Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Birmingham, Alabama

Report No. 05-02925-144 **May 15, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Executive Summary

Introduction

During the week of September 19–23, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Birmingham, AL. 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 258 employees. The medical center is part of Veterans Integrated Service Network (VISN) 7.

Results of Review

This CAP review focused on 14 operational activities. The medical center complied with selected standards in the following five activities:

- Accounts Payable
- Accounts Receivable
- Employee Survey
- Laboratory and Radiology Services
- Timekeeping for Part-Time Physicians

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

- Improve the environment of care (EOC) by correcting environmental deficiencies.
- Strengthen supply inventory management by reducing stock levels.
- Increase Medical Care Collections Fund (MCCF) collections by strengthening fee-basis billing procedures and improving the documentation of medical care and resident supervision.
- Strengthen controls over controlled substances by ensuring that suspicious losses are reported immediately and all required information is included on prescriptions.
- Enhance colorectal cancer (CRC) screening and the timeliness of gastrointestinal evaluations.
- Improve QM by documenting resident supervision, properly completing informed consent forms, performing timely peer reviews, and trending mortality data by individual provider.
- Strengthen controls over the Government purchase card program.
- Determine position risk levels and ensure that appropriate background investigations are completed for clinical and law enforcement personnel.

- Improve information technology (IT) security by ensuring that background investigations are completed for Information Resources Management (IRM) personnel, promptly terminating system access for separated employees, and updating the contingency plan.

This report was prepared under the direction of Mr. Michael E. Guier, Director, and Mr. Jehri Lawson, CAP Review Coordinator, Dallas Audit Operations Division.

VISN 7 and Medical Center Director Comments

The VISN 7 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 16–26 for the full text of the Directors' comments.) We will follow up on the implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. The medical center is an acute tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is provided at six community-based outpatient clinics located in Anniston, Decatur, Florence, Gadsden, Huntsville, and Jasper, AL. The medical center is part of VISN 7 and serves a veteran population of about 200,000 residing in 23 counties in Alabama.

Programs. The medical center has 114 operating beds and provides primary and tertiary care in the areas of dentistry, geriatrics, medicine, neurology, oncology, palliative care, physical medicine and rehabilitation, and surgery.

Affiliations and Research. The medical center is affiliated with the University of Alabama Medical School and supports 115.87 resident positions. It also has affiliations with numerous other institutions including Auburn University, Troy University, the University of South Alabama, the University of Southern Mississippi, the University of Tennessee, and Vanderbilt University.

In fiscal year (FY) 2005, the medical center had 39 research projects and a research budget of about $5.3 million. Important areas of research included cardiovascular diseases, infectious diseases, neurology, and oncology.

Resources. The medical center's medical care expenditures totaled $176 million in FY 2004. The FY 2005 medical care budget was $184 million. In FY 2004, the medical center had 1,296.3 full-time equivalent employees (FTE), which included 101.4 physician FTE and 321.2 nursing FTE.

Workload. The medical center treated 46,319 unique patients in FY 2004. The inpatient workload in FY 2004 totaled 4,943 discharges, and the average daily census was 91. The outpatient workload totaled 371,435 visits in FY 2004.

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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FY 2004 and FY 2005 through September 23, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Accounts Payable	Government Purchase Card Program
Accounts Receivable	Information Technology Security
Background Investigations	Laboratory and Radiology Services
Colorectal Cancer Management	Medical Care Collections Fund
Controlled Substances	Quality Management
Employee Survey	Supply Inventory Management
Environment of Care	Timekeeping for Part-Time Physicians

As part of the review, we interviewed 33 patients to survey patient satisfaction with the timeliness of service and the quality of care. The results were shared with medical center managers.

We also presented three fraud and integrity awareness training sessions. A total of 258 employees attended the training, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

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

Follow-Up on Prior CAP Review Recommendations

As part of this review, we also followed up on the recommendations resulting from our prior CAP review of the medical center (*Combined Assessment Program Review of the*

VA Medical Center Birmingham, Alabama, Report No. 02-01432-39, December 24, 2002). During this CAP review, we determined that the medical center continues to need improvement in the areas of supply inventory management, controlled substances, QM, the Government purchase card program, and IT security.

Results of Review

Opportunities for Improvement

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We inspected all patient care areas and found three areas that required management attention.

Operating Room Air Conditioning. Joint Commission on Accreditation of Healthcare Organizations EOC standards require periodic testing of air filtration, exchange, and pressurization for heating, ventilation, and air conditioning (HVAC) systems in hospital operating rooms. HVAC testing is a critical component of effective infection control and patient safety in operating rooms. The medical center's last HVAC system test certification was completed in January 2001. The medical center did not conduct any internal tests of the HVAC system operation and pressurization since that time.

