Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Boston Healthcare System

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Report No. 01–01253–14 **October 31, 2001**

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 agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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 May 21–25, 2001, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Boston Healthcare System (VABHCS). The purpose of the review was to evaluate selected healthcare system 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 about 200 employees.

Results of Review

VABHCS patient care and QM activities reviewed were generally operating satisfactorily. Management actively supported quality patient care and performance improvement. The QM program was comprehensive and provided effective oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the VABHCS needed to:

- Improve procurement practices including contract file administration, justifications for service contracts, competition to reduce costs of goods and services, and Government Purchase Card Program controls.
- Bill health insurers for inpatient episodes of care, pursue collection of accounts receivable, and offset current and former employee non-benefit debts more aggressively.
- Properly perform inspections of controlled substances.
- Improve procedures for communicating abnormal diagnostic test results.
- Ensure that background investigations are obtained for all newly hired practitioners.
- Improve physical plant environment and safety.
- Strengthen time and attendance controls for part-time physicians.
- Protect privacy of medical information and correct automated information systems security weaknesses.

VABHCS Director's Comments. The VABHCS Director concurred with the CAP review findings, recommendations, and suggestions; and provided acceptable plans to take corrective actions. We consider all CAP review issues to be resolved, but may follow up on implementation of planned corrective actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

VA Boston Healthcare System Profile

Organization. Based in Boston, Massachusetts, the VABHCS is a tertiary care system that provides a broad range of inpatient and outpatient healthcare services. The VABHCS is an integrated facility with three campuses located in West Roxbury, Jamaica Plain, and Brockton, Massachusetts. Integration of programs and staff began in March 2000 and is expected to be completed by 2005, when the construction phase to accommodate realigned programs is complete. Outpatient care is also provided at five community-based outpatient clinics located in Worcester, Framingham, Lowell, Quincy, and Boston, Massachusetts. The VABHCS is part of Veterans Integrated Service Network 1 and serves a veteran population estimated to be over 45,000 in a primary service area that includes 7 counties in Massachusetts. The VABHCS serves as a regional referral center for veterans throughout New England.

Programs. The VABHCS provides a broad range of medical services. The West Roxbury campus is a 179-bed tertiary care facility providing a broad range of services in medicine, surgery, and neurology. The Jamaica Plain campus offers state-of-the-art ambulatory and primary care services and has 18 hospital beds and 48 psychiatric residential rehabilitation care beds. The Brockton campus offers veterans a wide range of healthcare options including long term care composed of a chronic Spinal Cord Injury unit, mental health services, and comprehensive primary care. The campus has 177 hospital beds, 120 nursing home care beds, 70 domiciliary beds, and 15 psychiatric residential rehabilitation care beds.

Affiliations and Research. The VABHCS is affiliated with the Boston University Medical School and Harvard University Medical School, and supports 140 Boston University residents in 23 training programs and 110 Harvard University residents in 20 training programs. In Fiscal Year (FY) 2001, the VABHCS research program had 233 projects and a budget of approximately $28 million. Important areas of research include gastrointestinal disorders, cardiology and cardiovascular diseases, neuropsychology of mental illnesses, hemostasis, language and memory disorders, and infectious diseases.

Resources. The VABHCS FY 2001 medical care budget was $317.6 million. The FY 2000 medical care budget was $280.1 million, 1 percent less than the FY 1999 budget. FY 2000 staffing was 3,186 full-time equivalent employees (FTEE), including 149.4 full-time physicians, 80 part-time physician FTEE, and 475.7 nursing FTEE. FY 2001 staffing through March 31, 2001, was 2,934 FTEE, including 150.2 full-time physicians, 134 part-time physicians, and 556.6 nursing FTEE.

Workload. In FY 2000, the VABHCS treated 52,168 unique patients, a 2.7 percent decrease from FY 1999. The inpatient care workload totaled 11,864 discharges. The average daily census for FY 2000 was 565. The outpatient workload totaled 609,517 visits, an 8.5 percent decrease from FY 1999.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected medical center operations focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employees' understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful 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 activities:

Abnormal Diagnostic Test Results	Controlled Substances Accountability
Accounts Receivable	Government Purchase Card Program
Acute Medical-Surgical Units	Part-Time Physician Time and Attendance
Automated Information Systems	Primary Care Clinics
Background Investigations	Quality Management
Behavioral Health Care	Rehabilitation and Extended Care
Clinical Services Contracts	

As part of the review, we used questionnaires and interviews to survey patients' and employees' satisfaction with the timeliness of service and the quality of care. The full survey results were provided to VABHCS management.

