Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review

VA Tennessee Valley Healthcare System

Report No.: 01-00788-108
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Office of Inspector General
Washington, DC 20420

VA Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort 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. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- We evaluate how well the facility is meeting quality standards in specific core areas and the level of patient satisfaction with overall treatment.
- We review selected financial and administrative activities to ensure that management controls are effective.
- We conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

Combined Assessment Program Review
VA Tennessee Valley Healthcare System

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs (VA) Tennessee Valley Healthcare System (TVHS) during the week of March 12 – 16, 2001. The TVHS is comprised of the Nashville and Alvin C. York (ACY) VA medical centers located in Nashville and Murfreesboro, Tennessee. The purposes of the CAP review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to TVHS employees.

Patient Care and Quality Management (QM). To address patient care issues and enhance operations, we recommended that the TVHS Director

- review the quality of care and cost effectiveness of the surgery program at ACY,
- ensure that patient care and common areas are kept clean and free of odors,
- ensure timely access to outpatient clinics,
- ensure crash carts are properly inspected,
- convert the inpatient psychiatric unit to a locked ward,
- improve narcotics prescribing practices of attending psychiatrists,
- ensure that NHCU patients are not left unattended in the Physical Therapy (PT) clinic and are escorted to and from their PT appointments, and
- implement Veterans Health Administration's "*Pain as the 5th Vital Sign*" initiative.

We also made suggestions to improve the effectiveness of the QM program.

Financial and Administrative Management. To improve financial and administration functions, we made recommendations to the TVHS Director to

- increase medical care collection fund (MCCF) recoveries and improve the MCCF recovery process,
- ensure that inventory records are updated to reflect actual quantities on hand and inventories are reduced and maintained at 30-days or below levels,
- establish procedures to strengthen Pharmacy Service security, and
- establish procedures to ensure that part-time physicians are present during their core hours.

We also made suggestions for improvements in

- the Government purchase card program,
- automated information systems security,
- agent cashier functions,
- compensated work therapy payments,
- personal funds of patients,
- unliquidated obligations,
- security of patient medical records, and
- annual performance appraisals.

Fraud Prevention. TVHS management fully supported fraud prevention and detection efforts. During the review we provided fraud and integrity awareness training to 154 employees. The training included areas of interest for OIG investigations, requirements for reporting suspected wrongdoing, and referrals to the OIG.

TVHS Director Comments. You concurred with the findings, recommendations, and suggestions in the report; and provided acceptable implementation plans. Therefore, we consider the issues to be resolved. However, we may follow up on those planned actions that are not completed.

(Original signed by Michael L. Sullivan for:)

RICHARD J. GRIFFIN
Inspector General

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Introduction

Tennessee Valley Healthcare System

The Department of Veterans Affairs (VA) Tennessee Valley Healthcare System (TVHS) provides primary medical, surgical, and mental health care, as well as nursing home care. The TVHS is comprised of the Nashville and Alvin C. York (ACY) VA medical centers located in Nashville and Murfreesboro, Tennessee. TVHS outpatient clinics located in Knoxville, Cookeville, Clarksville, and Chattanooga, Tennessee. There are Vet Centers located in Knoxville and Chattanooga, and a community-based outpatient clinics (CBOCs) in Dover and Tullahoma, Tennessee, and Bowling Green and Hopkinsville, Kentucky. The TVHS is part of the Mid-South Veterans Healthcare Network, Veterans Integrated Service Network (VISN) 9. The primary service area for the TVHS contains about 430,000 veterans and includes 93 counties in Tennessee, Kentucky, Alabama, Georgia, and Virginia.

Affiliations and Programs. The TVHS facilities are affiliated with the Meharry Medical College, Vanderbilt University School of Medicine, and numerous allied health programs including schools of nursing at Tennessee State and Middle Tennessee State Universities. The TVHS supports a $5 million research program, which consists of participation in five national research studies.

Resources. The Fiscal Year (FY) 2001 budget is $264.2 million. Staffing totals 2,446 full-time equivalent employees (FTEE), including 152 physicians. Current operating bed levels include 168 for medicine, 42 for surgery, 164 for mental health, and 135 for the nursing home care unit (NHCU).

Workload. The TVHS served over 55,000 unique veterans in FY 2000 and provided 120,022 bed days of care to 8,464 medical, surgical, and mental health patients, and 40,319 bed days of care to 342 NHCU patients. The average daily census for FY 2000 was 147 for medicine, 24 for surgery, 156 for mental health, and 110 for the NHCU. In addition, the TVHS recorded 462,164 outpatient visits.

Objectives and Scope of Combined Assessment Program

The purposes of the Combined Assessment Program (CAP) review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to TVHS employees.

Patient Care and Quality Management (QM). We reviewed selected clinical activities to evaluate the effectiveness and appropriateness of patient care and QM. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and ensuring employee competence. The QM program is comprised of a set of integrated processes that are designed to monitor and improve the quality and safety of patient care and to

identify, evaluate, and correct actual or potential circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities.

To evaluate the QM program and patient care management, we inspected patient treatment areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. We also used questionnaires to determine patient satisfaction and solicited patients' opinions about the quality of care. We reviewed the following functions and services:

- QM Program
- Infection Control
- Surgical Service
- Outpatient Clinic Waiting Times
- Crash Cart Inspections
- Narcotics Prescribing Practices in the Mental Health Program
- Acute Psychiatry
- Nursing Home Care Unit
- Pain Management Program
- Acute Care
- Coding for Outpatient Billing
- Bone Marrow Transplant Unit
- Consult Returns to CBOCs
- Autopsy Rates

Financial and Administrative Management Review. We reviewed selected financial and administrative activities to evaluate the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, prevent and detect errors and fraud, and ensure that organizational goals and objectives are met. In performing the CAP review, we inspected work areas, interviewed managers and employees, and reviewed pertinent administrative, financial, and clinical records. The review covered the following financial and administrative activities and controls:

- Automated Information Systems (AIS) Security
- Pharmacy Service Security
- Medical Records Security
- Service Contracts
- Community Nursing Home (CNH) Contracts
- Enhanced Use Lease Agreements
- Inventory Management
- Unliquidated Obligations
- Government Purchase Card Program
- Agent Cashier Activities
- Personal Funds of Patients (PFOP)
- Employee Accounts Receivable
- Medical Care Collection Fund (MCCF) Recoveries
- Part-time Physicians' Attendance

Fraud Prevention. We conducted 6 fraud and integrity awareness briefings for 154 TVHS employees.

Scope of Review. The CAP review generally covered TVHS operations for the period January 1999 to March 2001. The review was performed in accordance with Combined Assessment Program Standard Operating Procedures, issued by the Department of Veterans Affairs Office of Inspector General (OIG).

Results, Recommendations, and Suggestions

The integration of the Nashville and ACY VA medical centers was approved on November 8, 1999. Although administrative integration, including the appointment of a new system director, the merging of data systems, and the approval of a new name and station number had occurred, the organizational integration was incomplete. An integrated organizational chart had not been approved and most clinical service chiefs had not been appointed. Several policies were being drafted, but in many cases, the two campuses had different, outdated policies for the same departments, or no policies at all. Cultural integration, wherein employees identify with the new system instead of their individual campus, will be a particular challenge, as evidenced by the fact that many employees of both campuses expressed resistance to the integration.

