addressed most of the recommendations and suggestions made in the prior CAP review report. However, we make two follow-up recommendations in this report related to MCCF and Patient Transportation Services.

Results of Review

Organizational Strength

Major Injuries Were Reduced Due to the Falls Prevention Program. The medical center's Falls Prevention program included the following interventions to help reduce serious fall-related injuries:

- Falls Prevention training provided for all clinical staff.
- Falls Prevention training provided for patients and family members as needed.
- Falls Risk Assessment Template completed on each patient.
- Falls checklist completed on each fall incident.
- Color-coded "Falls Precaution" bands placed on at-risk patients.
- Falling stars (star magnets) placed on doors of at-risk patients' rooms and at heads of beds.
- Falls Prevention strategies documented in at-risk patients' care plans.
- Monthly Pharmacy Service medication reviews completed for at-risk patients.
- Designated falls facilitator on each patient care unit.
- Monthly Falls Committee meetings to review falls and prevention strategies.
- Quarterly falls data displayed on each patient care unit.
- Falls Prevention poster in every patient room.

As a result of these interventions, the total patient falls decreased from 73 in the third quarter of FY 2005 to 48 in the fourth quarter of FY 2005. There were no major injuries resulting from the 121 falls.

Opportunities for Improvement

Contract Administration – Contract Administration Needed To Be Improved

Conditions Needing Improvement. VA contracting officers adequately documented contract objectives, competition requirements, price negotiations, and amendments in accordance with the Federal Acquisition Regulation. However, in reviewing two contracts, we found that an overpayment to one contractor was not fully recovered, and another contractor was not paid. Contracting Officer's Technical Representatives (COTRs) monitor contracts by verifying the performance of services and authorizing payments. To evaluate the effectiveness of the contracting activity, we reviewed contract administration documentation for 10 contracts valued at $3.1 million.

Inadequate Monitoring Resulted in Overpayment. A contract for architectural and engineering services required the contractor to perform 51 site visits at the negotiated price of $36,692. The contractor performed only 32 of the site visits at a cost of $17,463, resulting in an overpayment of $19,229. As a result of our review, the contracting officer amended the contract to provide for the actual number of site visits. Additionally, Fiscal Service issued a Bill of Collection for $13,241, representing the $19,229 overpayment, less $5,988 that had already been deducted from the payment of the vendor's final invoice. The amount of the overpayment was subsequently reduced to $12,134 as a result of funds owed the contractor.

Contractor Was Not Paid. The contract administration file of a dental fabrication services contract contained an unpaid invoice for $9,294 from October 2005. The COTR had inadvertently left the original invoice in the contract file and had taken no action. As a result of our review, Fiscal Service processed a payment to the vendor that included an interest penalty of $77 under the terms of the Prompt Payment Act.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director require COTRs to (a) improve monitoring of contract administration to prevent overpayments and (b) review invoices and approve payments timely.

The VISN and Medical Center Directors agreed with the findings and recommendations. The contractor has agreed to refund an overpayment of $12,134 for site visits not performed and a Bill of Collection will be issued. All invoices requiring certification will be sent to the VA Financial Services Center for payment and will be entered into the VA OnLine Invoice Certification System. The certifying employee will be notified by e-mail that they have an invoice to certify. Timely certification of invoices is included in COTR training and all COTRs have been reminded of this requirement. The implementation

plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Billing Backlog Still Needed To Be Reduced

Condition Needing Improvement. Our prior CAP review report for the medical center recommended that the VISN Director require the Medical Center Director to continue to reduce the backlog of unprocessed outpatient bills. The prior review showed that MCCF staff had 1,117 unbilled episodes of outpatient care valued at $247,520 as of June 30, 2003. During the first quarter of FY 2006, MCCF staff had 2,224 unbilled outpatient cases valued at $481,120. The prior report stated that during the third quarter of FY 2003 MCCF staff took an average of 59 days to initiate a bill, while current data showed that the average time had increased to 62 days during the first quarter of FY 2006. The Patient Financial Services Billing Manager for VISN 12 said that the outpatient billing backlog increased because a new coding software package was introduced during the first quarter of FY 2006, requiring coders to devote a week to training and mastering the new system.