During the review, we also conducted 6 fraud and integrity awareness training sessions to about 200 VABHCS 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.

The review covered VABHCS operations for FYs 2000 and 2001 (through May 31, 2001) and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that need corrective actions but are not significant enough to warrant OIG recommendations and follow-up.

Results of Review

Organizational Strengths

VABHCS management had created an environment supportive of quality patient care and performance improvement. The patient care administration, QM, financial, and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

The QM Program Was Comprehensive and Provided Effective Oversight. VABHCS management had a comprehensive QM program that generally provided effective oversight of the quality of care using national and local performance measures, risk management, utilization management, and peer reviews. Ongoing monitoring of quality of care and patient safety included trending and tracking of results in areas such as medication errors, infection control, and medical and surgical mortality and morbidity.

VABHCS QM results were appropriately reported to and acted upon by service-level and facility-wide committees such as the Medical Executive Committee and the Quality Management Integration Council. For patient incidents that occurred during the last year, QM and clinical managers used in-depth preliminary reviews, root cause analyses, and mortality and morbidity educational reviews rather than boards of investigations and individual peer reviews. Consequently, facility teams recommended and implemented solutions with system-wide improvement emphasis.

Opportunities for Improvement

Procurement Practices – Controls Need to Be Strengthened to Avoid Conflicts of Interest And Improve Administration of Contracts

Conditions Needing Improvement. VABHCS management needed to ensure that conflicts of interest did not occur during contract negotiations with affiliates, contracting officers complied with Federal contract administration policies and procedures, and the Government Purchase Card Program was administered effectively.

Conflicts of Interest. Controls needed to be strengthened to ensure that officials developing, soliciting, awarding, and administering contracts comply with conflict of interest statutes and contract administration procedures. Federal criminal statues prohibit a Government employee from participating personally and substantially in a matter in which the employee, to the employee's knowledge, has a financial interest, if the particular matter would directly and predictably affect that financial interest. As of April 2001, the VABHCS had 7 clinical services contracts (valued at $6.3 million) and 8 non-clinical services contracts (valued at $8.3 million), each exceeding $250,000 in value. To determine if contract negotiations and administrative procedures were effective, we reviewed 5 clinical services contracts and 1 non-clinical services contract (estimated combined cost = $3.6 million).

Potential conflicts of interest were identified in five contracts. The cases were referred to the OIG's Office of Investigations for further review and the investigations are pending.

Contract Administration. Federal Acquisition Regulations (FAR) require contracting officials to establish files containing records of significant contractual actions. VA policy requires field-pricing audits to determine the fairness and reasonableness of prices, and for contract clauses to describe contractors' record-keeping procedures. Veterans Health Administration (VHA) polices require contracting officers to send copies of Scarce Medical Specialist Services and Specialized Medical Resource contracts to the Director, Medical Sharing Office for review. VHA policy also requires contracting officers to send copies of sole source (non-competitive) contracts valued above $500,000 to the VHA Office of Finance, Sharing, and Purchasing for technical, legal, and program reviews and approvals.

Contracting officers did not always administer contracts according to the FAR, VA, and VHA policies and procedures. For example:

- Required price negotiation memorandum describing how parties arrived at the $750,000 price for management consultation services was not included in the contract file.

- Required field-pricing reports were not prepared on the fairness and reasonableness of pricing for 3 contracts with a combined cost of $2.4 million.

- Required descriptions of record-keeping procedures were not included in contract files for 2 contracts with a combined cost of $1.3 million.

- Required technical, legal, and program reviews were not obtained on 2 contracts with a combined cost of $1.6 million.