We attempted to evaluate TVHS programs as an integrated system; however, in general, this was not possible. Although we found some deficiencies that could be attributed to the incomplete integration, most could not. Many problems predated the integration. We found problems and deficiencies, as well as areas of excellence, on both campuses. Management should identify and consider the respective strengths of each facility when integrating programs.

Patient Care and Quality Management

Patients We Interviewed Were Satisfied With the Quality of Care. We interviewed a total of 35 inpatients and outpatients from both campuses. All patients interviewed were satisfied with the care they received and rated the quality of care provided as good, very good, or excellent. All of the inpatients and 95 percent of the outpatients interviewed felt that they were involved in decisions about their care. When asked if they would recommend medical care at this facility to an eligible family member or friend, more than 95 percent of the patients we interviewed stated that they would.

Recommendations for Improvement in Various Patient Care and Administrative Functions

Some identified issues required senior management action. We made recommendations for improvements in the following areas:

Quality of Care and Cost Effectiveness of the Surgical Program at ACY Should Be Reviewed. The volume of surgical procedures, case mix in the operating rooms, complication rates, and the anesthesia staffing level raised concerns about the quality of surgical care provided and cost effectiveness of the surgery program at ACY.

- **Volume** – There were 530 major surgeries,[1] and 446 minor surgeries conducted in FY 2000 at ACY. Staffing consisted of 6.15 FTEE surgeons (not including fee-basis surgeons and podiatrists who also contributed to the total surgical workload figures). This workload amounted to 18.96 surgical procedures per week for Surgical Service, 3.08 per week per FTEE, and 0.616 per day per FTEE. These low-volume figures raised concerns about the ability to maintain surgical professional proficiencies, and the cost effectiveness of the program.

- **Case Mix** – Some procedures typically performed in physicians' offices were entered in the ACY Annual Surgical Service Summary Report for FY 2000 as operative procedures. These procedures may have been incidental to other more substantive procedures, but gave the appearance of workload augmentation.

- **Complication rates** – Some of the perioperative[2] occurrences reported in the ACY Annual Surgical Service Summary Report for FY 2000 contributed to concerns about quality of care. For example:

  Colon resections – complication rate of 56.3%
  Cholecystectomies – complication rate of 28.6%

- **Anesthesia staffing** – ACY had one full-time anesthesiologist and two full-time Certified Registered Nurse Anesthetists for two operating rooms and one cystoscopy room. Major surgeries averaged 10 per week, or 2 per day. This raises a question of cost effectiveness and appropriate allocation of medical resources.

Recommendation 1: The TVHS Director should initiate a review of the surgical program at ACY to assess the quality of care provided and cost effectiveness of the program.

TVHS Director Comments

The Director concurred with the recommendation and stated that he has requested a comprehensive evaluation of the entire Surgical Program from a system standpoint in order to assess current processes. The goal is to develop and implement a system-wide approach to provide timely and efficient surgical care to veterans served throughout the TVHS. The committee is co-chaired by the TVHS Chief, Medicine Service and ACY Chief, Surgical Service and has a multidisciplinary composition. Target date for report: August 24, 2001.

[1] Major surgery is any operation performed under general, spinal, or epidural anesthesia, plus all inguinal herniorrhapies and carotid endartrectomies, regardless of anesthesia administered.
[2] Perioperative means the period surrounding the operation, which extends up to 48 hours after surgery.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Cleanliness of Patient Care and Common Areas Needs Improvement. Many patient care and common areas at ACY were dirty and poorly maintained. Specifically, the acute care unit (1A), NHCU (both east and west wings), hospice unit (1B), and many common hallways and bathrooms were found to have ground-in dirt and trash on the floors, accumulated dust and cobwebs on ceiling vents and in corners, water-stained ceiling tiles, and the bathrooms had filthy commodes and sinks. Soiled linen carts that produced a strong urine odor were stored in a hallway leading to the NHCU. We were told that Environmental Management Service had storage space for the carts, but did not use it. We found similar cleanliness deficiencies on the medical ward (2N) at Nashville.

Recommendation 2: The TVHS Director should ensure that patient care and common areas are kept clean and free of odors.

TVHS Director Comments

The Director concurred with the recommendation and stated that the Chief, Environmental Management Service and Associate Director/Clinical Support Services (Chief Nurse) are developing a plan which will include, 1) cleaning schedule for all patient care areas; 2) Responsibility Grid – who is responsible for cleaning, who is responsible for monitoring and evaluating; and, 3) review of outcome by Management Team. Target date for plan: June 15, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Clinic Appointment Waiting Times Need to Be Reduced. The TVHS facilities met the 30-day timeliness standard for waiting times in only 2 (20 percent) of 10 outpatient clinics reviewed. Veterans Health Administration (VHA) policy requires outpatient clinic appointments to be scheduled within 30 days of request. We examined the TVHS' compliance with this policy for several clinics known to be outliers nationally and found the following average appointment waiting times (in days):

TVHS Clinic Waiting Times (Days)

Clinic	Nashville	ACY
Primary Care	79.8	18.4
Audiology	51.7	10.3
Cardiology	49.2	37.9
Eye Clinic	94.0	64.4
Urology	111.4	36.2

The next available appointment waiting times at the ACY campus were less than the same clinics at Nashville. ACY managers had implemented several initiatives including use of mid-level practitioners, follow-up clinics operated by nurses, and routine follow-up clinics extended out to 6 months or a year. Nashville also used mid-level practitioners, but had not implemented other waiting time reduction strategies and initiatives.

We found that Nashville and ACY did not share specialists between the two campuses. This condition may have contributed to the wide variation in waiting times for the two campuses. In an effort to decrease waiting times, TVHS management should evaluate the feasibility of sharing physicians and other specialty resources and develop an implementation plan for waiting time reduction initiatives at Nashville.

Recommendation 3: The TVHS Director should ensure that appropriate initiatives are implemented and resources are shared between campuses to improve access to outpatient clinics.

TVHS Director Comments

The Director concurred with the recommendation and stated that the Chief of Staff, ACY Campus and Acting Chief of Staff, Nashville Campus are coordinating the development of a plan in conjunction with the re-design of Primary Care. Recommendations from Primary Care consultant visit and the Institute for Healthcare Improvement piloted at ACY and Chattanooga will be components of the plan. In addition, the input of the incoming TVHS Chief of Staff (due date July 1, 2001) will be requested, and of the selected Primary Care Service Line Manager. The target date for the plan: August 1, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Crash Cart Inspections in the Nashville Medical Intensive Care Unit (MICU) Need to Be Documented. Required inspections of MICU crash carts at Nashville were not documented. According to TVHS policy, crash carts must be inspected for functional status once per shift. We found 12 occasions where no documented evidence was

present to indicate that required MICU crash cart inspections were performed during the period January 1 to March 13, 2001.

Recommendation 4: The TVHS Director should ensure that Nashville MICU clinicians document crash cart inspections.