Recommended Improvement Action 2. We recommended that the VISN Director take action to require the Medical Center Director to reduce the backlog of unprocessed outpatient bills.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the average number of days to bill has significantly decreased, and that coding productivity and billing have improved. The VISN has created a report to track coding validation workload that will be monitored weekly. The implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

Quality Management Program – Peer Review Process and Invasive Procedures Reviews Needed Improvement

Condition Needing Improvement. The QM program was generally effective and senior managers were supportive of and participated in QM initiatives. Appropriate review structures were in place for 12 of the 14 program areas reviewed.

Protected Peer Reviews. The Patient Safety Improvement Team (PSIT) reviewed all peer reviews monthly through May 2005. The PSIT was discontinued, and a new committee, the Clinical Administrative Review Team (CART), was established to fulfill the same purpose. However, there was a lapse of 3 months between the last meeting of the PSIT and the first meeting of the CART which began in September 2005. Eleven peer reviews remained open as of the May PSIT meeting; 5 were administratively closed in August. CART has not addressed the six remaining reviews during any of their meetings since it convened.

When peer reviews led to identification of situations that were correctable, actions were not always followed through. For example, one peer review found "recurrent system problems" to be a contributing factor. Although the specific system problems were not identified, corrective actions were proposed. There was no evidence to ensure that system problems had been resolved and that the situation would not reoccur.

Veterans Health Administration (VHA) policy requires that employees who conduct peer reviews and committee members who evaluate peer reviews receive specialized training to perform these duties. This training was not accomplished.

Invasive Procedures Reviews. Although no surgeries are performed at the medical center, diagnostic and other invasive procedures are performed. QM managers did not collect, trend, or analyze invasive procedures data as required by VHA policy. Trending and analysis of this data could reveal potential problems and identify opportunities to improve patient care.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director require that: (a) CART members complete a review of the six peer reviews that remained open as of the May 2005 PSIT meeting; (b) criteria are established to evaluate effectiveness of actions and ensure conditions that lead to peer reviews are corrected; (c) CART members and designated employees who will conduct peer reviews receive the required training; and (d) QM managers collect, trend, and analyze invasive procedures data.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that CART members have completed a review of the six open peer review cases. Criteria have been established to evaluate peer reviews. Review findings will be documented and tracked until they are resolved. Staff have received peer review training. Invasive procedures data will be tracked and trended. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Diabetes and Atypical Antipsychotic Medications – Monitoring of Diabetic Patients' Laboratory Values Needed Improvement

Condition Needing Improvement. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for developing diabetes). Studies show that patients who take atypical antipsychotic medications are more at risk to develop diabetes than those on conventional antipsychotic medications. Clinicians needed to improve laboratory monitoring for mental health patients with diabetes.

VHA clinical practice guidelines for the management of diabetes suggest that diabetic patients' hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury; and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter.

We reviewed a sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days. Three of the 13 patients had diabetes. Our review showed that the medical center did not meet VHA clinical practice guidelines for management of diabetes through monitoring of HbA1c and LDL-C levels for one of the three diabetic patients. This patient was seen in the Primary Care Clinic in January 2004, and the clinician ordered laboratory testing. Records show that the test sample was not suitable for analysis, yet there was no follow-up testing to further monitor the patient's laboratory values even though the patient had multiple return appointments in the Mental Health Clinic during 2004 and 2005. Clinicians contacted the patient by telephone during our review, and were informed that a private physician in the community was monitoring the patient's diabetes.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director require clinicians to closely monitor laboratory values of diabetic patients who take atypical antipsychotic medications.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the Chief of Staff has established a clinical reminder in the Computerized Patient Record System to identify diabetic patients who are taking atypical antipsychotic medications, and clinicians have been informed of the need to monitor patients on these medications for diabetes. An auditing process has been implemented to ensure follow-up of critical laboratory results. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Inspection Controls Needed To Be Strengthened

Condition Needing Improvement. Pharmacy Service staff conducted 72-hour inventories and biennial inventories. Narcotics inspectors were appropriately rotated for the monthly narcotic inspections, inspectors received training, and training was documented. However, inspection procedures needed strengthening.