Outstanding Work Orders. Of 354 work orders relating to EOC problems identified by the medical center's Environmental Safety Committee more than 6 months prior to July 2005, 266 (75 percent) were still open. The medical center's EOC policy required environmental tours every 6 months to identify environmental deficiencies, hazards, and unsafe practices. The medical center's Environmental Safety Committee is responsible for monitoring and resolving EOC issues arising from the environmental tours. However, we found that the medical center had not developed a plan for reviewing and completing the outstanding work orders from previous environmental tours.

Fire Safety. Fire safety codes require that materials be stored no closer than 18 inches from the ceiling to allow water sprinklers to operate effectively. However, medical center staff stored boxes to the ceiling of clean/sterile storage room 6310, as shown by the photograph on the following page.

Clean/Sterile Storage Room 6310

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director requires that: (a) HVAC systems be scheduled for periodic testing, (b) outstanding work orders related to EOC problems be reviewed and completed timely, and (c) items be stored (regardless of the designation of the room) no higher than 18 inches from the ceiling.

The VISN and Medical Center Directors agreed with the finding and recommendations. They reported that the HVAC systems will be tested at the completion of a renovation project and local policy will be revised to ensure that the HVAC systems are tested periodically. Completion of work orders resulting from environmental tours will be tracked, and the target completion time for routine maintenance work orders will be within 30 calendar days after being reported. In addition, the medical center removed the items that were stored within 18 inches of the ceiling. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Stock Levels Needed To Be Reduced

Condition Needing Improvement. The medical center needed to reduce stock levels of supplies. Veterans Health Administration (VHA) policy requires that medical facilities use the automated Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, the medical center's supply inventory included 1,493 line items valued at $419,787.

To assess the accuracy of GIP and PIP data, we inventoried 80 line items with a combined recorded value of $94,477 and found that the stock levels recorded in GIP and PIP were accurate. We also compared the quantities on hand to usage data for the 80 line items that we inventoried to determine if stock levels could be reduced while still meeting the medical center's needs. Our review showed that the medical center needed to reduce stock levels for 39 (49 percent) of the 80 line items. The value of the excess stock was

$28,581, which was 30 percent of the total value ($94,477) of the 80 items we inventoried. Overstocking ties up money in stock and increases the risk of damage, outdating, contamination, or obsolescence of inventory items.

Recommendation 2. We recommended that the VISN Director ensure the Medical Center Director takes action to reduce stock levels to the minimum needed to meet the medical center's needs.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that stock levels were reviewed and were set at the minimum levels needed to meet the medical center's needs. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Medical Care Collections Fund – Fee-Basis Billing Procedures and Clinical Documentation Could Be Improved

Condition Needing Improvement. The medical center could increase MCCF collections by strengthening billing procedures for fee-basis care and improving documentation of medical care and resident supervision. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the medical center collected $14.6 million, which exceeded its collection goal of $14.2 million. The medical center collected $16.3 million during FY 2005 (through September 22, 2005), which exceeded its FY 2005 collection goal of $16.2 million. However, we identified two areas where the medical center could further increase MCCF collections.

Fee-Basis Billings. From October through December 2004, the medical center paid 2,812 fee-basis claims totaling $330,129 to non-VA clinicians for the care of veterans with health insurance. To determine if the medical center had billed the insurance carriers for this care, we reviewed a random sample of 19 fee-basis claims totaling $35,642. Ten of the claims were not billable to the insurance carriers because the fee-basis care was for service-connected conditions, the veterans did not have insurance coverage on the dates of care, or the care provided was not billable under the terms of the insurance plans. The medical center appropriately issued bills to the insurance carriers for three of the fee-basis claims. However, the remaining six fee-basis claims totaling $34,868 should have also been billed.

Medical Record Documentation. Medical care providers needed to improve the documentation of care. VHA policy requires medical care providers to enter documentation into medical records at the time of each encounter so that MCCF employees can bill health insurance carriers for the care provided. The policy also requires that medical records clearly demonstrate attending physicians' supervision of residents in each resident-patient encounter. The "Reasons Not Billable Report" for the 3-month period ending December 31, 2004, listed 188 potentially billable cases totaling

$13,652 that were not billed for 1 of 3 reasons—insufficient documentation, no documentation, or non-billable provider (care provided by a resident physician). We reviewed a random sample of 50 potentially billable cases and found 43 (86 percent) missed billing opportunities totaling $8,436 (an average of $196.19 per missed billing opportunity) that could have been billed if medical documentation had been complete. For example, MCCF personnel did not issue bills for 35 of the missed billing opportunities because attending physicians' supervision of residents was not adequately documented in the veterans' medical records. Based on our sample results, we estimated that 162 (188 potentially billable cases x 86 percent) additional bills totaling $31,783 (162 estimated billable cases x $196.19) could have been issued.