TVHS Director Comments

The Director concurred with the recommendation and stated that the Associate Director/Clinical Support Services (Chief Nurse) has addressed the failure of the Nashville Campus MICU staff to follow the crash cart inspection policy. He has required the following: 1) documentation of inspection of the MICU crash cart every shift; 2) documentation of Nurse Manager review of every shift inspection; and, 3) report of previous actions (#1 and #2) to him on a weekly basis. This is current and ongoing. In addition, a system-wide (all sites, including CBOCs) procedure with accountability/monitoring components is in development. Target completion date: June 15, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Patient Care Management in the Mental Health Program at Nashville Needs Improvement. We reviewed patient care management at the Nashville campus and found that the establishment of a locked psychiatric unit could improve patient care and reduce costs; and, prescribing practices for narcotics needs management attention.

The Inpatient Acute Psychiatric Unit Should Be Converted to a Locked Ward. Ward 4B is the sole inpatient psychiatric unit at the Nashville facility and is designated as an acute unit, not a locked unit, and cannot accommodate dangerous or committed patients. The absence of a locked psychiatric unit at Nashville has impacted patient care management by (i) delaying patient treatment, (ii) limiting admissions of female patients, and (iii) increasing transportation and fee basis costs of patients requiring admission to a locked psychiatric unit at other VA and non-VA facilities.

We found the following conditions:

- Patients requiring admission to a locked psychiatric unit must wait in the triage area under one to one (1:1) supervision until they can be transferred to a locked unit facility. During the period January 1 to March 14, 2001, the Nashville facility spent about $6,235 for 1:1 supervision costs ($31,200 annually).

- During the period October 1, 2000, to March 14, 2001, 77 patients were transported from Nashville via ambulance to another VA or non-VA facility, at a cost of about $17,385 ($38,700 annually).

- Also, during the period October 1, 2000, to March 14, 2001, 8 patients had to be transferred to non-VA facilities at a cost of about $ 13,335 ($30,000 annually).

- All patient rooms on Ward 4B at the Nashville facility were private or semi-private and while they could accommodate female patients, they could not accommodate dangerous or committed female patients. ACY had only one patient room on the acute psychiatry unit that could accommodate a female patient. Consequently, if more than two female patients needed locked units, they were sent to other facilities.

The Nashville psychiatric unit had sufficient staff to convert it to an acute locked psychiatric unit. Converting Ward 4B to a locked unit would result in

- more timely treatment of patients,

- increased capacity to treat female psychiatric patients, and

- reduced operating costs of an estimated $100,000 per year through reduced 1:1 supervision in triage, transportation, and fee-basis costs.

The Director agreed that these particular costs would be reduced, but noted that other costs would increase substantially as a result of converting to a locked ward.

Prescribing Narcotics Without Examining Patients or Reviewing and Co-signing Progress Notes Should Be Discontinued. A psychiatrist at the Nashville campus inappropriately prescribed narcotics without examining the patients or reviewing and co-signing progress notes. We reviewed the prescribing of narcotics for maintenance purposes by attending psychiatrists. We identified one psychiatrist who prescribed controlled substances without examining the patients or reviewing and co-signing the progress notes of the patients' primary care provider (PCP), a nurse practitioner. This practice was unacceptable.

Recommendation 5: The TVHS Director should:

a. Convert the inpatient psychiatric ward to a locked unit.

b. Ensure that physicians examine patients or review and co-sign progress notes of the patients' PCP prior to prescribing narcotics.

TVHS Director Comments

The Director concurred with the recommendations and stated that:

a. He has appointed a multi-disciplinary team, including Engineering and Nursing, to address all issues involved with securing the unit. This would include staffing,

environmental modifications, training and education, competency and assessing both patient and staff mix. Target plan due date: June 15, 2001.

b. The Nashville Campus Acting Chief of Staff and Chief, Psychiatry Service have reviewed the process of obtaining physician signature for controlled substances when the patient is managed by a physician extender. They have instructed that physicians must, at a minimum, review progress notes in order to document concurrence with treatment plan prior to co-signing orders for narcotics. This change has already been implemented. In addition, the revised TVHS Narcotic Control Policy will clearly reflect the modification in the process. The target date for the policy: June 15, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Leaving Patients Unattended on Physical Therapy (PT) Equipment Should Be Discontinued at ACY. During our inspection of the NHCU, we found three patients were left unattended on PT equipment at the ACY campus while the physical therapist was picking up other patients for their PT appointments, or returning the patients to their rooms when their sessions were completed. This practice compromises patient safety. Use of escorts instead of the therapist would reduce the risk of injury to patients and would be a better use of the therapist's time.

Recommendation 6: The TVHS Director should:

a. Ensure that NHCU patients are not left unattended in the PT clinic.

b. Provide an escort to accompany NHCU patients to and from their PT appointments.

TVHS Director Comments

The Director concurred with the recommendation and stated that the Associate Director/Clinical Support Services (Chief Nurse) is coordinating the development of an internal TVHS Transport Plan. Escort personnel are either currently under Nursing or A&MM at each campus and have varying procedures. The focus will be safe and timely transport of patients to support the efficient and effective use of staff and patient services. The target date for the plan: June 15, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Improvements Were Needed in the Pain Management Program. VHA launched its "*Pain as the 5th Vital Sign"* (Pain) initiative in 1998 in response to national studies, which suggested that pain was not routinely assessed and treated in hospital and clinic settings. The purpose of our review was to assess bedside compliance with VHA's Pain initiative and determine whether assessments, treatments, and documentation in medical records were appropriate. We conducted medical record reviews on patients with selected diagnoses who may have experienced pain during their hospital stays. In addition, we examined the educational records of randomly selected caregivers and evaluated the TVHS draft policy on pain management.

Overall, the pain management program at TVHS lacked coordination and consistency, and had not achieved the level of implementation expected after 2 years of the mandate. We found that the integrated pain management policy for the TVHS had been in draft form since FY 2000. Because the draft policy had not been implemented, it resulted in differing assessments, treatments, and documentation practices not only between campuses, but also between programs and wards on the same campus. Although many pain components were documented in either the hard copy medical records or the computerized patient records, there was little consistency in the location, format, or quality of the documentation. We reviewed 10 medical records of selected inpatients and outpatients from each campus in the past year and found the following results.[3]

TVHS PAIN INITIATIVE COMPLIANCE

	Compliance		
VHA Pain Initiative Component	**Nashville**	**ACY**	**Combined**
Initial pain assessment	90%	90%	90%
Pain assessment includes:			
Score	67%	50%	59%
Location	89%	75%	82%
Character	67%	60%	65%
Duration	78%	60%	71%
Pain is consistently assessed and recorded with other vital signs	0%	100%	50%
Nursing care plan addresses pain management if indicated	78%	80%	79%
Patient response to pain is documented	67%	50%	58%
Patient/family education regarding pain management is documented	50%	44%	47%

[3] Some Pain initiative components did not apply in certain cases; thus, changing the denominator. This change accounts for those percentages that are not divisible by 10.

The interdisciplinary Pain Management Committee, comprised of members from Nashville and ACY, needs to develop a system to ensure that pain is consistently assessed and recorded every time vital signs are taken. Clinical managers at both facilities need to ensure that clinicians record patients' responses to pain interventions, and that patient and family education is consistently provided and documented.

We also reviewed the education records of 10 nursing employees and 4 physicians to determine if they had received Pain management training in the past year. We found that Pain management training was documented for 60 percent of nursing personnel at Nashville and 90 percent of nursing personnel at ACY in the past year. None of the four physicians had documented Pain management training within the past year.