VHA and medical center policies require inspectors to conduct physical counts and examine stock for outdated items during the controlled substances inspections. During the OIG-observed inspection of the inpatient pharmacy vault, the inspectors did not check the expiration dates of controlled substances or remove individual packages of pills from plastic bags to ensure that a pill was in each pocket when verifying the counts. The

pharmacy technician agreed that expiration dates should be checked and the counts of individual packages verified but stated that, due to time constraints, this was not done.

Also, during the inspection of the outpatient pharmacy vault the inspector did not count pills in eight unsealed bottles. The pharmacy technician stated that these bottles were filled from bulk stock with 100 pills for each bottle. During the inspection each bottle was assumed to contain 100 pills without actually verifying the count.

Although we found no evidence of missing drugs, inspection controls should be strengthened to include checking expiration dates, inspecting individual packages, and counting pills in unsealed bottles.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director require inspectors to check stock for outdated items and to verify counts of individual packages and unsealed bottles for each controlled substance.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the Controlled Substances Coordinator (CSC) instructed all controlled substances inspectors to review each pill packet, check expiration dates on pill packages, and count each pill in unsealed bottles. The CSC is training inspectors on the new procedures and will develop a written guideline and checklist that incorporates all requirements. Unsealed bottles have been removed from the pharmacy. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Patient Transportation Services – Follow-Up Screenings of Volunteer Drivers Needed To Be Completed

Condition Needing Improvement. Volunteer driver screening was accomplished during the volunteer's initial orientation and included verification of driver's license, proof of personal insurance, and review of the individual's driving record. Occupational health practitioners provided initial volunteer health examinations. However, the Voluntary Service manager did not have a system in place to conduct follow-up screenings of volunteer drivers. VHA policy requires repeat screenings of valid licensure, insurance, and driving records at least every 4 years. Health examinations are required every 4 years or more frequently based on prior examination findings.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director require that follow-up volunteer driver screenings are conducted as required.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that volunteer drivers will be made aware of the requirement for recurring

physical examinations. Voluntary Service will conduct an annual review of volunteers for valid drivers' licenses, automobile insurance, and good driving records. Volunteers will receive safe driving education and will be scheduled for physical examinations through VA Employee Health at least every 4 years. Volunteer drivers will be required to sign an agreement in which they agree to notify Voluntary Service of a change in their health, issuance of moving violations, or involvement in any accidents. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Personal Funds of Patients – Controls Needed To Be Improved

Conditions Needing Improvement. PFOP accounts were generally well-maintained, but some improvements were needed. End-of-month reconciliations of PFOP accounts were not sent to the Medical Center Director, signature cards were not maintained, and Patient Administrative Service staff did not send the correct forms to claimants of the personal funds of deceased patients.

End-of-Month Reconciliations Needed To Be Sent To the Director. VA policy requires that end-of-month reconciliations of PFOP accounts be performed with the Fiscal Officer signing the reconciliation statements and routing them to the Medical Center Director. The Director, as trustee for incompetent accountholders, may need to act on information provided in these reconciliations. The Assistant Fiscal Officer did not route the end-of-month reconciliations to the Director because she was unaware of the requirement.

Signature Cards Were Needed for Accountholders. VA policy requires that signature cards be maintained for PFOP accountholders to ensure identification whenever transactions take place. When the medical center converted to electronic maintenance of PFOP account records, it disposed of the hard copy ledgers that contained the accountholders' signatures, but did not replace these documents with signature cards. Currently, the PFOP clerk identifies patients by looking at the names on their wristbands. The use of signature cards would reduce the risk of erroneous payments.

Correct Form Needed To Be Sent To Claimants. VA policy requires that upon the death of a veteran having funds in a PFOP account, the person designated by the veteran be notified by the "Notice to Person Designated by Veteran Regarding Personal Effects" (VA Form 10-1171). Our review of 15 dispositions totaling $4,245 from calendar year 2005 showed that the medical center sent a standard Government form, "Claim Against the United States for Amounts Due in the Case of a Deceased Creditor" (SF 1055), to next-of-kin or estates of deceased veterans having funds on deposit in PFOP accounts. In 12 dispositions the details section clerk should have sent VA Form 10-1171 because the claimants were next-of-kin designated by the veterans' admission applications. VA Form 10-1171 requires only the signature and address of the claimant, while the SF 1055 requires the claimant to obtain the signature of two witnesses. A former supervisor had erroneously established the practice of sending SF 1055. Use of the VA Form 10-1171

expedites processing of payments; lessens the compliance burden for designated beneficiaries; and provides details of legal rights, obligations, and time limits for making claims.