Government Purchase Card Program. Program controls for the use of Government purchase cards were generally effective. VA employees must use the Government purchase cards for all micro-purchases (those under $2,500) and to the maximum extent practicable, for all purchases up to $100,000. The facility purchase card coordinator is responsible for implementing the program and ensuring that cardholders and approving officials are trained. The facility dispute officer is responsible for coordinating and monitoring disputed procurements, credits, and billing errors. The Government Purchase Card Program at the VABHCS included 318 cardholders and 90 approving officials. Cardholders made 30,823 purchases totaling approximately $15.6 million between October 1, 1999 and February 28, 2001. During the first quarter of FY 2001, the Government Purchase Card Programs at the three campuses were consolidated into one program. The following areas affect program effectiveness:

- Training and other program files were not transferred to a central location following the consolidation.

- The Government purchase card coordinator and the dispute official duties needed to be clearly separated because the coordinator inappropriately assisted cardholders with vendor disputes.

- The VABHCS Government purchase card policy did not reflect June 2000, VHA program changes.

- Reconciliation and certification timeliness standards were not met.

In addition, only selected VA employees may have Government purchase cards. At the Jamaica Plain campus prior to consolidation, the Government purchase card coordinator issued cards to an employee of the VABHCS' affiliated non-profit research corporation, as well as to three Boston University employees working at the VABHCS' research facility and a Boston University employee working in the VABHCS' Women's Health Initiative. In total, the 5 cardholders made 1,764 purchases valued at approximately $605,000 between October 1999 and February 2001. However, a review of a selected sample of purchases disclosed no evidence that the 5 cardholders made invalid purchases.

Competition. Acquisition personnel, including cardholders did not always promote competition to the maximum extent practicable in order to obtain supplies and services from sources whose prices were most advantageous to the Government. For the 15-month period ending March 29, 2001, cardholders placed 21 orders totaling $93,000 for prosthetic hip implants and accompanying components using a Government purchase card without soliciting competition. Data obtained from the National Acquisition Center, Federal Supply Schedule (FSS) Service showed that FSS vendors offered comparable items at lower prices.

The following example illustrates the benefit of seeking competition. A VABHCS Acquisition & Materiel Management Service (A&MMS) purchasing agent purchased a prosthetic hip system implant and accompanying components on January 29, 2001, on the open market for $6,738. The price for a comparable prosthetic hip system implant and accompanying components from an FSS vendor would have been $3,618. As a result, VA paid approximately $3,120 (46 percent) more on the open market. If the cardholder had used the FSS vendor for the 21 orders, the VABHCS could have saved approximately $42,780 ($93,000 x 46 percent).

Recommended Improvement Action 1. We recommended that the VABHCS Director ensure controls are implemented to: (a) eliminate conflicts of interest during negotiations; (b) comply with Federal, VA, and VHA contract administration policies and procedures; (c) administer the Government Purchase Card Program effectively; and (d) promote competition to the maximum extent practicable.

The Director generally concurred with the recommendation and reported that necessary steps to eliminate conflicts of interest will be taken during negotiation, field pricing reports will be completed, price negotiation memoranda will be documented in the file, purchase cardholders received training in May 2001, annual training for cardholders will be conducted annually, and when required, purchases of goods and services will have competition to the maximum extent possible. The implementation actions are acceptable, and we consider the issues resolved. (The Director's comments to the recommendations are shown in detail in Appendix A, page 15. The monetary benefits associated with recommendation 1d is shown in Appendix B, page 18.)

Accounts Receivable – Billing and Collection Should Be Improved

Conditions Needing Improvement. VABHCS management needed to ensure Medical Care Collection Fund (MCCF) staff billed third-party insurers in a timely manner and aggressively followed up with insurers, especially when third follow-up letters were sent to insurers, to improve collection efforts. Also, management needed to ensure non-benefit debts of current and former employees were collected or offset against current salaries in a more timely manner.

Billing for Inpatient Episodes of Care. Title 38, United States Code authorizes VA to collect from insurers to offset the cost of providing medical care for non-service connected conditions. We reviewed 90 unbilled episodes of inpatient care for the period July 1, 2000 through December 31, 2000. We requested MCCF staff to review the unbilled listing to determine if insurers should be billed. The review showed that 35 episodes were not billable because treatments were for service-connected conditions or not covered by insurance policies. The remaining 55 episodes of care (61 percent) totaling $878,020 were billed to insurers as a result of our inquiry. The average age of the 55 accounts receivable was 8 months. By applying VABHCS' historical collection rate of 33 percent for billable care, we estimated that the MCCF staff could have collected $289,747 in a more timely manner.