Recommendation 7: The TVHS Director should implement the Pain initiative to include:

a. Signing, distributing, and implementing the draft pain policy immediately.

b. Ensuring that pain management documentation is organized, consistent, and easily retrievable from the medical record.

c. Ensuring that clinicians participate in pain management educational opportunities on an annual basis, and that this training is properly documented.

TVHS Director Comments

The Director concurred with the recommendation and stated that:

a. The Pain Management policy was signed and distributed to TVHS staff on April 26, 2001.

b. The policy requires that, at a minimum, documentation for pain and use of the pain scale will be included in CPRS Vital Signs package with graphic and numerical retrieval capability. The goal is to consistently include response to treatment/medication will be in CPRS Progress Notes. Target date: June 30, 2001.

c. Pain Week programs (April 30 – May 4, 2001) included training and education which were documented in staff TEMPO Training files. Pain education will be a component of annual staff training program being developed by the Staff Education Committee with targeted completion for all staff by October 2001. Documentation of any training activity is in TEMPO with organizational and service retrieval capability. Service chiefs are expected to review training of staff as a component of meeting performance standards.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Opportunities for Improvement in Various QM Functions

During our QM review, we noted some issues that warranted management attention and made suggestions for improvement. Improvements were needed in trending data and documenting the rationale for conclusions in minutes of meetings, tracking planned corrective actions to completion, coordinating corrective actions that cross service lines, and documenting the use of Quality Management/Performance Improvement (QM/PI) data in the reprivileging process. Management agreed with our suggestions during the CAP review and agreed to take appropriate corrective actions.

Trending data and documenting the rationale for conclusions in minutes of meetings could be improved. Although QM program employees collected data and performed required functions, the analysis and trending of data could be improved. For example, tort claims were tracked, but were not analyzed for trends. Minutes of the QM/PI committee meetings lacked evidence of issues having been trended over time and lacked rationale for conclusions reached. The Quality Manager needs to write an annual summary for tort claim tracking and to improve the minutes of QM/PI meetings.

Planned corrective actions should be tracked to completion. Follow-up actions on problems identified in Boards of Investigation, Root Cause Analyses, and Focused Reviews were not tracked to completion. Evidence was not documented showing that the recommended actions had been taken. Senior managers need to require status reports of follow-up actions from the responsible line managers, or document the rationale for any decisions not to implement recommended actions.

Coordinating corrective actions that cross service lines needs to be improved. We noted that systemic issues in the Infection Control Committee minutes at Nashville had not been fully addressed to remove the identified vulnerabilities to infections. These vulnerabilities had not been fully corrected because of unresolved differences of opinion between service lines about responsibilities for various actions. QM should track the out-of-line conditions identified by the infection control committee to ensure that all corrective actions have been implemented.

Documenting the use of QM/PI data in the reprivileging process should be performed. We found Nashville had adequate procedures in place to review QM/PI data in the reprivileging process, but ACY did not. The process at ACY provided for service chiefs to verbally report their findings and conclusions at the Professional Standards Board meeting, but the board minutes did not indicate that QM/PI data had been discussed. The TVHS Director should ensure that review of QM/PI data is included in the reprivileging process at ACY.

Financial and Administrative Management

Management Controls Were Generally Effective

Financial and administrative activities reviewed were generally operating satisfactorily, as evidenced by the following.

Service Contracts. Administrative controls over service contracts at both campuses were satisfactory. We reviewed the contract award process, contract terms, and pricing for five contracts with a cumulative estimated annual cost of $2.3 million and found no problems.

CNH Contract Rates. We reviewed 17 CNH contracts for the TVHS facilities and found that the rates were generally negotiated at, or less than, the VA benchmark of the state Medicaid rate plus 15 percent.

Employee Accounts Receivable. The TVHS facilities had 46 employee accounts receivable totaling about $40,200. We reviewed 10 accounts receivable at each facility and found that demand letters were used appropriately to follow up on employee accounts, and seriously delinquent accounts were referred to the Department of Treasury Offset Program.

Recommendations for Improving Management Controls

We made recommendations for improvement in

- MCCF recoveries,
- inventory management,
- Pharmacy Service security, and
- time and attendance for part-time physicians.

MCCF Recoveries Could Be Increased. Third-party reimbursement claims for TVHS facilities were not processed effectively or efficiently. The Mid-South Customer Account Center (MCAC), which is located at the TVHS and operates at the VISN 9 level, is responsible for third-party reimbursements, including final disposition of billing actions and accounting for funds recovered. VISN 9 facilities are responsible for data validation and coding. We found that there was a significant backlog in billing for outpatient care, bills were being issued for outpatient care without validating the coding, and coding for outpatient care was frequently incorrect.

Outpatient Bills were Severely Backlogged and Billing Lag Times Were Excessive. The MCAC collected a total of $13.1 million for the TVHS facilities during the period October 1, 1999, to February 28, 2001. However, Nashville and ACY were backlogged by an estimated 70,205 third-party reimbursement claims valued at about $10.5 million for the same period. A backlog of this magnitude is unreasonable. In addition, the lag-time

(time required to prepare a bill following delivery of outpatient care) averaged about 241 days. The industry standard is 9 days. Studies have shown that shorter billing lag times improve recovery rates. Allowing a rate of 60 percent for uncollectible accounts, the MCAC Program Director estimated that they could increase MCCF recoveries by about $3.2 million by processing outpatient bills that are currently backlogged.

Data Validation Needed Improvement. Some outpatient episodes of care for Nashville and ACY patients were being billed without validation or review of medical record documentation that supports the claims. Submitting claims to insurance carriers prior to validation can expose VHA to litigation for erroneous billing practices. The MCCF Coordinator stated that low-level codes (1 and 2 – office visits with a lower complexity of care) were being billed without data validation because TVHS staff thought they were authorized to do so, and because the risk of significant losses was minimal. However, further discussions with MCAC and TVHS staff indicated that in some instances, high-level codes (3 and up – higher level of complexity of care) were being billed with no data validation. Also, we found that the MCAC had contracted with a commercial vendor to have the backlogged cases billed prior to data validation. We emphasized to MCAC and TVHS officials that billing insurance carriers prior to data validation is inappropriate and is not an option. The TVHS Director assured us that sufficient resources would be assigned to data validation and that backlogged cases would be validated prior to billing.

Outpatient Visits Were Coded Incorrectly. We reviewed 40 medical records to determine clinicians' compliance with coding and billing standards. We used reporting criteria outlined by the Health Care Financing Administration. Our review included medical records based on predefined outpatient encounter codes that encompassed routine to complex care. We found that documentation did not support the assigned encounter codes in 26 (65 percent) of 40 medical records reviewed. Of the 26 encounters that were incorrectly coded

- 15 (58 percent) were up-coded (reflecting a higher complexity of service actually occurred), and
- 11 (42 percent) were down-coded (reflecting a lesser complexity of service than actually occurred).

The 65 percent error rate in coding demonstrates the importance of validating claims prior to billing.

Recommendation 8: The TVHS Director should increase MCCF recoveries and improve the MCCF recovery process by ensuring that:

a. Backlogged cases are validated and billed.

b. Outpatient episodes of care are validated and billed in a timely manner to reduce billing lag times.

c. Training is provided, as required, for coders and medical providers to achieve a reasonable confidence level relative to data validation.