Recommended Improvement Actions 7. We recommended that the VISN Director ensure that the Medical Center Director require: (a) the Assistant Fiscal Officer to send end-of-month PFOP reconciliation statements to the Medical Center Director, (b) signature cards for PFOP accountholders, and (c) VA Form 10-1171 to be sent to the persons designated by the veterans to receive possession of personal property after the veterans' deaths.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that sending end-of-month PFOP reconciliation statements to the Medical Center Director, using signature cards, and sending VA Form 10-1171 to deceased veterans' next-of-kin have been implemented. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. VA policy requires that the medical center be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected a sample of occupied and made-ready patient rooms and their restrooms (private and communal). We found that the medical center was clean and effectively maintained. However, we identified two conditions that required management attention.

Emergency Call System Cords. A cord in a patient restroom was too long, with an extra foot of cord on the floor near the commode. This created an infection control concern. Cords in two patient showers were too short and were inaccessible to a person from floor level.

Privacy Curtains. Stained privacy curtains were noted in two patient rooms and needed to be cleaned or replaced. Managers stated that a project was currently underway to replace many of the privacy curtains in patient care areas.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director require that environmental deficiencies are corrected.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported two stained privacy curtains and three emergency call system cords of improper length have been replaced. Standard operating procedures have been revised to include daily checking and quarterly cleaning of all privacy curtains. Facilities Zone Engineers will routinely review all patient bathroom emergency call system cords for

proper length and take corrective actions. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Other Observations

All Employee Survey — Data Utilized To Improve Employee Satisfaction and Acknowledge Medical Center Strengths

The Executive Career Field Performance Plan for FY 2005 directs that the VISN will ensure results from the 2004 All Employee Survey (AES) are widely disseminated throughout the network by, at a minimum, conducting a town hall meeting open to all employees at each facility during the rating period. VISNs were to perform an analysis of the 2004 AES results, with formulation of action plans to address items for improvements, completed by September 30, 2004. Plans must demonstrate milestones that include timelines and measures that assess achievement.

The 2004 AES yielded a 68 percent employee response. The medical center met the requirement of disseminating the AES information to staff through town hall meetings, electronic messages, and information posted in the medical center's *Weekly Highlights*. Managers completed a detailed analysis of the survey results, identified areas for improvement, and formulated appropriate action plans.

Breast Cancer Management — Processes Were Timely and Appropriate

The VHA breast cancer screening performance measure assesses the percentage of patients screened according to prescribed timeframes. The medical center exceeded the fully satisfactory level for all 4 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in one patient diagnosed with breast cancer during FY 2004.

Timely radiology, surgery, and oncology consultative and treatment services were offered to the patient through a fee-basis provider. An interdisciplinary treatment plan was developed, and providers promptly informed the patient of diagnosis and treatment options.

Appendix A

VISN 12 Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2006

From: VISN 12 Director (10N12)

Subject: Combined Assessment Program Review of the VA Medical Center Tomah, Wisconsin

To: Director, Chicago Regional Office Audit Operations Division

Attached please find the Combined Assessment Program Review response from VAMC Tomah. If anything additional is needed, please contact my office at (708)202-8400. Thank you.

James W. Roseborough

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2006

From: Medical Center Director (676)

Subject: Combined Assessment Program Review of the VA Medical Center Tomah, Wisconsin

To: VISN 12 Director (10N12)

Attached please find the Combined Assessment Program review from VAMC Tomah. If additional information is needed, please contact my office at (608)372-1777. Thank you.

Stan Johnson

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

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires COTRs to:

(a) Improve monitoring of contract administration to prevent overpayments.

Concur **Target Completion Date:** May 31, 2006

ACTION PLAN: The A-E contractor has agreed to refund an overpayment of $12,133.89 for site visits that were not performed under the contract identified. The actual decrease for the site visits not made was $19,229.00. The VA still owed the contractor $7,095.11 under the contract. The difference is $12,133.89. A Bill of Collection for the refund will be issued to the contractor by March 31, 2006.

(b) Review invoices and approve payments timely.