Potential Collections. Improved billing procedures for fee-basis care and better clinical documentation would enhance revenue collections. We estimated that additional billings totaling $66,651 ($34,868 + $31,783) could have been issued. Based on the medical center's FY 2004 collection rate of 23 percent, MCCF employees could have increased collections by $15,330 ($66,651 x 23 percent). As a result of our review, MCCF employees issued 15 bills totaling $24,064 and were working to issue additional bills for the remaining missed billing opportunities.

Recommendation 3. We recommended that the VISN Director ensure the Medical Center Director requires that (a) all billable fee-basis care be identified and billed and (b) medical care providers adequately document resident supervision and the care provided in veterans' medical records.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that a software program has been developed to enable management to track billable fee-basis care and to prevent missed billing opportunities. Procedures have been implemented to ensure medical care providers adequately document resident supervision and the care provided, and the medical center is recruiting a medical records administrative specialist to monitor resident supervision. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Controlled Substances – Discrepancies Needed To Be Reported and Prescriptions Needed To Be Properly Completed

Condition Needing Improvement. The medical center maintained a perpetual inventory of all of its controlled substances, ensured that controlled substances inspectors were properly trained, and conducted an effective controlled substances inspection program. However, we identified two areas that required management attention.

Discrepancy Reporting. VA policy requires medical facilities to immediately report suspected thefts, diversions, or other suspicious losses of controlled substances to the VA Police and the OIG. In addition, for each suspicious loss, medical facilities must submit a "Report of Theft or Loss of Controlled Substances" to the Drug Enforcement

Administration (DEA) using DEA Form 106. However, our review showed that the medical center did not immediately report suspicious losses of controlled substances to the VA Police, OIG, and DEA. For example, the medical center submitted 31 DEA Forms 106 to the VA Police on April 22, 2004, to report losses dating back to November 2003. All of the forms were dated April 20, 2004. The OIG and DEA were not notified of the losses until the VA Police forwarded copies of the forms to them.

Prescriptions for Controlled Substances. VHA policy requires that prescribing physicians include the patient's full name and address as well as the prescribing physician's name, address, and DEA registration number on all prescriptions for controlled substances. We reviewed 10 prescriptions for controlled substances dispensed to outpatients and found that all 10 prescriptions were missing the patients' and prescribing physicians' addresses.

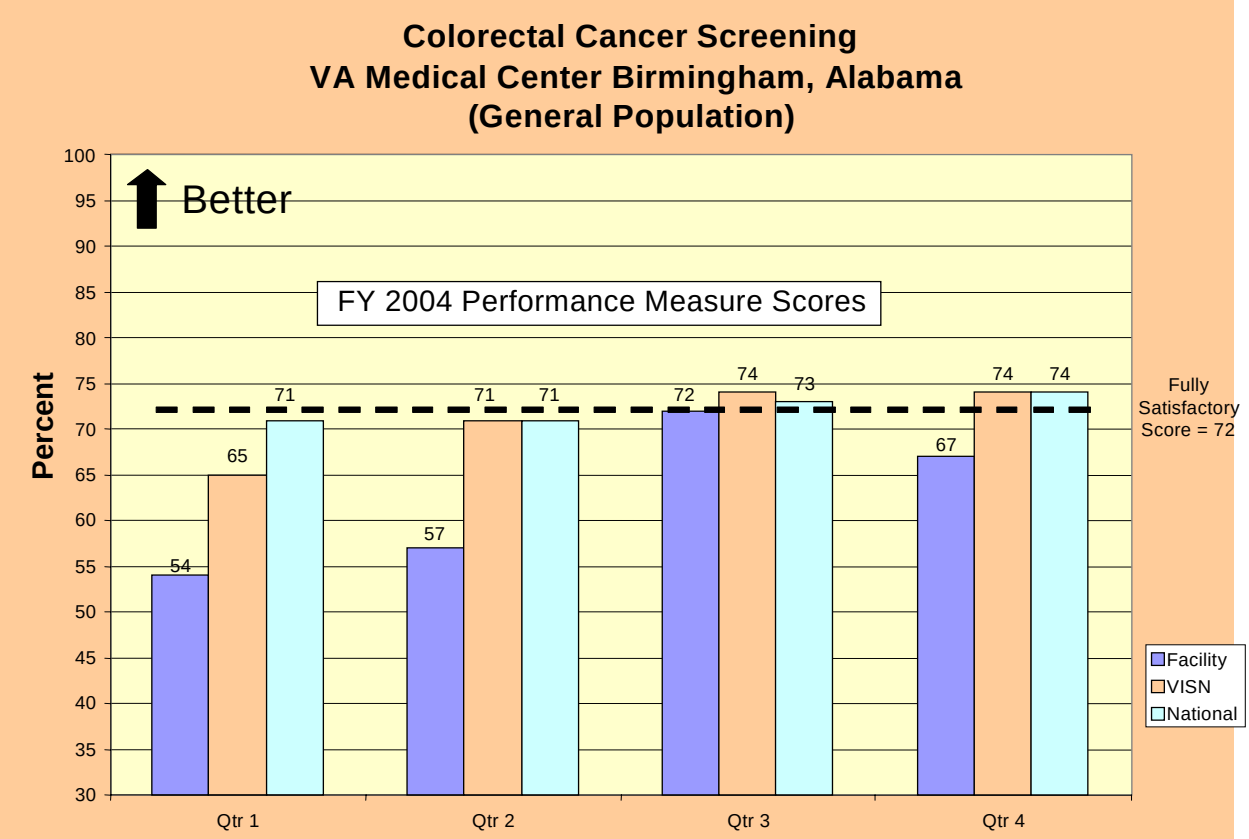
Recommendation 4. We recommended the VISN Director ensure the Medical Center Director requires that (a) suspected thefts, diversions, or suspicious losses of controlled substances be reported immediately to the VA Police, OIG, and DEA and (b) prescribing physicians complete all required prescription information.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that the medical center's local policy now includes procedures for reporting suspicious losses of controlled substances. Prescribing physicians have received additional training on proper prescription procedures, and compliance with requirements is being tracked. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Colorectal Cancer Management – Timeliness of Colorectal Cancer Diagnosis Needed To Be Improved

