Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection
Management of Government Resources and Personnel Practices
VA North Texas Health Care System
Dallas, Texas

Report No. 06-01319-156

June 29, 2007

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the inspection was to determine the validity of allegations concerning mismanagement of Government resources, prohibited personnel practices, and contract and procurement irregularities between VA North Texas Health Care System (system) and its medical school affiliate.

We concluded eye clinic employees had been supervised and managed by a contractor-employed administrator in conflict with specific acquisition regulations. It states that contracts shall not be used for the performance of inherently governmental functions. The contract terms did not call for the contractor to provide administrative oversight (supervision of clinics or VA staff). Additionally identified contract variances from standard practices require resolution. Acquisition planning for ophthalmology services offered no support, such as workload analysis, for manpower requirements. The sharing agreement between the medical school and the system did not receive a preaward review. The Surgical Service Administrative Officer is serving as the Contracting Officer's Technical Representative; however, there is no evidence of this in the contract file. Finally, a possible conflict of interest exists between an employee and the medical school. This matter was referred for further review.

We did not substantiate the allegation that the system Director ordered eye clinic physicians to perform Lasik surgery that was not medically necessary. Although not part of the original allegation, we found that eye clinic management kept a "shadow" system of medical records that was in violation of Veterans Health Administration (VHA) and local policy regarding the computerized patient record system and patient privacy

We made recommendations that the system should:

- Comply with acquisition regulations regarding supervision of VHA employees.
- Conduct a workload analysis to determine how many staff are required for ophthalmology services before renewing any sharing agreement.
- Obtain a preaward review before awarding ophthalmology service sharing agreements or other contracts valued at $500,000 or more.
- Direct the contract officer to create a Contracting Officer's Technical Representative designation memorandum to be placed in the contract file.
- Require medical record documentation in the eye clinic comply with VHA and local directives, since no shadow record systems may be maintained.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N17)

SUBJECT: Healthcare Inspection – Management of Government Resources and Personnel Practices, VA North Texas Health Care System, Dallas, TX

Purpose

The purpose of the inspection was to determine the validity of allegations concerning mismanagement of Government resources, prohibited personnel practices, and contract and procurement irregularities between VA North Texas Health Care System (system), and its affiliate, University of Texas Southwestern Medical School (UTSW).

Background

The system has a contract with its affiliate, UTSW, to manage the system's eye clinic at the Dallas Division. The complainant contacted the Office of Inspector General (OIG) Hotline division with concerns regarding this contract between the system and UTSW.

The complainant alleged that when the contract was first established, the contractor was to provide full onsite ophthalmology services including the services of an ophthalmologist, residents, and technical support staff. As the contract evolved, UTSW was providing managers under contract to supervise all VA employees within the eye clinic.

The complainant stated that as part of their duties under the contract administrator's direction, VA employees were mandated to attend meetings, teach ophthalmology residents, make weekly rounds, present cases, and meet UTSW qualifications for clinical appointments.

The complainant stressed that the administrator was the sole authority over this particular group of VA employees, controlling decisions to hire and to determine pay rate, discipline or reward personnel, set clinical privileges, and establish work schedules. In effect, the complainant noted, this arrangement limited these employees' rights to usual Federal personnel protections.

According to the complainant, UTSW had control of clinical issues impacting patient care. The decision regarding which VA patients have access to care, medical treatment, and testing was solely at the discretion of the Director of the Ophthalmology Service. Additionally, a "shadow"[1] system of medical records was kept within the clinic; these shadow records contained comments not found in the original medical record system.

The complainant alleged the system Director ordered the eye clinic to perform Lasik surgery, which is not considered a medical necessity, for at least one non service-connected (NSC) veteran. The complainant noted VA does not typically offer this procedure for any patient, service-connected (SC) or otherwise.

Scope and Methodology

The VA OIG Office of Healthcare Inspections (OHI) and Office of the Counselor reviewed allegations of mismanagement of Government resources, prohibited personnel practices, and contract and procurement irregularities between the system and its affiliate, UTSW.