TVHS Director Comments

The Director concurred with the recommendation and stated that:

a. The backlog of cases for FY 2000 have been completely validated and cleared. For FY 2001, management has authorized the use of overtime, unscheduled hours, and contract employees to complete the backlog and stay current on outpatient billing. The process requires validation and tracking for timeliness. Target: October 1, 2001.

b. Processes have been implemented that require the validation of 100% of outpatient episodes prior to release for billing.

c. The Compliance Officer and Chief, HIMS are developing a formal Compliance Training Program. Target date for program development: July 1, 2001.

The Director also stated that the processes involved in increasing the amount of MCCF recovery is not exclusive or totally dependent on local (TVHS) efforts. Staff from TVHS are in communication and discussion with the VISN 9 MCAC to address response to increased workload. The flow of this process is that facilities code, validate and release bills to MCAC for actual billing. TVHS fully recognizes its responsibilities in this process and has developed the plan mentioned above to address the deficiencies identified during the survey under the direction of the Chief, HIMS and Compliance Officer.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved. In addition, we will forward this issue to the Director, VISN 9 for consideration.

Controls Over Inventory Management Should Be Improved. Employees at Nashville and ACY used the Generic Inventory Package (GIP) to manage inventories. Nashville had 3 primary inventory areas, which contained 4,838 line items of stock valued at about $748,000. ACY had 9 primary inventory areas, which contained 3,947 line items of stock valued at about $721,000. We reviewed inventory records and conducted physical counts of line items in Supply Processing and Distribution (SPD) at Nashville, and SPD and the warehouse at ACY. Our review showed that (i) inventory records were inaccurate, and (ii) the TVHS had excess stocks on hand.

Inventory Records at Nashville Were Inaccurate. We inventoried a judgment sample of 20 line items valued at about $1,760 from the GIP inventory for SPD at Nashville, which contained 701 line items valued at about $260,300. We found that quantities on hand for 16 items (80 percent) were different from the quantities in GIP. The net difference in

the book value of the 20 items was $445, causing the inventory to be understated by 25 percent. Therefore, the book value of the entire inventory, adjusted for the 25 percent error, would be about $325,375, instead of the $260,300 shown in GIP. Once the inventory records are corrected, the TVHS Director should ensure that inventory levels are reduced to 30 day levels or below.

Stock Levels at ACY Were Excessive. GIP records for the period March 1, 2000, to February 21, 2001, showed that stock levels in the warehouse exceeded a 30-day supply for 65 line items, valued at $54,400. Additionally, stock levels for 795 line items, valued at $104,600, in the SPD inventory exceeded a 30-day supply. Generally, inventories should not exceed a 30-day supply, and even lower supply levels for additional economies can be achieved using present day electronic commerce initiatives. The 860 line items, valued at about $159,000, exceeded a 30-day supply level by about $103,000.

Recommendation 9: The TVHS Director should ensure that:

a. Inventory records are updated to reflect actual quantities on hand.

b. Inventories are reduced and maintained at 30-day or below levels.

TVHS Director Comments

The Director concurred with the recommendations and stated that:

a. Under the leadership of the Chief, A&MM, the service is reorganizing and establishing item manager positions to be responsible for specific inventories. This phase is close to completion. The item managers will ensure accurate maintenance of inventory records and improved accountability.

b. A&MM has initiated an ongoing review of quantities on hand exceeding a thirty (30) day supply. The correction of records and transfer of excess stock is being accomplished as needed with concurrent level adjustments. Target completion of this process: September 30, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Pharmacy Service Security Needs Strengthening. Internal controls over controlled substances were not operating satisfactorily. We examined records of the monthly unannounced inspections of controlled substances for September 1999 through January 2001 and found that (i) monthly inspections were incomplete, (ii) training was not documented, (iii) destructions of unusable controlled substances were not performed timely, and (iv) physical security was inadequate.

Monthly Unannounced Inspections Were Incomplete. Monthly unannounced inspections of controlled substances were not conducted at outpatient clinics, unusable controlled substances were not inspected, and dispensing records were not reconciled with patient medical records. During the period of our review, four inspections at the Chattanooga Vet Center were not conducted in September and November 1999, or in September and November of 2000. Additionally, no inspections of controlled substances were conducted at the Tullahoma CBOC. Inspectors did not conduct inspections of the unusable controlled substances and reconcile the ledger with the sealed-bagged narcotics maintained in a locked storage cabinet within the Pharmacy Service vault. Inspectors were not reconciling patient records with the dispensing sheets to ensure that controlled substances documented as being dispensed for patients were documented in the patients' records.

Training Was Not Documented. Training provided to narcotics inspectors for conducting the monthly unannounced inspections was not documented at either facility. There was no structured training process in place and the time spent training new inspectors was not tracked.

Destructions of Unusable Controlled Substances Were Not Performed Timely. We reviewed documentation relating to the last four destructions of unusable controlled substances and determined that Pharmacy Service staff had not conducted quarterly destructions of unusable controlled substances, as required. The last dated destruction for calendar year 2000 was done in September and the most recent destruction was completed on February 8, 2001.

Physical Security Was Inadequate. The outpatient pharmacy at ACY had two windows that did not have security screening, as required by VA policy.

Recommendation 10: The TVHS Director should establish procedures to ensure that:

a. Monthly unannounced controlled substances inspections are conducted at the outpatient clinic sites.

b. Narcotics inspectors include unusable controlled substances in monthly unannounced narcotics inspections and reconcile the results with the unusable controlled substances ledger.

c. Inspectors reconcile medication dispensing records with inpatient records to ensure that patients received the medications.

d. A structured training program for controlled substances inspectors is implemented and training is documented.

e. Unusable controlled substances destructions are performed quarterly.

f. Windows in the outpatient pharmacy are secured.

TVHS Director Comments

The Director concurred with the recommendations and stated that the TVHS policy for comprehensive Narcotic Surveillance and Inspection is in the concurrence phase. The policy includes provisions for narcotic inspections throughout the system and requirement for documented unannounced inspections. Pharmacy Service and Office of the Chief of Staff will verify that all of the cited components (a. - e.) are addressed in the policy, including training and implementation. Target date for policy distribution and implementation by Pharmacy and the Office of the Chief of Staff: June 15, 2001.

The Director also stated that the Pharmacy dispensing windows at the Alvin C. York Campus, Building 3, has been secured; and the window in Building 5 will be secured by June 29, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Part-Time Physicians' Attendance Should Be Monitored to Ensure Compliance. While most part-time physicians at Nashville and ACY generally complied with their work schedules, some did not. VA policy requires part-time physicians to work specified tours of duty and to meet their attendance requirements. Our discussions with timekeepers disclosed no attendance problems for the 11 part-time physicians at ACY. However, we attempted to locate 10 of the 126 part-time physicians at Nashville during their designated tours of duty and found that 3 were not on duty or approved leave. We did locate two of the three physicians who responded to our pages from the Vanderbilt University School of Medicine. We were unable to locate the third part-time physician, a practitioner in gastroenterology.

Recommendation 11: The TVHS Director should establish procedures to ensure that part-time physicians are present during their core hours, or have otherwise been granted leave or excused absences.