Condition Needing Improvement. Clinicians needed to improve the timeliness of CRC diagnosis by improving screening procedures for CRC and reducing the time from gastrointestinal (GI) evaluation referrals to patient evaluations.

The VHA CRC screening performance measure assesses the percent of patients screened according to prescribed timeframes. The table on the following page shows the medical center's CRC screening performance for FY 2004.



The medical center's CRC screening mean performance measure score for FY 2004 was 63 percent compared to mean scores of 71 and 72 for VISN and national levels, respectively.

Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal outcomes. We reviewed a random sample of 10 of the 29 patients diagnosed with CRC at the medical center in FY 2004 and found that 5 of the 10 patients had not been screened for CRC. Two of the five patients transferred from other medical facilities and should have been screened at those medical facilities. The remaining three patients were not appropriately screened for CRC by the medical center. The medical center was in the process of developing a hemoccult clinic to follow up on pending fecal occult blood tests and to remind veterans of annual CRC screenings. This clinic should increase the number of patients screened for CRC.

Of the nine patients in our sample who were referred for GI evaluations, five were not diagnosed within 30 days as required by the medical center's policy. GI evaluations were backlogged because primary care clinic personnel made inappropriate referrals, such as duplicate referrals for the same patient and referrals that did not warrant GI evaluations. In order to reduce evaluation delays and duplications, the medical center implemented a task group in FY 2005 to screen evaluation referrals for appropriateness. This resulted in

a decrease in evaluations from 2,056 in FY 2003 to 1,942 in FY 2004. The medical center also initiated Saturday clinics in FY 2004 to help physicians complete the required evaluations within the 30-day timeframe.

Recommendation 5. We recommended that the VISN Director ensure the Medical Center Director requires that patients receive (a) appropriate CRC screening and (b) timely GI evaluations.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that the medical center has implemented several improvement efforts that raised its CRC screening score to 80 percent in FY 2005. The medical center has also implemented procedures to improve timeliness of GI evaluations and hired a case manager to track all cancer cases to ensure timely intervention. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Quality Management – Resident Supervision, Informed Consent, Surgical Peer Review, and Mortality Analysis Needed Improvement

Condition Needing Improvement. The QM program was comprehensive and generally effective. However, we found four areas that required strengthening.

Resident Supervision. VHA policy requires appropriate entries in progress notes to document resident supervision. The medical center's "Surgical Service Report for FY 2005" showed 65 percent compliance with the requirements for documenting resident supervision. We reviewed a random sample of 30 patient records for the period October 2004 through July 2005 and found that 27 (90 percent) did not have the required attending physician documentation in the resident progress notes.

Informed Consent. VHA policy requires that patient consent forms be completed before clinical staff proceed with surgical procedures. The completed consent forms should include the surgeon's signature, date and time, and a description of the procedure to be performed. Of 1,728 consent forms generated for surgical procedures in FY 2004, 241 (14 percent) were not signed by the physician, 270 (16 percent) were not dated, 844 (49 percent) did not show the time, and 151 (9 percent) did not include a description of the procedure.

Peer Reviews. VHA policy requires that all deaths associated with uncertain or unusual factors be peer reviewed within 45 days. Of the five cases we reviewed that were completed in FY 2005, two had timely peer reviews. Conversely, one case involved a surgical death that occurred on August 27, 2003, but the peer review was not completed until March 16, 2005. The remaining two cases were referred for surgical mortality review, but there was no documentation of further review beyond the initial mortality screening.

The Associate Director for Inpatient Care stated that peer reviews were generally performed at the affiliate's offices as part of their private patient mortality reviews. The medical center did not have its own surgical morbidity and mortality committee. The Associate Director acknowledged the need to establish a surgical morbidity and mortality committee within the medical center in order to ensure timely peer reviews, document the need for follow-up corrective actions, and provide systemic information for quality improvement purposes.