We interviewed the staff and management at Dallas VA Medical Center (VAMC); Sam Rayburn Memorial Veterans Center (SRMVC), Bonham, TX; and the Fort Worth, TX, Community Based Outpatient Clinic (CBOC). We toured the eye clinics and related areas in the three facilities. We reviewed medical records, Veterans Health Administration (VHA) and local policies pertaining to eye clinic management and surgical treatment authorization, contracts, and prosthetic order processes. We also reviewed human resource records, including credentialing and privileging files of eye clinic personnel, to assess compliance with VHA Handbook 1100.19, *Credentialing and Privileging*, and applicable local policy.

The assignment and approval of clinical privileges is a system determination and was not addressed in this report.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Management and Supervision of VA Employees

We substantiated the allegation that eye clinic employees were being supervised and managed by an administrator employed by a contractor. Federal Acquisition Regulation (FAR) Subpart 7.5 states that contracts shall not be used for the performance of inherently governmental functions. The Director of the Ophthalmology Service, who

[1] A duplicate set of records which may contain information not maintained in the VA system of medical records.

was a contract employee at the time, evaluated the performance of VA employees and made recommendations for promotions. A few days before our onsite visit, the contract employee was converted to a full-time VA employee. Subsequently, the contracting officer prepared a modification removing the Director of Ophthalmology Service from the contract.

We did not substantiate the allegation that under the contract administrator's direction, VA employees were mandated to attend meetings at UTSW, teach ophthalmology residents, make weekly rounds, present cases, or meet UTSW qualifications for clinical appointments.

We reviewed the sharing agreement contract file and found that the contract was awarded properly and contract modifications were appropriate. Prior to the initial award of the contract, VA Central Office, Acquisition Program Management Division, conducted a business clearance review of the contract, and the statement of work was changed to eliminate language implying that the contractor would perform services that are inherently governmental or would be appropriate only if VA had personnel service contract authority, which VA does not. Thus, the contract terms did not call for the contractor to provide administrative oversight (supervision of clinics or VA staff).

Although we concluded that the contract was properly awarded, we identified the following deficiencies:

Lack of Acquisition Planning.
Surgical Service requested a contract for ophthalmology services and provided the contracting officer with a statement of work and the number of full-time equivalent employees (FTE) required. However, there was no supporting documentation, such as workload analysis, for the FTE requirement.

Preaward Review Not Requested.
VHA Directive 99-056, *Negotiating Non-Competitive Clinical Services Contracts*, requires a preaward review of all sole-source procurements in excess of $500,000 including option years. The sharing agreement between UTSW and the system was approximately $3 million. However, a preaward review was not requested because the contracting officer did not realize that one was required.

Contracting Officer's Technical Representative Designation Memorandum Not in Contract File.
VA Acquisition Regulation 801.603-70 requires that a Contracting Officer's Technical Representative (COTR) designation memorandum be in writing and define the scope and limitation of the representative's authority. The Surgical Service Administrative Officer was serving as the COTR; however, there was no evidence of this in the contract file.

Conflict of Interest.
According to VHA Handbook 1660.3, *Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis and Intergovernmental Personnel Act Agreements (IPAS)*, "No VA employee who is an employee, officer, director, or trustee of an affiliated university, or who has a financial interest in the contract, may lawfully participate in a VA contract or any other Government contract with the university." We discovered a conflict of interest exists between an employee and UTSW. This matter was referred for further review.

Issue 2: Performance of Lasik Surgeries

We did not substantiate allegations the system Director ordered the eye clinic to perform Lasik surgery that was not medically necessary.

One fee basis Lasik procedure was performed on a SC veteran in March 2005. Before surgery was performed, system managers reviewed the case and determined that Lasik surgery was justified due to his "100% SC disability of SCI [spinal cord injury] which prevents him from putting in contact lens and or putting on his glasses. Quality of life is a major part of this justification since he needs assistance with all ADLs [activities of daily living] and is functionally limited in any activities he can do. He watches TV, uses an adapted computer, and reads as functional activities."

A second Lasik procedure was approved in September 2005 for an NSC veteran who requested the procedure due to his dissatisfaction with available prophylactic corrective lenses. However, this procedure was never performed. At our suggestion, the procedure was reevaluated by system managers to assess medical necessity and compliance with the intent of VHA Directive 2004-045, *Therapeutic Laser Eye Procedures*, and was not found to be medically necessary. As a result, the procedure was not done.