TVHS Director Comments

The Director concurred with the recommendation and stated that the Chiefs of Staff (ACY and Nashville) are taking the following actions:

a. Developing process/policy for physician accountability within the services with auditing by Service Chiefs.

b. The policy will include methodology for validation, reporting of any discrepancies and variation and actions taken to the Service Chief and review by Chief of Staff.

c. The Nashville Campus Chief of Staff will obtain clarification on part-time research MDs being at the affiliate doing VA research during core hours.

The target date for the plan: June 30, 2001.

Office of Inspector General Comments

The Director's actions are responsive to the intent of the recommendation and we consider this issue resolved.

Suggestions for Management Attention

During our review, we noted some financial and administrative issues that warranted management attention. Management agreed with our suggestions during the CAP review and agreed to take appropriate corrective actions. We made suggestions for improvements in the following areas:

Internal Controls Over the Government Purchase Card Program Should Be Strengthened. During the period October 1, 2000, through January 31, 2001, TVHS cardholders processed 12,107 purchase card transactions valued at $8.5 million. Cardholders are required to reconcile 75 percent of transactions within 10 days and 95 percent within 17 days of receiving the transaction statement. We found that TVHS cardholders had reconciled 83 percent of transactions within 10 days and were at a 91 percent reconciliation rate for transactions within 17 days. However, we noted that approving officials were not certifying reconciled purchase card transactions timely, and some cardholder purchases were improper.

Certifications Were Not Timely. Approving officials are required to certify reconciled purchase transactions within 14 days of cardholder reconciliation. Approving officials exceeded this threshold about 9 percent of the time (1,111 transactions valued at $751,522) at the TVHS. Delinquent certifications ranged from 15 to 112 days, with about 2 percent (180 transactions valued at $170,897) taking longer than 60 days.

Improper Purchases Were Made By Cardholders. Our review showed that an acquisitions contract specialist at ACY improperly charged about $26,000 to a purchase card for cellular services during the period October 1, 1999, through December 31, 2000. VA policy does not allow the use of purchase cards for telecommunications services. The review also found that a cardholder at Nashville used the purchase card to pay for a hotel room for a consultant. VA policy does not allow the use of purchase cards for consultant services.

Although quality reviews and audits of the purchase card program were being performed, we suggested that the TVHS Director (i) ensure that approving officials certify reconciled purchase card transactions more timely, and (ii) provide refresher training to cardholders to ensure proper use of purchase cards.

Automated Information System (AIS) Security Should Be Enhanced. We found that Nashville had an Independent Gateway (a link with Vanderbilt University School of Medicine) that had not been certified within the past 3 years, as required by VA policy. In addition, TVHS management had not designated an official to certify in writing that computer storage media is cleared of sensitive information prior to disposal. We also found that phone numbers of key staff in the facility Contingency Plan were not current. We suggested that TVHS management enhance AIS security by obtaining certification for the Independent Gateway, designating an official to certify in writing that computer storage media is cleared of sensitive information prior to disposal, and updating phone numbers in the facility Contingency Plan.

We also found that the Information Security Officer created a unique retrievable database of information security policies, procedures, and guidelines for handling incidents involving the 11 major systems in use at the TVHS facilities. The systems information for these 11 systems has been recorded on compact discs, along with answers to 150 relative systems questions, for use by system administrators and managers. Such a database could serve as a benchmark for other VA medical centers.

Physical Security and Financial Controls Over the Agent Cashier Function Should Be Improved. Our review found that security of the agent cashier office was inadequate and unannounced audits were not random.

Physical Security Was Inadequate. The agent cashier cage at ACY did not meet VA security requirements. We found two ground-level windows providing access to the cage from outside the building that did not have required security mesh screening. VA policy requires that windows in the agent cashier cage must have security screening. Two inspection reports dating back to 1999 had identified the need to install security screening for the agent cashier section, but no actions were taken. We suggested that management enhance the security of the agent cashier cage by installing appropriate screening to windows.

Unannounced Audits Were Predictable. Unannounced audits at Nashville were not random and were not performed within a 90-day window, as required by VA policy. We reviewed the results of unannounced audits performed during the period January 1, 1999, to January 18, 2001. We found that the dates of unannounced audits were not adequately varied to prevent the establishment of a pattern. Audits followed a pattern in that they were never performed within the first 75 days of the 90-day period following the previous audit. The interval between audits ranged from 75 to 105 days. In addition, five of the eight unannounced audits reviewed exceeded the 90-day time frame. Scheduling five or six audits a year on different days of the week and at different times will generally ensure compliance with VA policy.

Cash Management Practices Related to Compensated Work Therapy (CWT) Payments Should Be Changed. The agent cashier at ACY was making monthly cash payments of about $4,000 from the agent cashier advance for the CWT payroll. Disbursements should be made by electronic funds transfer (EFT) whenever possible, as required by VA policy. Nashville uses convenience checks to pay the CWT payroll, and ACY should as well. The TVHS facilities should be consistent in the method of payment used to pay the CWT payroll.

Controls Over PFOP Accounts Should Be Strengthened. Controls over PFOP accounts were weak. Staff at ACY maintained the PFOP accounts for both facilities. As of March 12, 2001, Nashville and ACY had a total of 400 PFOP accounts valued at about $417,500. We reviewed transactions related to 10 PFOP accounts for the period October 1, 2000, through March 12, 2001. We noted that management attention was required in relation to (i) competency ratings, (ii) postings to subsidiary accounts, and (iii) annual audits of PFOP accounts.

Competency Ratings Were Not Timely. Patients admitted for psychiatric care did not receive competency ratings within 10 days following admission, as required by VA policy. We found 5 of 10 patient records (50%) reviewed exceeded the 10-day requirement for competency ratings. Patients are generally denied access to personal funds until ratings are assigned. We suggested that TVHS management ensure that patients receive competency ratings within 10 days of admission as required.

Postings to Subsidiary Accounts Were Delinquent. Nashville had not made timely postings of receipt and withdrawal transactions to PFOP subsidiary accounts in 15 out of 16 months reviewed between October 1999 and January 2001. As a result, significant adjustments were required to reconcile the subsidiary accounts with the general ledger. Untimely postings distort the accuracy of the patients' accounts and may cause the accounts to be overdrawn. We suggested that management make timely postings of receipt and withdrawal transactions to PFOP subsidiary accounts.

Required Quality Management Audits Were Not Performed. Fiscal Service staff did not conduct quality management audits of PFOP accounts in FY 2000. The last audit was performed in June of 1999. VA policy requires annual audits of PFOP accounts. We suggested that TVHS management ensure that annual audits of PFOP accounts are conducted as required.

Unliquidated Obligations Should Be More Aggressively Pursued. Fiscal Service staff at Nashville needed to improve timeliness in canceling unneeded obligations. As of January 31, 2001, the TVHS facilities had 828 unliquidated obligations valued at $5.5 million that were over 90 days old. To determine whether Fiscal Service staff reviewed obligations each month and cancelled unneeded obligations, we reviewed a judgment sample of 20 obligations (10 accrued services payable valued at $539,783 and 10 undelivered orders valued at $2,485,758) which were over 90 days old. We identified three accrued services payable valued at $46,076 and one undelivered order valued at

$12,517 that had not been reviewed by Fiscal Service staff and should have been cancelled. The Chief, Accounting, agreed that the obligations were not needed and should have been cancelled.