Mortality Trending. Although the medical center trended deaths in considerable detail, including by time of death and location, it did not trend deaths by individual provider as required by VHA policy. When informed of the requirement, the Quality Control Manager initiated trending of deaths by individual provider.

Recommendation 6. We recommended that the VISN Director ensure the Medical Center Director requires that: (a) residents are properly supervised and the supervision is documented, (b) VHA policy is followed for informed consent prior to surgery, (c) mortality assessments and peer reviews are completed in a timely fashion, (d) a surgical morbidity and mortality committee is established within the medical center and peer review outcomes are reviewed for quality improvement purposes, and (e) mortality data is trended by provider.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that a template has been developed to ensure that resident supervision is properly documented and that the medical center is performing documentation reviews prior to surgical procedures to ensure that patient consent forms are properly completed. Timeliness requirements have been emphasized, and peer review assessments are now being completed within 45 days. The medical center established a formal monthly morbidity and mortality review in November 2005 and has incorporated trending of mortality data by provider in its review process. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Government Purchase Card Program – Controls Needed To Be Strengthened

Condition Needing Improvement. The medical center needed to strengthen controls over the Government purchase card program. We evaluated the effectiveness of management controls designed to detect inappropriate purchases made by medical center employees using their Government purchase cards. Our review covered the transactions that occurred during the 6-month period ending July 31, 2005. The purchase card program included 53 approving officials and 113 cardholders, who made about $8.8 million in purchases during the 6-month period. During our review, we identified five issues that required management attention.

Timeliness of Reconciliations. VHA policy requires cardholders to reconcile 75 percent of their transactions within 10 calendar days after receipt of billing information and 95 percent of their transactions within 17 calendar days. All of the transactions must be reconciled within 30 calendar days. The medical center did not meet the 95 percent timeliness standard for 3 of the 6 months we reviewed, and it did not meet the 100 percent timeliness standard during any of the 6 months.

Segregation of Duties. VA policy requires a segregation of duties for approving purchase card transactions, making purchases, and recording the transactions. The policy also states that a billing officer cannot be a cardholder or an approving official. However, the medical center's billing officer was an approving official for three cardholders.

Cancellation of Purchase Cards. VA policy requires the purchase card program coordinator to retrieve and cancel cardholders' purchase cards when cardholders terminate their employment. We reviewed the employment status of 10 cardholders and found that 1 of the cardholders was no longer employed by the medical center. However, the program coordinator had not cancelled the purchase card for this former employee, who retired on July 1, 2005.

Split Purchases. VHA policy states that a cardholder cannot split a purchase into more that one transaction to avoid the $2,500 micropurchase limit. Our review of 26 transactions totaling $139,394 identified 3 purchases that cardholders had improperly split into 7 transactions totaling $14,857. For example, on January 12, 2005, a cardholder split the purchase of a steam trap costing $4,978 into two transactions costing $2,487 and $2,491, respectively.

Warrant Authorities. VHA policy requires approving officials to be warranted at the same level or higher than the cardholders they monitor to ensure they have adequate knowledge of acquisition regulations, which is needed to properly monitor their cardholders. Our review of 10 cardholders who made purchases greater than $2,500 showed that all 10 cardholders had appropriate warrant authorities. However, 3 of the 4 approving officials for the 10 cardholders did not have warrant authorities at the same level or higher than their cardholders.

Recommendation 7. We recommended the VISN Director ensure that the Medical Center Director requires that: (a) cardholders meet the timeliness standards for reconciling transactions, (b) the billing officer not be an approving official, (c) the program coordinator cancel cardholders' purchase cards when the cardholders terminate employment, (d) cardholders not split purchases into more than one transaction, and (e) approving officials be warranted at the same level or higher than the cardholders they monitor.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that the medical center will terminate cardholders' purchase cards if they are

delinquent in their reconciliations. The billing officer is no longer an approving official, and purchase cards are canceled immediately when cardholders leave the medical center. The purchase card coordinator reviews purchase card orders daily for split purchases, and all approving officials have been properly warranted. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Background Investigations – Position Risk Levels Needed To Be Determined and Background Investigations Needed To Be Completed

Condition Needing Improvement. The medical center did not ensure that appropriate background investigations were completed. VA policy requires Human Resources Management employees to ensure that position risk levels are determined and that background investigations corresponding with those risk levels are completed.

We reviewed the Official Personnel Folders (OPFs) of eight clinical and two law enforcement employees to determine if appropriate background investigations were completed. The medical center had not ensured that appropriate background investigations were completed for 6 of the 10 employees. According to the Human Resources Management Director, the medical center is recruiting a personnel specialist who will be responsible for performing a comprehensive review to ensure that all appropriate background investigations are completed.