Issue 3: Medical Record Documentation and Security

We substantiated that Dallas VAMC was not in compliance with VHA Manual M-1, Part I, Chapters 5 and 9 and system Memorandum No. MR-1, *Medical Records Management Committee*, regarding a system of records, medical record security, and the use of the computerized patient record system (CPRS).

Eye clinic management kept a "shadow" system of medical records. These files were physically located in two file rooms within the eye clinic. One file room opened directly into a patient waiting area, and neither room was secure when unattended. The records must be maintained in the VA records system. According to the department procedure for that system, "all records containing personal information are maintained in secured file cabinets or in restricted areas, access to which is limited to authorized personnel." While we did not find any evidence that patient information was improperly accessed or compromised, we found the practice of leaving medical records unsecured unacceptable.

We compared documentation in the CPRS medical records with the eye clinic "shadow" files for 44 patients. We found additions/deletions in the documented treatment plans or expectations of care in 26 (59 percent) of the "shadow" files. The additions/deletions included, but were not limited to, changes in patient treatment plans and provider diagrams of the patient's retinal changes. VHA and local directives maintains the patient's right to access his or her records, make copies, and request amendments to medical records. CPRS records which are incomplete deny patients these rights and may lead to unsafe clinical practice.

At the time of this review, CPRS in the Dallas VAMC eye clinic had been in use by the optometrists for 3 years and by the ophthalmologists for approximately 1 month. SRMVC and the Fort Worth CBOC complied with CPRS standards; however, the records may not be complete due to the use of "shadow" files used by Dallas VAMC.

We concluded that the practice of keeping "shadow" medical records in the eye clinic is a violation of VHA and local directives, puts a burden on clinic staff, and potentially places patients at risk. We further concluded that all patient encounters must be documented in CPRS as required by VHA and local policy.

Issue 4: Patient Care Concerns

We did not find that patient care was negatively impacted because of contract management. We reviewed clinic access, medical records, and patient complaint data. There were no indications that patients were made to wait for procedures or not scheduled for necessary testing or treatments. Part of the Director of Ophthalmology Service's role is to manage patient activities and system resources. We found no indication that patient care was managed inappropriately.

Conclusion

We concluded eye clinic employees had been supervised and managed by an administrator employed under contract in conflict with FAR Subpart 7.5. This regulation states that contracts shall not be used for the performance of inherently governmental functions. The contract terms did not call for the contractor to provide administrative oversight or supervision of clinics or VA staff.

Contract variances from standard practices require resolution. Acquisition planning for ophthalmology services offered no support, such as workload analysis for the manpower requirements. The sharing agreement between UTSW and the system did not receive a preaward review. The Surgical Service Administrative Officer is serving as the COTR while no evidence of this was found in the contract file. Finally, a possible conflict of interest exists between an employee and UTSW. This matter was referred for further review.

Compliance with VHA guidance and local policies for documentation is inconsistent. The practice of keeping "shadow" medical records in the eye clinic is a violation of VHA and local policy and potentially places patients at risk. All patient encounters must be documented in CPRS in accordance with VHA and local policy.

Recommendations

Recommendation 1. We recommend that the VISN Director ensure the system Director takes action to comply with FAR, Subpart 7.5, *Inherently Governmental Function*, regarding supervision of VA employees.

Recommendation 2. We recommend that the VISN Director ensure the system Director takes action to conduct a workload analysis to determine how many FTE are required for ophthalmology services before renewing any sharing agreement.

Recommendation 3. We recommend that the VISN Director ensure the system Director takes action to obtain a preaward review before awarding ophthalmology service sharing agreements or other contracts valued at $500,000 or more, inclusive of option years.

Recommendation 4. We recommend that the VISN Director ensure the system Director takes action to direct the contract officer to create a COTR designation memorandum to be placed in the contract file.

Recommendation 5. We recommend that the VISN Director ensure the system Director takes action to require medical record documentation in the eye clinic comply with VHA and local directives. No shadow record systems may be maintained.