The MCCF Coordinator stated that the backlog of unbilled episodes of care was due to staff productivity issues, a staffing shortage, and ongoing consolidation of the three campuses. To improve timeliness, VABHCS management established new minimum productivity standards and assigned an additional person to the inpatient billing staff.

Pursuing Third-Party Insurer Accounts Receivable. Improvement was needed in pursuing collections of third-party insurer accounts receivable. As of March 31, 2001, the VABHCS had 899 active MCCF third-party accounts receivable over $1000 valued at approximately $5.5 million. Of these, 333 accounts receivable (37 percent) valued at approximately $2.2 million were more than 90 days old.

A sample of 30 accounts receivable over 90 days old valued at $939,982 showed that 7 (23 percent) valued at $267,583 required more aggressive collection actions. VA policy requires that at the time the third notice is sent, telephone follow-up should be made with insurers. Although MCCF staff had sent the initial claim documents and second and third notices to insurers for the 30 accounts receivable, staff did not follow-up with telephone calls. By applying VABHCS' historical collection rate of 33 percent, we estimated that the MCCF staff could have collected $88,302 ($267,583 x 33 percent) in a more timely manner.

The following example illustrates the benefits of timely follow-up with insurers. During the CAP review, a MCCF staff member telephoned an insurer to follow-up on 1 of the 7 accounts receivable valued at $163,090. Because of untimely follow-up, the staff member learned in May 2001, that the insurer needed additional information to process the claim which had been submitted on September 9, 2000. MCCF staff submitted the information to the insurer on June 4, 2001. The MCCF Coordinator agreed to change procedures to ensure staff contacts third-party insurers by telephone at the time third notices are sent, and makes a record of the contacts.

Debts of Current and Former Employees. More aggressive actions are needed to collect or offset debts of current and former employees. VA may collect by offset (from current salary, final salary, lump sum payment, Civil Service Retirement System, and Federal Employee Retirement System benefits) overpayments and non-benefit debts owed to VA by Federal employees. Debts of former employees, as well as current employees, may also be referred to the Treasury Offset Program (TOP) for collection.

As of March 31, 2001, VABHCS records showed 28 active current employee accounts receivable valued at $79,318 and 97 active former employee accounts receivable valued at $126,453. It took Fiscal Service staff an average of 5 months to refer the current employee accounts receivable to TOP. The staff was also untimely in referring former employee debts to TOP, taking an average of 8 months. During the CAP review, management agreed to immediately offset the salaries of 4 current employees whose combined debts totaled $65,874.

Recommended Improvement Action 2. We recommended that the VABHCS Director ensure collection efforts were improved by: (a) billing episodes of care in a timely manner; (b) following up with insurers when third notices are sent; and (c) offsetting current employees' debts and referring former employees' debts to TOP in a timely manner.

The Director concurred with the recommendation and reported that the Patient Accounts Manager is running the unbilled list bi-weekly and monthly, Patient Accounts staff were following up with insurance companies, and referrals to TOP were now more timely. The implementation actions are acceptable, and we consider the issues resolved. (The Director's comments to the recommendations are shown in detail in Appendix A, page 16. The monetary benefits associated with recommendations 2a, 2b, and 2c are shown in Appendix B, page 18.)

Controlled Substances – Inspection Procedures and Pharmacy Security Need To Be Improved

Conditions Needing Improvement. VABHCS management needed to ensure that controlled substances inspections were conducted regularly and security was effective. VHA policy requires Directors of medical facilities to establish an adequate and comprehensive system for Schedule II-V controlled substances in order to ensure safety and control of stocks. Controls at the Jamaica Plain, West Roxbury, and Brockton campuses that required improvement included:

- Monthly unannounced controlled substances inspections during the 12-month period April 2000 through March 2001 were not performed at West Roxbury for 10 months, at Jamaica Plain for 5 months, and at Brockton for 2 months.

- Documentation to corroborate orientation and training of inspectors did not exist.

- Inspectors were not always disinterested persons. For example, an inventory management specialist participated in one inspection at the Jamaica Plain campus. A physician and physician's assistant were on the list of potential inspectors at the Brockton campus.

- Inspectors at each campus did not consistently verify dispensing entries in all clinic and ward areas to ensure that amounts removed from clinic and ward inventories were supported by doctors' medication orders and drug administration records in patients' records.