Recommendation 8. We recommended the VISN Director ensure the Medical Center Director requires that position risk levels be determined and ensures that appropriate background investigations are completed for all medical center employees who need them.

The VISN and Medical Center Directors agreed with the finding and recommendations and reported that the medical center has completed position risk level assessments on all of its positions and will initiate background investigations for all medical center employees who need them. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Information Technology Security – Controls Needed To Be Strengthened

Condition Needing Improvement. Medical center managers needed to strengthen controls over IT security. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, or misuse, and ensured continuity of operations following a disruption or disaster. Our review showed that physical security measures in computer and telecommunications rooms complied with VA requirements. In addition, Local Area Network and Veterans Health Information Systems and Technology Architecture (VistA)

system password controls were adequate. However, we identified two areas that required management attention.

Background Investigations. The medical center did not ensure that background investigations were completed for IRM personnel. We reviewed the OPFs for 17 IRM employees who needed background investigations and found that 10 of the IRM employees did not have the required background investigations.

Contingency Plan. The medical center's VistA contingency plan could be improved by adding a comprehensive list of personnel to contact in the event of an emergency. A contingency plan addresses the procedures for responding to emergencies, backing up data files and storing backup tapes offsite, ensuring that essential business functions can be conducted after disruption of IT support, and restoring facility processing capability. Although the medical center's VistA contingency plan outlined disaster recovery procedures, it did not include a comprehensive list of personnel to contact in the event of an emergency.

Recommendation 9. We recommended the VISN Director ensure the Medical Center Director requires that (a) background investigations be completed for all IRM employees who require them and (b) the VistA contingency plan include a comprehensive list of personnel to contact in the event of an emergency.

The VISN and Medical Center Directors agreed with the finding and recommendations. They reported that the medical center has initiated background investigations for all IRM employees who require them and updated the VistA contingency plan to ensure that it includes a comprehensive list of personnel to contact in the event of an emergency. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Other Observation

All Employee Survey Was Effectively Administered. The Executive Career Field Performance Plan for FY 2005, which was developed to establish performance measures for facility executives, required the VISN to ensure that the results of an all employee survey performed in FY 2004 were provided to all employees at each facility. The plan also required the VISN to analyze the survey results and develop an improvement action plan that included implementation timelines and performance measures needed to assess whether the actions achieved the desired results. The action plan was to be completed by September 30, 2005.

Medical center managers met all of the requirements associated with the all employee survey. The medical center's analysis of the survey results included a review of low scores with a focus on the factors the managers felt they could improve. Medical center managers identified diversity acceptance and job control as areas needing improvement, and more areas were identified on the service line and unit levels. The action plan identified appropriate timelines for implementation and included suitable performance measures. The medical center used staff meetings, town hall events, electronic mail, posters, and a newsletter to distribute the survey results and the action plan to its employees. Actions taken to improve the work environment were well documented.

Appendix A

VISN 7 Director Comments

Department of Veterans Affairs

Memorandum

Date: MAY 04 2006

From: Acting Director, VA Southeast Network (10N7)

Subj: CAP – VA Medical Center Birmingham

To: Director, Dallas Audit Operations Division (52DA)

1. Attached is Birmingham's response to the Office of Inspector General (OIG) Combined Assessment Program Review Site Visit September 19-23, 2005. I have reviewed the CAP recommendations, which have been individually addressed.

2. I concur with the comments and actions taken by the Medical Center Director to improve processes at the Birmingham VA Medical Center.

Thomas A. Cappello

Thomas A. Cappello, FACHE

Attachments

VA FORM MAR 1989 **2105**

VHA Core Values: Trust, Respect, Commitment, Compassion, Excellence

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 4, 2006

From: Director, VA Medical Center Birmingham (521/00)

Subject: **VA Medical Center Birmingham, Alabama**

To: VISN 7 Acting Network Director (10N7)

1. Attached is Birmingham's response to the Office of Inspector General (OIG) Combined Assessment Program visit September 19-23, 2005. I have reviewed the CAP recommendations, which have been individually addressed.

2. This response is due to OIG May 5, 2006.

Y C Parris

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

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure the Medical Center Director requires that: (a) HVAC systems be scheduled for periodic testing, (b) outstanding work orders related to EOC problems be reviewed and completed timely, and (c) items be stored (regardless of the designation of the room) no higher than 18 inches from the ceiling.

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

a. The operating rooms are currently undergoing improvements, the facility will have the HVAC systems balanced and air exchange rates verified upon completion of the project. The facility policy Medical Center Memorandum 138-21, Utility Systems Management Plan, will be revised to include requirements for annual verification of air exchange rates and re-balancing for the HVAC systems or after major HVAC systems repairs and/or replacement.