Fiscal Service should coordinate with Acquisition & Material Management Service to ensure that obligations are necessary, as required by VA policy. Additionally, Fiscal Service should analyze accrued services payable and undelivered orders reports on a monthly basis to identify outstanding payables and delinquent orders. We suggested that the TVHS Director strengthen controls by reviewing all undelivered obligations more than 90 days old and ensuring that unneeded obligations are cancelled.

Security of Patient Medical Records Needs Improvement. Patient medical records at Nashville were not properly secured. Patient medical records are confidential and VA policy requires local safeguards to (i) limit access to patient medical record file areas to authorized personnel, and (ii) lock patient medical record file areas and other areas where patient records are temporarily stored when responsible personnel are not present to ensure that the area is secured. At Nashville, unattended patient medical records were stored along the walls in two corridors that had unrestricted access. We suggested that storage space be allocated for medical records so they can be secured in accordance with VA requirements. The Chief, Quality Management, stated that appropriate space for storing patient medical records would be created at Nashville by transferring all inactive patient medical records to ACY.

Annual Performance Appraisals Need to Be Completed. Employees should be evaluated annually for the rating period ending March 31 of each year, as required by VA policy. We found that 60 TVHS employees did not have current performance ratings. Ten employees had not received any performance ratings at all. One employee who entered on duty in June 1998 had never been rated. Another employee was last rated in 1997. A total of 24 of the 60 delinquent performance appraisals were concentrated in the Ambulatory Care area, and 21 were in Radiology Service. The remaining 15 were spread through 7 other cost centers. We suggested that the TVHS Director ensure that employee performance is properly evaluated, in accordance with VA requirements.

Fraud and Integrity Awareness

Management Fully Supported Fraud Prevention and Detection

TVHS management fully supported fraud prevention and detection efforts. The OIG hotline number was posted for the information of employees, patients, and visitors. We conducted 6 (3 at each facility) fraud awareness briefings for 154 employees. The attendees were attentive and asked questions. A handout was provided to all attendees, which contained information regarding the OIG's role in conducting investigations, highlights of cases conducted by the OIG, copies of press releases, and phone numbers to assist in contacting the OIG.

Workers' Compensation

The Office of Workers' Compensation Program was reviewed and discussed with TVHS staff.

- ACY: This facility currently has 102 cases. Expenditures for the last recorded period (January – September 2000) totaled $617,585. One case has been identified for further scrutiny to determine if fraud is involved.

- Nashville: This facility currently has 58 cases. Expenditures for the last recorded period (July 1999 – through June 2000) totaled $794,000. Of this total, $470,000 is attributed to one patient who is now deceased. One case has been identified for further scrutiny to determine if fraud is involved.

Pharmacy

Pharmacies at both facilities have not been properly reporting their drug diversions and losses. This matter has been discussed with TVHS management, Pharmacy Service management, and the VA Police. It is the opinion of the OIG Office of Investigations and TVHS management that this issue has been resolved and the problem will not reoccur.

B L A N K P A G E

Fraud and Integrity Awareness Briefings

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, over billing, false claims, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, compensation and pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, theft, and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA policy outlines employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Managers are required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that is not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, division employees assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by

the OIG. If DOJ accepts the case, an indictment or criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** -- Names, position titles, connection with VA, and other identifiers.
- **What** -- The specific alleged misconduct or illegal activity.
- **When** -- Dates and times the activity occurred.
- **Where** -- Where the activity occurred.
- **Documents/Witnesses** -- Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

To Report Suspected Wrongdoing in VA Programs and Operations, Call the OIG Hotline -- (800) 488-8244.

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review
VA Tennessee Valley Healthcare System

Project Number: 2001-00788-R3-0082

Recommendation Number	Category/Explanation Of Benefits	Better Use of Funds	Questioned Costs
9	Reduced inventories	$103,000	
Total		**$103,000**	

B L A N K P A G E

TVHS Director Comments

Department of Veterans Affairs

Memorandum

Date: June 25, 2001

From: System Director (00/626), VA Tennessee Valley Healthcare System (TVHS), Nashville, TN

Subj: DRAFT REPORT: Combined Assessment Program Review – VA TN Valley Healthcare System, (Project No. 2001-00788-R3-0082) – REVISED

To: Assistant Inspector General for Auditing (52)

1. Per the instructions of your May 4, 2001 memorandum, below are our written comments regarding the recommendations contained in your DRAFT REPORT.

PATIENT CARE AND QUALITY MANAGEMENT

Recommendation 1 *– the TVHCS Director should initiate a review of the surgical program at ACY to assess the quality of care provided and cost effectiveness of the program.*

Response – We concur with the recommendations. The Director has requested a comprehensive evaluation of the entire Surgical Program from a system standpoint in order to assess current processes. The goal is to develop and implement a system-wide approach to provide timely and efficient surgical care to veterans served throughout the TN Valley Healthcare System. The committee is co-chaired by the TVHS Chief, Medicine Service and ACY Chief Surgical Service and has a multidisciplinary composition. Target date for report: August 24, 2001

Recommendation 2 *– the TVHCS Director should ensure that patient care and common areas are kept clean and free of odors.*

Response – We concur with the recommendation. The Chief, Environmental Management Service and Associate Director/Clinical Support Services (Chief Nurse) are developing a plan which will include, 1) cleaning schedule for all patient care areas; 2) Responsibility Grid – who is responsible for cleaning, who is responsible for monitoring and evaluating; and, 3) review of outcome by Management Team. Target date for plan: June 15, 2001

Recommendation 3 – *the TVHCS Director should ensure that appropriate initiatives are implemented and resources are shared between campuses to improve access to outpatient clinics.*

Response – We concur with the recommendation. The Chief of Staff, ACY Campus and Acting Chief of Staff, Nashville Campus are coordinating the development o a plan in conjunction with the re-design of Primary Care. Recommendations from Primary Care consultant visit and IHI piloted at ACY and Chattanooga will be components of the plan. In addition, the input of the incoming TVHS Chief of Staff (due date July 1, 2001) will be requested and of the selected Primary Care Service Line Manager. The target date for the plan: August 1, 2001

Recommendation 4 – *the TVHCS Director should ensure that Nashville MICU clinicians document crash cart inspections.*

Response – We concur with the recommendation. The Associate Director/Clinical Support Services (Chief Nurse) has addressed the failure of the Nashville Campus MICU staff to follow the crash cart inspection policy. He has required the following: 1) documentation of inspection of the MICU crash cart every shift; 2) documentation of Nurse Manager review of every shift inspection; and, 3) report of previous actions (#1 and #2) to him on a weekly basis. This is current and ongoing.

In addition, a system-wide (all sites, including CBOCs) procedure with accountability/monitoring components is in development. Target completion date: June 15, 2001

Recommendation 5 – *the TVHCS Director should:*

a. Convert the inpatient psychiatric ward (Nashville) to a locked unit, and,
b. Ensure that physicians examine patients or review and co-sign progress notes of the patients' PCP prior to prescribing narcotics (Nashville)

Response – We concur with the recommendations.

a. The Director has appointed a multi-disciplinary team, including Engineering and Nursing, to address all issues involved with securing the unit. This would include staffing, environmental modifications, training and education, competency and assessing both patient and staff mix. Target plan due date: June 15, 2001
b. The Nashville Campus Acting Chief of Staff and Chief, Psychiatry Service have reviewed the process of obtaining physician signature

for controlled substances when the patient is managed by a a physician extender. They have instructed that physicians must, at a minimum, review progress notes in order to document concurrence with treatment plan prior to co-signing orders for narcotics. This change has already been implemented. In addition, the revised TVHS Narcotic Control Policy will clearly reflect the modification in the process. The target date for the policy: June 15, 2001

Recommendation 6 *– the TVHCS Director should:*

a. Ensure that NHCU patients are not left unattended in the PT clinic, and,
b. Provide an escort to accompany NHCU patients to and from their PT appointments.