- Management did not trend inspection results to identify potential problem areas needing improvement.

- Inspections did not include controlled substances held for disposal at the three campus pharmacies. Drugs held for disposal were not in a locked area of the pharmacy at West Roxbury and were not stored in sealed containers at Jamaica Plain.

- A current copy of 21 Code of Federal Regulations, Part 1300 was not in the A&MMS Chief's office or in the master controlled substances storage location.

Other issues affecting the security of controlled substances at the VABHCS were:

- ***(b)(2)*** ……. ***(b)(2)*** …….

- ***(b)(2)*** …….

- Pharmacy Service management did not maintain documentation to substantiate that all pharmacy employees had viewed the video "Employee Integrity and Pharmacy Security."

On May 24, 2001, an armed robbery occurred at the Jamaica Plain outpatient pharmacy after regular clinic hours. This matter is currently under investigation by the OIG Office of Investigation, VABHCS Police and Security Service, and the Federal Bureau of Investigations.

Recommended Improvement Action 3. We recommended that the VABHCS Director establish a strengthened, adequate, and comprehensive system for Schedule II-V controlled substances to ensure safety and control of stocks consistent with VHA policies.

The Director concurred with the recommendation and reported that the Narcotics Inspection Program was reassigned to the Chief, Police and Security Service and a new policy was implemented addressing control weaknesses. The implementation actions are acceptable, and we consider the issues resolved. (The Director's comments to the recommendation are shown in detail in Appendix A, page 16.)

Abnormal Diagnostic Test Results – Procedures for Communicating and Documenting Results Need Improvement

Conditions Needing Improvement. VABHCS management needed to improve procedures for notifying patients' physicians of abnormal diagnostic test results and for documenting notifications in patients' medical records. To evaluate the effectiveness of communicating abnormal diagnostic test results to physicians, we reviewed 30 patients' medical records. The 30 records included 10 abnormal clinical laboratory results, 10 abnormal anatomical pathology results, and 10 abnormal radiology imaging results. Pathologists personally communicated all of the abnormal clinical laboratory results to primary care providers, but only 9 of 10 of the abnormal anatomical results. Radiologists personally communicated 9 of 10 abnormal imaging results.

Clinical laboratory policy requires staff to document in patient medical records that abnormal test results were immediately reported verbally to the patients' physicians. The required notation was included in 10 medical records reviewed for patients having abnormal clinical laboratory results.

Anatomical pathology and radiology imaging policies, however, contained no requirement for pathologists and radiologists to document immediate notifications. Patients' medical records contained no documentation that pathologists immediately reported abnormal anatomical pathology test results to physicians in 6 of the 10 (60 percent) sampled cases. Similarly, patients' medical records contained no documentation that radiologists immediately reported abnormal radiology imaging test results to physicians in 8 of the 10 (80 percent) sampled cases.

Suggested Improvement Actions. We suggested that the VABHCS Director improve policies and procedures to ensure that: (a) abnormal diagnostic test results are personally communicated to patients' physicians immediately; and (b) the communications are documented in medical records by the pathologists or radiologists who notified the patients' physicians.

The Director concurred and responded that a multidisciplinary team will study the current processes of communicating abnormal test results and make appropriate recommendations for improvement. The implementation plan is acceptable, and we consider the issue resolved. (The Director's comments to the suggestion are shown in detail in Appendix A, page 16.)

Background Investigations – Investigations Should Be Documented For All Employees

Condition Needing Improvement. VABHCS management needed to ensure that Human Resources Service followed required procedures for fingerprinting new employees, forwarding background investigation forms to the Office of Personnel Management (OPM) for processing, and completing Certifications of Suitability for Employment upon completion of satisfactory background investigations.

VABHCS records showed that the Brockton and West Roxbury campuses submitted required fingerprints and forms to OPM, but no documentation existed to support that background investigations were ever done on Jamaica Plain employees. VABHCS management amended the record-keeping process in May 2001 to include dates employees entered on duty and dates forms were sent to OPM.

Suggested Improvement Action. We suggested that the VABHCS Director ensure that employees have properly documented background investigations in their personnel files, including fingerprints and Certifications of Suitability for Employment.