Target Completion Date: May 30, 2006

b. Medical Center Memorandum 00-47 entitled *Physical Environment* has been revised to include the reporting requirement for the Executive Safety Committee that was already occurring. The target completion time for routine maintenance work orders resulting from EOC Rounds/Inspections will be within 30 calendar days from receipt of the report. Any deficiencies/items that require capital funding and/or other project funding are not being included/counted as routine maintenance. Completion of work orders resulting from EOC Rounds/Inspections is being tracked to ensure that all items are completed within specified timeframes.

Target Completion Date: Completed

c. The box found closer than 18 inches to the sprinkler head was removed. However, according to NFPA 13-8.6.6, the 18 inch dimension is not intended to limit the height of shelving on a wall or shelving against a wall. Where shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, can extend above the level of a plane located 18 inches below ceiling sprinkler deflectors. Shelving, and any storage thereon, directly below the sprinklers can not extend above a plane located 18 inches below the ceiling sprinkler deflectors. As this was a single, isolated incident, we request that it be removed from the final report to reflect our total commitment to the JCAHO EOC standards.

Target Completion Date: Completed

Recommendation 2. We recommend that the VISN Director ensure the Medical Center Director takes action to reduce stock levels to the minimum needed to meet the medical center's needs.

Concur **Target Completion Date:** Completed

A review of all GIP inventory locations was conducted to ensure that stock levels were set at an appropriate level. It was determined that the stock levels were set at the minimum level needed to meet the medical center's needs.

Recommendation 3. We recommend that the VISN Director ensure the Medical Center Director requires that (a) all billable fee-basis care be identified and billed and (b) medical care providers adequately document resident supervision and the care provided in veterans' medical records.

Concur **Target Completion Date:** Completed

a. Development of a computerized software program for Fee billing. This software program was developed to include all inpatient and outpatient fee. The VISTA software program developed includes a field to document if visit/hospitalization was billable and/or the reason not billable. This program will enable management to track the billable fee encounters and prevent missed billing opportunities.

Target Completion Date: Completed

b. Action 1: Residency supervision mandatory templates to document resident supervision have been completed and are being utilized. The templates require the resident to document the attending physician and choose the level of supervision in the outpatient clinics, procedures and consultations.

Target Completion Date: Completed

Action 2: A monthly monitor for MCCR reasons not billable listing for no documentation, insufficient documentation and non-billable providers (resident) has been developed to ensure there are no missed billing opportunities. This data is being tracked on a monthly basis.

Target Completion Date: Completed

Action 3: Birmingham has begun recruitment for a Medical Records Administrative Specialist to conduct the "reasons not billable" list review and perform the required residency supervision monitors.

Target Completion Date: Completed

Action 4: Development of monthly and fiscal year cumulative provider profiling regarding the residency supervision requirements for pre-operative note and admission note was completed.

Target Completion Date: Completed

Action 5: Development of attending physician surgical templates to improve compliance with residency supervision requirements and JCAHO standards.

Target Completion Date: Complete

Recommendation 4. We recommend the VISN Director ensure the Medical Center Director requires that (a) suspected thefts, diversions, or suspicious losses of controlled substances be reported immediately to the VA Police, OIG, and DEA and (b) prescribing physicians complete all required prescription information.

Concur **Target Completion Date:** Completed

a. Pharmacy had been reporting losses. There may have been miscommunication. This has been resolved and the process is now outlined in Medical Center Memorandum 119-10 entitled *Accountability of Controlled Substances*. The reporting process appears to be working fine.

b. Additional education of prescribing physicians related to the requirements for completion of all required prescription information has been completed through the Pharmacy & Therapeutics Committee. Compliance with requirements is being tracked to identify subsequent areas for improvement and need for additional education.

Recommendation 5. We recommend that the VISN Director ensure the Medical Center Director requires that patients receive (a) appropriate CRC screening and (b) timely GI evaluations.

Concur **Target Completion Date:** Completed

a. In 2005, we implemented several corrective measures to improve our CRC screening. As part of our performance improvement efforts, we obtained patient feedback on the reasons fecal occult blood test (FOBT) cards were not returned. Based on patient feedback: we changed and simplified patient education regarding FOBT cards; we developed an FOBT packet to give to patients which also included a postage paid self addressed return envelope to return the cards after specimen collection; and we created reminder letters to patients. As a result of these efforts, our Colorectal Screening improved from 64% in FY 04 (72% for VISN and National) to 80% in FY 05 (75% for VISN and National). Our goal is to continue improving our CRC screening which will be reported and monitored during our Quarterly Performance Measures call with the Network Director. Our Associate Chief of Staff for Primary Care Services is giving each provider their Performance Measures data and is holding them accountable for their performance. Our EPRP value for colorectal cancer screening is at the exceptional level (75%) as or the 2nd quarter 2006.

Target Completion Date: Completed

b. Patients are being scheduled appropriately and timely based on clinical needs. We have implemented several corrective measures to improve timely GI evaluations:

(1) GI consult criteria and the consult package was modified so that consult requests that were not filled out accurately or not properly assessed before referral were sent back to the requesting provider for action.