Response – We concur with the recommendation. The Associate Director/Clinical Support Services (Chief Nurse) is coordinating the development of an internal TVHS Transport Plan. Escort personnel are either currently under Nursing or A&MM at each campus and have varying procedures. The focus will be safe and timely transport of patients to support the efficient and effective use of staff and patient services. The target date for the plan: June 15, 2001

Recommendation 7 *– the TVHCS Director should implement the Pain initiative to include:*

a. Signing, distributing, and implementing the draft Pain Management policy immediately.
b. Ensuring the Pain Management documentation is organized, consistent, and easily retrievable from the medical record.
c. Ensuring that clinicians participate in Pain Management educational opportunities on an annual basis, and that this training is properly documented.

Response – We concur with the recommendations.

a. The Pain Management policy was signed and distributed to TVHS staff on 4/26/01.
b. The policy requires that, at a minimum, documentation for pain and use of the pain scale will be included in CPRS Vital Signs package with graphic and numerical retrieval capability. The goal is to consistently include response to treatment/medication will be in CPRS Progress Notes. Target date: June 30, 2001
c. Pain Week programs (April 30 – May 4, 2001) included training and education which were documented in staff TEMPO Training files. Pain education will be a component of annual staff training program being

developed by the Staff Education Committee with targeted completion for all staff by October 2001. Documentation of any training activity is in TEMPO with organizational and service retrieval capability. Service chiefs are expected to review training of staff as a component of meeting performance standards.

FINANCIAL AND ADMINISTRATIVE MANAGEMENT

Recommendation 8 *– the TVHCS Director should increase MCCF recoveries and improve the MCCF recovery process by ensuring that:*

a. Backlogged cases are validated and billed.
b. Outpatient episodes of care are validated and billed in a timely manner to reduce billing lag times.
c. Training is provided, as required, for coders and medical providers to achieve a reasonable confidence level relative to data validation.

Response/Comment – We concur with the recommendation.

Comment: The processes involved in increasing the amount of MCCF recovery is not exclusive or totally dependent on local (TVHS) efforts. Staff from TVHS are in communication and discussion with the VISN9 Mid-South Customer Accounts Center (MCAC) to address response to increased workload. The flow of this process is that facilities code, validate and release bills to MCAC for actual billing. TVHS fully recognizes its responsibilities in this process and has developed the following plan to address the deficiencies identified during the survey under the direction of the Chief, HIMS and Compliance Officer.

a. The backlog of cases for FY00 have been completely validated and cleared. For FY2001, management has authorized the use of overtime, unscheduled hours and contract employees to complete the backlog and stay current on outpatient billing. The process requires validation and tracking for timelines. Target: October 1, 2001.
b. Processes have been implemented that require the validation of 100% of outpatient episodes prior to release for billing.
c. The Compliance Officer and Chief, HIMS are developing a formal Compliance Training Program. Target date for program development: July 1, 2001.

Recommendation 9 *– the TVHCS Director should ensure that:*

a. Inventory records are updated to reflect actual quantities on hand.
b. Inventories are reduced and maintained at 30-day or below levels.

Response – We concur with the recommendations.

a. Under the leadership of the Chief, A&MM, the service is reorganizing and establishing item manager positions to be responsible for specific inventories. This phase is close to completion. The item managers will ensure accurate maintenance of inventory records and improved accountability.
b. A&MM has initiated an ongoing review of quantities on hand exceeding a thirty (30) day supply. The correction of records and transfer of excess stock is being accomplished as needed with concurrent level adjustments. Target completion of this process: August 30, 2001.

Recommendation 10 *– the TVHCS Director should establish procedures to ensure that:*

a. Monthly unannounced controlled substance inspections are conducted at the outpatient clinic sites.
b. Narcotic inspectors include unusable controlled substances in monthly unannounced narcotic inspections and reconcile the results with the unusable controlled substance ledger.
c. Inspectors reconcile medication dispensing records with inpatient records to ensure that patients received medications.
d. A structured training program for controlled substance inspectors is implemented and training documented.
e. Unusable controlled substance destructions are performed quarterly.
f. Windows in the outpatient pharmacy are secured.

Response – We concur with the recommendations.

a. – e.
The TVHS policy for comprehensive Narcotic Surveillance and Inspection is in the concurrence phase. The policy includes provisions for narcotic inspection throughout the system and requirement for documented unannounced inspections. Target date for policy distribution and implementation by Pharmacy and the Office of the Chief of Staff: June 15, 2001.
Addendum (June 15, 2001): Pharmacy Service and Office of the Chief of Staff will verify that all of the cited components (a. – d.) are addressed in the policy, including training and implementation.

f. Pharmacy Dispensing Windows – The Pharmacy dispensing windows at the Alvin C. York Campus, Building 3 has been secured; the window in Building 5 will be secured by June 29, 2001.

Recommendation *11 – the TVHCS Director should establish procedures to ensure that part-time physicians are present during their core hours, or have otherwise been granted leave or excused absence.*

Response – We concur with the recommendation. The Chiefs of Staff (ACY and Nashville) are taking the following actions:

a. Developing process/policy for physician accountability within the services with auditing by Service Chiefs.
b. The policy will include methodology for validation, reporting of any discrepancies and variation and actions taken to the Service Chief and review by Chief of Staff.
c. The Nashville Campus Chief of Staff will obtain clarification on accounting for time for part-time research MDs.

The target date for the plan: June 30, 2001.

CATEGORY/EXPLANATION OF BENEFITS & BETTER USE OF FUNDS

Recommendation 9 *– Reduce stock inventory = $103,000.000*

Response – We concur with this amount. We do not anticipate any added cost to the process of reducing stock inventory. There will be simultaneous FTEE reduction and the necessary training will be performed in-house.

2. If you have any questions or require additional information regarding our response to the DRAFT REPORT, please do not hesitate to contact my office at (615) 327-5332.

//s//
Roland E. Moore

Final Report Distribution

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Senate Ranking Member, Committee on Veterans' Affairs
Chairman, Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations
Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations
Chairman, Senate Committee on Governmental Affairs
Ranking Member, Senate Committee on Governmental Affairs
Chairman, House Committee on Veterans' Affairs
Ranking Democratic Member, House Committee on Veterans' Affairs
Chairman, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations
Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations
Chairman, House Committee on Government Reform and Oversight
Ranking Member, House Committee on Government Reform and Oversight

Non-VA Distribution (Continued)

Chairman, Subcommittee on Benefits, House Committee on Veterans' Affairs
Ranking Member, Subcommittee on Benefits, House Committee on Veterans' Affairs
Chairman, Subcommittee on Health, House Committee on Veterans' Affairs
Ranking Member, Subcommittee on Health, House Committee on Veterans' Affairs
Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
Ranking Member, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
Staff Director, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs

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