The Director concurred and responded that the Chief, Human Resources Management Service has implemented a process to complete background investigations. The implementation plan is acceptable, and we consider the issue resolved. (The Director's comments to the suggestion are shown in detail in Appendix A, page 16.)

Physical Plant – Facility Maintenance and Safety Issues Need Greater Management Attention

Conditions Needing Improvement. VABHCS management needed to improve the general appearance of the Brockton campus. Trash and cigarette butts were present on the grounds, especially near entrances and in stairwells. Paint on walls was chipped and floor perimeters were not clean. Patient bathrooms had dirty walls, floors, and sinks and the automatic door opener in one bathroom did not work. Employees stated that there were too few employees to clean patient rooms and offices properly. Although the general maintenance of the West Roxbury campus was acceptable, equipment and supplies cluttered inpatient care area hallways. Administrative buildings at the Jamaica Plain campus needed painting and cleaning.

Safety issues existed at the Brockton campus. Fire alarms and emergency telephones enclosed in locked cabinets in tunnel passageways presented safety hazards for visitors and patients because only employees had keys to the cabinets. VABHCS management stated that locked cabinets prevented patients from initiating false alarms. In addition, a security button was not functioning in one Mental Health Clinic.

Suggested Improvement Action. We suggested that the VABHCS Director correct maintenance and safety deficiencies.

The Director concurred and reported that monthly environment of care rounds are made throughout the VABHCS and deficiencies noted are documented and corrective actions taken. The implementation plan is acceptable, and we consider the issue resolved. (The Director's comments to the suggestion are shown in detail in Appendix A, page 17.)

Part-Time Physician Timekeeping – Time and Attendance Controls Should Be Strengthened

Conditions Needing Improvement. VABHCS management needed to ensure that part-time physicians' attendance was properly documented. Part-time physicians are physicians hired to

work less than a normal 40-hour duty week. Timekeepers are required to ensure that timecards accurately reflect any shortened and irregular tours. VA policy states that timekeepers are responsible for completing timecards to show part-time physicians' assigned tours of duty, actual hours worked, and any charges to leave. A timekeeper's personal knowledge of physician attendance is a key element of the control for accurately reporting timecards.

Physicians' Tours of Duty. In a sample of 27 part-time physicians' tour of duty records, 4 were not accurate. The four part-time physicians changed their tours of duty, but their respective timekeepers in Medical and Surgical Services did not notify Fiscal and Human Resources Services. Consequently, the correct duty schedules were not entered into the payroll system. During the CAP review, administrative officers in Medical and Surgical Services took immediate actions to correct the part-time physicians' tour of duty records.

Timekeepers Training. VA requires the Employees Accounts Section to conduct initial training of newly appointed unit timekeepers within 30 days of their appointments and annually thereafter. The Employees Accounts Section has not provided initial or annual refresher timekeeping training since 1994.

Suggested Improvement Actions. We suggested that the VABHCS Director ensure that: (a) timekeepers notify Fiscal and Human Resource Services of changes in part-time physicians' tours of duty; and (b) all timekeepers receive initial and annual refresher training.

The Director concurred and reported that Fiscal Service will create a monitor to audit time cards of part-time physicians on a regular basis and that initial and annual refresher training for timekeepers will be scheduled. The implementation plan is acceptable, and we consider the issue resolved. (The Director's comments to the suggestion are shown in detail in Appendix A, page 17.)

Automated Information Systems – Controls Need To Be Strengthened

Conditions Needing Improvement. VABHCS management needed to improve automated information systems (AIS) controls to prevent unauthorized release of medical information, password-protect computer systems to force booting from hard drives, and display warning banners prior to the network system users authentication.

Confidentiality of Patient Medical Information. Protection of patients' medical information was generally effective. All VABHCS employees received medical record privacy training during employee orientation, annually, and when new requirements were published. VABHCS management had a current policy governing access, use, and release of medical record information. Nevertheless, the following privacy breaches relating to access, use, and release of patients' medical information were noted during our inspection of 10 patient care areas:

- Computer monitors were within public view in three areas.

- Medical records were left unsecured or unattended in three areas.

- Open documents were left on unattended computer terminals in two areas.

- Anti-virus protection software was not installed on one computer.

Security of AIS Software. VABHCS AIS security controls in the areas of security program planning and management, access for system software changes, and service continuity policies and practices were generally adequate. However, computer resource (hardware) access needed to be strengthened.