(2) GI pre-procedure prep was modified to reduce the stress to patients.

(3) Patients are being contacted at least 24 hours before the procedure to remind them to perform the prep and ensured the patient was still going to have the procedure (this dramatically reduced our no-show rate).

(4) Additionally, we have recruited and hired a nurse case manager to track cancer cases to ensure timely intervention which include GI patients.

Target Completion Date: Completed

Recommendation 6. We recommend that the VISN Director ensure the Medical Center Director requires that: (a) residents are properly supervised and the supervision is documented, (b) VHA policy is followed for informed consent prior to surgery, (c) mortality assessments and peer reviews are completed in a timely fashion, (d) a surgical morbidity and mortality committee is established within the medical center and peer review outcomes are reviewed for quality improvement purposes, and (e) mortality data is trended by provider.

Concur **Target Completion Date:** Complete

(a) Birmingham has developed a new template for use in the Surgical Clinics to more effectively document Resident Supervision. Templates are currently being utilized.

Target Completion Date: Completed

(b) A documentation review of resident supervision prior to the surgical procedure has been implemented to assist with continued education and to ensure compliance.

Target Completion Date: Completed

(c) Our Patient Safety/Risk Manager has inserviced our Peer Review committee on the requirement to complete the Peer Review assessment within 45 days. Each case is entered into the Peer Review tracking database to ensure the review process is timely. Our peer review cases within the last quarter have all been reviewed and finalized within the 45 day period.

Target Completion Date: Completed

(d) A formal monthly morbidity and mortality (M&M) review began November 22, 2005. This M&M summary is conducted and discussed to improve outcomes for quality improvement purposes.

Target Completion Date: Completed

(e) Provider specific mortality data was trended at the time of the CAP review and has been incorporated in our review process. This trending analysis is performed on a quarterly basis and is presented at our Health Systems Council meetings.

Target Completion Date: Completed

Recommendation 7. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) cardholders meet the timeliness standards for reconciling transactions, (b) the billing officer not be an approving official, (c) the program coordinator cancel cardholders' purchase cards when the cardholders terminate employment, (d) cardholders not split purchases into more than one transaction, and (e) approving officials be warranted at the same level or higher than the cardholders they monitor.

Concur **Target Completion Date:** Complete

a. Timeliness of Reconciliations: All cardholders have been notified that if they become delinquent in their reconciliations, it will result in their purchase card will be terminated.

b. Segregation of Duties: The Billing Officer is no longer an Approving Official.

c. Cancellation of Purchase Cards: Purchase cards are cancelled through the Citibank system immediately upon clearance of the purchase card holder.

d. Split Purchases: The cardholder identified during the CAP Review has been warranted so that this will no longer occur. The Purchase Card Coordinator will continue to review daily purchase card orders placed for potential split orders.

e. Warrant Authorities: All approving officials of warranted card holders have also been warranted at the same level or higher.

Recommendation 8. We recommend the VISN Director ensure the Medical Center Director requires that position risk levels be determined and ensures that appropriate background investigations are completed for all medical center employees who need them.

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

An assessment of risk levels for all positions at the medical center has been completed and a determination has been made as to whether appropriate employees have undergone the level of clearance appropriate for their position. All non-IT employees whose positions require a background investigation (BI) either have a current clearance, have recently initiated a request for an investigation or a query has been made to OPM to verify status. For those in the latter category, the appropriate paperwork, if lacking, has been initiated. All requests to initiate BI or modified background investigation (MBI) investigations, with the exception of 3 employees, have been submitted

Recommendation 9. We recommend the VISN Director ensure the Medical Center Director requires that (a) background investigations be completed for all IRM employees who require them and (b) the VistA contingency plan include a comprehensive list of personnel to contact in the event of an emergency.

Concur **Target Completion Date:** Completed

a. To date we have assessed all positions assigned to IRM for appropriate risk level and screened the records of all IRM employees to verify existence of required level of investigation. All packages have been completed and submitted to Little Rock for action. Federal Investigators are

now on board conducting interview for personnel who were submitted for investigation in January 2006.

b. The VistA Contingency Plan dated April 12, 2005, contains the following personnel lists (below) in separate pages. The contingency plan was updated to include all of the contacts in a single appendix.

1. Emergency Contact List, (pages 30-31)
2. Emergency Failure Response, (page 36)
3. Emergency Fan-out List for Systems Failures, pages (39-40)
4. Site Installation Tracking, (page 41)
5. ADP Application Coordinators (ADPAC Listing), (page 46)

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Reducing stock levels would make funds available for other uses.	$28,581
3	Ensuring all billable VA and fee-basis care is billed would increase MCCF collections.	15,330
	Total	$43,911

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Michael E. Guier (214) 253-3301
Acknowledgments	Marisa Casado
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Appendix E

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