Concur **Target Completion Date:** May 31, 2006

ACTION PLAN: Effective March 8, 2006, all invoices requiring certification, regardless of dollar value, are sent directly to the VA Financial Services Center for payment and are put in the VA OnLine Invoice Certification System. The certifying employee receives an e-mail message indicating they have an invoice in the system to certify. Timely certification of invoices is included in COTR training and during training for the on-line certification system. An electronic mail message has also been sent to all COTRs to remind them of this requirement.

Timely certification of the invoices in the OnLine Invoice Certification System is now monitored by the facility Fiscal Service accounting department.

This requirement will be emphasized during training for all new COTRs and certifying officials, as well as in COTR refresher training. Monitoring by the accounting department for timeliness of invoice certification will continue to be ongoing.

Recommended Improvement Action 2. We recommend that the VISN Director take action to require the Medical Center Director to reduce the backlog of unprocessed outpatient bills.

Concur **Target Completion Date:** Request Closure

Action Plan: As noted during the review the coding validation process was negatively impacted by the introduction of the Quadramed Coding and Compliance Module (CCM). Coding staff experienced a drastic reduction in productivity during this first quarter due to the learning curve. Currently at Tomah, the average number of days to bill from date of service to date bill dropped is 41 days (POWER website - January data). There is now no backlog in outpatient coding validation. The Coding staff is working on validating current outpatient encounters after February 8th. The VISN has created a report to track coding validation workload and will monitor weekly. There is a noted increase in coding productivity and billing is sufficient to support achieving the FY06 MCCF collections. Tomah collections through February 2006 are $2,465,783 or 41% of the annual goal of $5,978,684.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) CART members complete a review of the six peer reviews that remained open as of the May 2005 PSIT meeting.

Concur **Target Completion Date:** March 24, 2006

ACTION PLAN: CART members completed the review of six open cases from the May 2005 meeting and all are closed as of March 24, 2006.

(b) Criteria are established to evaluate effectiveness of actions and ensure conditions that lead to peer reviews are corrected.

Concur **Target Completion Date:** April 30, 2006

ACTION PLAN: Criteria have been established to evaluate the effectiveness of the peer review. Any system opportunities for improvement identified during a peer review will be documented in the CART minutes and issues will be forwarded to Medical Staff Executive Committee and tracked as an action item until resolved. This process will be added to the Medical Center Memorandum on Protected Peer Review by April 15, 2006.

(c) Members of CART and designated employees who will conduct peer reviews receive the required training.

Concur **Target Completion Date:** March 1, 2006

ACTION PLAN: Members of the CART and staff conducting peer reviews have been trained on the Medical Center Memorandum and the Peer Review process as of March 1, 2006.

(d) QM managers collect, trend, and analyze invasive procedures data.

Concur **Target Completion Date:** April 30, 2006

ACTION PLAN: Data will be tracked and trended on invasive procedures and reported to the Performance Improvement Council. The semi-annual report will be presented at the April 25, 2006 meeting.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires clinicians to closely monitor laboratory values of diabetic patients who take atypical antipsychotic medications.

Concur **Target Completion Date:** March 31, 2006

ACTION PLAN: The Chief of Staff (COS) has established a clinical reminder in the Computerized Patient Record System (CPRS) to identify patients who are diabetic and on atypical antipsychotic medications without a fasting glucose or Hgb A1c in the previous 180 days. Fulfilling the reminder will require ordering the appropriate laboratory study.

Education has been provided during the COS Professional Services meeting to indicate the need to monitor for Diabetes Mellitus in patients who are on atypical antipsychotic medications.

An auditing process has been put in place to ensure follow-up of critical lab results. View alerts in the CPRS inform providers of non-critical lab results.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires inspectors to check stock for outdated items and to verify counts of individual packages and unsealed bottles for each controlled substance.

Concur **Target Completion Date:** April 30, 2006

It should be noted that no outdated medications were found during this review and a process was in place to check for outdates. Expiration dates were being checked but not in the method that the auditor expected.

While it was recommended that the Pharmacy needs to take the action on the Controlled Substances Accountability issue, we believe the improvement action needs to be taken by the Controlled Substances Coordinator.

ACTION PLAN: The Controlled Substances Coordinator sent an educational e-mail to all controlled substance auditors with detailed information, indicating the need to:

(a) Review each individually packed pill packet

(b) Check the expiration date on pill packages

(c) Check for unsealed bottles and count each pill in an unsealed bottle.