VA policy for computer hardware access requires that each personal computer be set and password-protected to force booting from only the hard drive. At the Jamaica Plain campus, three of five systems were not password-protected and were accessible to potential users to make changes to the PC basic hardware configurations. All five systems' start-up routines were not set up to boot only from the hard drives to prevent the possibility of boots from operating systems on removable media. Three systems did not display the required security banner. At the Brockton and West Roxbury campuses, the five systems' start-up routines were not password-protected, not setup to boot only from hard drives, and did not display warning banners prior to the network system users authentication.

Suggested Improvement Actions. We suggested that the VABHCS Director ensure that: (a) employees adhere to VABHCS policy governing access, use, and release of medical record information; (b) start-up routines requiring booting only from hard drives; and (c) all PCs display warning banners prior to the network system users authentication.

The Director concurred and responded that the Information Security Officer will provide training to all employees regarding the release of medical record information. Actions will be taken to ensure that start-up routines require booting only from the hard drive and that all PCs display warning banners. The implementation plan is acceptable, and we consider the issue resolved. (The Director's comments to the suggestion are shown in detail in Appendix A, page 17.)

Other Observation

Chemical Control Weapons. VABHCS management provided us with information about three incidents in which Police and Security Service discharged chemical control weapons while subduing unruly patients during the period October 9, 2000 to May 3, 2001. Three employees were also sprayed during the incidents with one requiring medical attention. Management handled these incidents properly by conducting a root-cause analysis that resulted in reasonable recommendations that should prevent the occurrence of similar incidents in the future.

Appendix A

VA Boston Healthcare System Director Comments

Department of Veterans Affairs

Memorandum

Date: September 24, 2001

From: Director (00/523), VA Boston Healthcare System

Subj: OIG Combined Assessment Program (CAP) Review-VABHCS, May 2001

To: Assistant Inspector General for Auditing (52)

1. Enclosed please find our response and action plan regarding the recent OIG CAP Team's observations and recommendations resulting from your review May 21 – 25, 2001. We have reviewed the report findings and generally concur with the recommendations and suggestions. We also generally concur with the "Monetary Benefits" noted for recommendations one and two.

2. If you require any additional information or further assistance, please do not hesitate to contact Ms. Cathleen Stephens at (617) 232-9500 extension 5267.

/signed/

Michael M. Lawson
Director, VABHCS

Appendix A

VA Boston Healthcare System

Action Plan

Topic: OIG CAP Review of May 21-25, 2001 **Date: September 24, 2001**

Recommendation/ Suggestion	Action	Target Completion Date
1. Ensure that controls are implemented to: (a) eliminate conflicts of interest during negotiations, (b) comply with Federal, VA, and VHA contract administration policies and procedures, (c) administer the Government Purchase Card Program effectively, and (d) promote competition to the maximum extent practicable.	(a.) We have taken the necessary steps to appoint appropriate individuals as the Contracting Officers Technical Representative (COTR) for our scarce medical contracts. For example, the VA will require a Harvard Affiliate to review a BU Affiliate procurement and vice versa. In addition to appointing new COTRs, the Chief, A&MMS or designee will question prospective COTRs regarding other sources of income from the affiliates with whom we contract. (b.) Contracts will have field pricing reports completed. Those contracts over $500,000 will be forwarded to Central Office for legal and technical review. All contracts which require price negotiation memorandums will be documented in the file. (c.) Training for all purchase cardholders was provided by the Chief, A&MMS in May. Refresher training will be conducted as needed. Annual training will be conducted for all purchase cardholders by the Chief, A&MMS or designee. Monthly a random sampling of purchases made by purchase cardholders will be reviewed by A&MMS staff to ensure that these purchases are in compliance with VA Rules and Regulations. Action will be taken on deficiencies found. These will be tracked and trended by the Chief, A&MMS and reported to the Associate Medical Center Director. (d.) When required, purchases for goods and services will have competition to the maximum extent possible. This will be documented in the purchase files.	Ongoing. This will be dependent upon the expiration and/or initiation of the contract. Done May 2001 and refresher training as needed. Done