Comments

The VISN and system Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7–11, for the full text of the Directors' comments.)

The actions planned by the VA North Texas Health Care System met the intent of our recommendations. We will follow up on the planned actions pending receipt of documentation verifying completion dates have been met.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2007

From: VISN Director

Subject: Healthcare Inspection - Management of Government Resources and Personnel Practices, VA North Texas Health Care System, Dallas, Texas

To: Office of Inspector General

1. Attached is VA North Texas Health Care System's response to the Office of Inspector General (OIG) Hotline Review Site Visit conducted in 2006. I have reviewed the OIG 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 VA North Texas Health Care System.

(original signed by:)

Thomas Stranova

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

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

OIG Recommendations

We recommend the VISN Director ensure the System Director take action to:

Recommendation 1. Comply with FAR, Subpart 7.5, Inherently Governmental Function, regarding supervision of VHA employees.

Concur **Target Completion Date:** March 26, 2006

Recommendation 2. Conduct a workload analysis to determine how many FTE are required for ophthalmology services before renewing any sharing agreement.

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

Recommendation 3. Obtain a preaward review before awarding ophthalmology service sharing agreements or other contracts valued at $500,000 or more, inclusive of option years.

Concur **Target Completion Date:** July 16, 2006

Recommendation 4. Direct the contract officer to create a COTR designation memorandum to be placed in the contract file.

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

Recommendation 5. Require medical record documentation in the eye clinic comply with VHA and local directives. No shadow record systems may be maintained.

Concur **Target Completion Date:** October, 2006

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 23, 2007

From: System Director

Subject: Healthcare Inspection - Management of Government Resources and Personnel Practices, VA North Texas Health Care System, Dallas, Texas

To: Network Director, VISN 17 (10N17)

Attached is VA North Texas Health Care System's (VANTHCS) response to the recommendations in the subject healthcare inspection report.

(original signed by:)
Betty Bolin Brown

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

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

OIG Recommendations

We recommend the VISN Director ensure the system Director take action to:

Recommendation 1. Comply with FAR, Subpart 7.5, Inherently Governmental Function, regarding supervision of VHA employees.

Concur **Target Completion Date:** March 26, 2006

As of March 26, 2006, supervision of staff in the eye clinic was provided by a physician employed by VA North Texas Health Care System.

Recommendation 2. Conduct a workload analysis to determine how many FTE are required for ophthalmology services before renewing any sharing agreement.

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

With the help of OIG staff from VACO, a complete workload analysis has been completed to determine the number of FTE required for the ophthalmology contact. The analysis is being used in the contracting process.

Recommendation 3. Obtain a preaward review before awarding ophthalmology service sharing agreements or other contracts valued at $500,000 or more, inclusive of option years.

Concur **Target Completion Date:** July 16, 2006

Pre-award OIG audits price proposals valued at $500,000 or more, inclusive of years, have been requested and received for the pending long-term ophthalmology contract as well as other pending long term contracts with UTSW.

Recommendation 4. Direct the contract officer to create a COTR designation memorandum to be placed in the contract file.

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

There is currently a COTR designation memorandum in the file identifying the COTR in the ophthalmology contract file.

Recommendation 5. Require medical record documentation in the eye clinic comply with VHA and local directives. No shadow record systems may be maintained.

Concur **Target Completion Date:** October, 2007

The Ophthalmology clinic began utilizing CPRS for eye clinic notes as identified by the Office of Inspector General staff. The clinic providers make any additions to the CPRS eye clinic notes for resident supervision purposes, or clarification of information, using an addendum. Hand written comments are not utilized. All visual field exams are scanned into VistA imaging and appear in the record. Old visual field exams are available in the clinic for reference (as supplemental information) as a part of continued care for long standing patients. It is anticipated that these will no longer be necessary for care as of October 2007.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Karen Moore, Associate Director Dallas Regional Office of Healthcare Inspections (214) 253-3332
Acknowledgments	Linda DeLong, Director Shirley Carlile Theresa Cinciripini Glen Gowans Roxanna Osegueda George Wesley, M.D.

Appendix D

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