The Controlled Substances Coordinator now monitors the auditors on portions of the audit to demonstrate and educate on the above instructions. The February and March auditors have been trained on this process. April auditors will be trained.

The Controlled Substances Coordinator is developing a written guideline and checklist for inspectors to use during the monthly inspection process that incorporates all the requirements identified above.

The bottles identified by the IG auditor have been removed from the pharmacy.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires that follow-up volunteer driver screenings are conducted as required.

Concur **Target Completion Date:** April 30, 2006

ACTION PLAN: Volunteers will be made aware of the requirement for recurring physical examinations through a mailing in April 2006. Volunteers will be asked to sign a form stating they have read the requirements and agree to follow them. As new volunteer drivers enroll in the Veterans Affairs Voluntary Services (VAVS) program, they will be asked to sign the same form.

On an annual basis (during the month of May), VAVS will conduct review of the following:

(a) Current and valid driver's license (obtained from volunteer driver)

(b) Current automobile insurance (obtained from volunteer driver)

(c) Driving record (obtained from Wisconsin Court Access System)

(d) Safe driving education (mailing will be sent to all drivers and drivers will be asked to review the material and return form verifying they have read and understood the material).

Every four years, volunteer drivers will be scheduled for a physical through VA Employee Health. If the Employee Health provider determines an individual volunteer needs more frequent screening, examinations will be scheduled accordingly. VAVS will provide Employee health with a list of volunteers to be scheduled for physicals; the list will be generated based on the volunteer's last physical date. VAVS will maintain a spreadsheet listing when individuals became volunteers, had their first screening, and when their next physical is due.

Volunteer drivers will be asked to sign a "self-reporting" agreement, whereby they agree to notify the VAVS if their health status changes, if they are issued any moving violations, or if they are involved in any accidents.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires:

(a) The Assistant Fiscal Officer to send end-of the month PFOP reconciliation statements to the Medical Center Director.

Concur **Target Completion Date:** January 30, 2006

ACTION PLAN: As of October 2005, Tomah VAMC is compliant with routing end-of-month reconciliation statements of Personal Funds of Patients which have been signed by the Fiscal Officer to the facility Director, per VHA Handbook 1730.2 requirements.

(b) Signature cards for PFOP accountholders.

Concur **Target Completion Date:** January 30, 2006

ACTION PLAN: Signature cards were developed locally for use. Current inpatients were contacted to obtain their signature on a card. The cards are maintained in the Patient Funds Clerk office for inpatients. The cards have also been

placed in the Admission packet to obtain patient signatures upon admission.

(c) VA Form 10-1171 to be sent to the persons designated by the veterans to receive possession of property after the veterans' deaths.

Concur **Target Completion Date:** January 30, 2006

ACTION PLAN: Proper form is more convenient for claimants. VA Form (VAF) 10-1171 is now being utilized, versus Standard Form (SF) 1055, when the claimant is next of kin and has been designated by the veteran's admission application. SF 1055 is being used only when required.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires that environmental deficiencies are corrected.

Concur **Target Completion Date:** March 14, 2006

ACTION PLAN: We have addressed the issues identified, however, it should be noted that we were told throughout the review that the facility was exceptionally clean and well maintained.

(a) The two stained privacy curtains in question were replaced prior to the IG leaving. A 100% review of our privacy curtains was conducted. It showed the two curtains in question represented 1% of the total number of curtains.

Staff education was completed at the March 14, 2006 Facilities Service staff meeting. Standard Operating Procedure #22 has been revised to include the daily checking of privacy curtains and at least quarterly cleaning of all privacy curtains. Purchase order 676-GT6006 has been placed to replace all privacy curtains in building 406.

(b) There were concerns with the length of three emergency call system cords in patient bathrooms. These 3 call system cords were out of 52 call system cords reviewed or 6%. Staff education was completed at our March 14, 2006 Facilities Service all-employee meeting. Facilities Zone Engineers have

been tasked to routinely review all patient bathroom emergency call system cords for proper length and to make corrective actions when necessary.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Improved contract administration could avoid overpayments and interest penalties.	$12,211

Appendix D

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Appendix E

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