Appendix A

2. Ensure collections efforts improve by: (a) billing episodes of care in a timely manner, (b) following up with insurers when third notices are sent, (c) off setting current employees' debts and referring former employees' debts to TOP in a timely manner.	(a.) Patient Accounts Manager is running the unbilled list bi-weekly. Bills are processed depending upon the age of the receivable. A more detailed unbilled list is run monthly with the same action. This allows us to capture all unbilled episodes of care. Due to our volume of billing, we are reviewing the possibility of contracting out our billing to increase our timeliness. (b.) Patient Accounts staff are calling insurance companies regarding outstanding receivables and documenting this information in the bill comment log. (c.) Referrals of employees and ex employees' debts are forwarded timely via the VISTA System to TOPS. All debts that qualify are transferred monthly. TOPS implements necessary corrective action to collect the debt.	Implemented Implemented Implemented
3. Establish a strengthened, adequate, and comprehensive system for Schedule II-V controlled substances to ensure safety and control of stocks consistent with VHA policies.	In April of 2001, a review of the Narcotics Inspection Program revealed the need for improvement. This program has been reassigned to the Chief, Police & Security Service. A new policy has been implemented which provides for a comprehensive plan for the monthly inspections, proper disposal of narcotics, and training of the inspectors. Tracking and trending of inspection results are submitted to the Administrative Executive Board.	July 2001
4. Improve policies and procedures to ensure that: (a) abnormal diagnostic test results are personally communicated to patient's physicians immediately and (b) the communications are documented in medical records by the pathologist or radiologist who notified the patient's physician.	A root cause analysis team has been established concerning the follow up of abnormal diagnostic test results. This multidisciplinary team will study the current processes and systems and make recommendations for improvement to the Interdisciplinary Clinical Practice Committee.	Recommendation October 2001 Implementation December 2001
5. Ensure that employees have properly documented background investigations in their personnel files including fingerprints and Certifications of Suitability for Employment.	The Chief, Human Resources Management Service has implemented a process to complete background investigations. He has developed and implemented a system to document the dates employees entered on duty and dates forms are sent to the Office of Personnel Management.	May 2001

6. Correct maintenance and safety deficiencies.	Monthly environment of care rounds are made throughout the VA Boston Healthcare System. Deficiencies noted are documented and corrective action taken to resolve. These results are tracked and trended within the Environment of Care Committee. Facility Management Service has a computerized work order system to track and trend maintenance deficiencies. These are monitored and followed up by the FMS Operational Managers.	Done
7. Ensure that: (a) timekeepers notify Fiscal and Human Resource Services of changes in part-time physicians' tours of duty and (b) all timekeepers receive initial and annual refresher training.	(a.) The responsibility of physician supervisors for monitoring part-time physicians leave activity has been reinforced through various venues including the Medical Executive Committee. Fiscal Service will create a monitor to audit the time cards of part-time physicians on a regular basis. (b.) Fiscal Service will schedule annual refresher training for timekeepers which will include timekeepers and certifying officials to ensure accuracy of time and attendance cards. Fiscal Service will also provide orientation training to all new timekeepers and certifying officials.	Done Ongoing December 2001
8. Ensure that: (a) employees adhere to VABHCS policy governing access, use, and release of medical record information, (b) CMOS routines boot only from hard drives, and (c) all PCs display warning banners prior to the network system users authentication.	(a.) Information Security Officer will provide training to all Services on the release of medical record information. This will be one of our mandatory training topics for Fiscal year 2002. (b.) The thin client technology being installed eliminates the CMOS problem. While accompanying the auditor and finding the deficiencies we assured him that we would make the necessary corrections to those machines with CMOS issues and those not displaying the warning banner as we performed maintenance. (c.) Information Service Line is developing a process to display warning banners.	Ongoing during 2002 Ongoing Ongoing

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the VA Boston Healthcare System

Report Number: 01-01253-14

Recommendation	Explanation of Benefits	Better Use of Funds
1d	Better use of funds by promoting competition to the maximum extent practicable.	$ 42,780
2a	Better use of funds by timely billing inpatient episodes of care.	289,747
2b	Better use of funds by telephoning insurers at the time third notices are sent.	88,302
2c	Better use of funds by collecting debts owed by employees by offsetting from current salaries.	65,874
	Total	$486,703

Appendix C

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Appendix C

This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG web site for 2 fiscal years after it is issued.