Office of Inspector General

Combined Assessment Program Review

Royal C. Johnson Memorial VA Medical and Regional Office Center

Sioux Falls, South Dakota

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VA Office of Inspector General

Combined Assessment Program Reviews

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- We evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- We review selected administrative and financial 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.

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Combined Assessment Program Review
Royal C. Johnson Memorial
VA Medical and Regional Office Center
Sioux Falls, South Dakota

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program review of the Royal C. Johnson Memorial VA Medical and Regional Office Center (VAM&ROC) Sioux Falls, South Dakota during the week of July 24 to 28, 2000. The purposes of the review were to evaluate selected clinical and administrative operations, focusing on the quality of care delivered and the effectiveness of medical center and benefit program management controls. We also provided fraud and integrity awareness training to VAM&ROC employees.

The VAM&ROC operates a 95-bed secondary care facility and a Transitional Care Unit, providing general medical, surgical, psychiatric, and rehabilitative services. Outpatient services are provided to veterans throughout eastern South Dakota, northwestern Iowa, and southwestern Minnesota through the VAM&ROC and community-based outpatient clinics located in Pierre, South Dakota and Sioux City, Iowa. The VAM&ROC's regional office provides compensation and pension (C&P) and vocational rehabilitation and employment services to veterans and their dependents residing in the State of South Dakota.

For Fiscal Year (FY) 1999, the medical center had a budget of about $60 million and employed 587 full-time equivalent employees (FTEE). During FY 1999, 2,347 inpatients were treated at the medical center and a total of 130,433 outpatient visits were reported. During FY 1999, the regional office's budget was about $1 million, and 18 FTEE were employed. In FY 1999, the regional office administered about $59 million in C&P and $3 million in vocational rehabilitation and employment benefits to veterans and their dependents.

Quality Management and Patient Care. VAM&ROC managers created an environment that supported high quality patient care and performance improvement. The VAM&ROC had a comprehensive quality management program that provided strong oversight of the quality of care. To further improve patient care management, we recommended that the VAM&ROC Director ensure that medical staff review community nursing home contracts prior to approval and that monthly inspections be conducted and reviewed by managers. Other areas that required management attention included:

- Management of chronic pain
- Prevention counseling for sexually transmitted diseases
- Nurse staffing
- Environment of care

- Results of patient and employee interviews and surveys
- Documentation of informed consents for surgery
- Documentation of patient signatures

Medical Center Financial and Administrative Management. In the areas reviewed, VAM&ROC managers maintained an effective system of financial and administrative management controls over medical center activities. Areas in need of improvement were:

- Follow-up of monthly controlled substances inspections
- Information technology security
- Medical Care Collection Fund (MCCF)
- Medical supplies inventories
- Government purchase card program
- Hazardous materials inventories
- Accounts receivable
- Agent Cashier operations
- Equipment inventories

Estimated monetary benefits associated with improvements in MCCF operations are contained in Appendix II.

Regional Office Operations. VAM&ROC managers maintained an effective system of controls over the benefits delivery process. Areas reviewed which required greater management attention included:

- Fiduciary and field examinations
- Security of claim folders
- Physical security for information technology
- Information technology access
- Internal controls over returned mail

VAM&ROC Director's Comments. The Director concurred with all recommendations and suggestions and reported acceptable implementation actions. We consider all issues resolved, but may follow up on implementation actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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Introduction

The Department of Veterans Affairs Royal C. Johnson Memorial VA Medical and Regional Office Center (VAM&ROC) in Sioux Falls, SD operates a 95-bed secondary care facility and a Transitional Care Unit (TCU) providing general medical, surgical, psychiatric, and rehabilitative services. The medical center is part of Veterans Integrated Service Network (VISN) 13, and its primary service area includes eastern South Dakota, northwestern Iowa, and southwestern Minnesota. The VAM&ROC also operates community-based outpatient clinics (CBOCs) located in Sioux City, Iowa and Pierre, South Dakota.

The VAM&ROC's regional office provides compensation and pension (C&P) and vocational rehabilitation and employment (VR&E) services to eligible veterans and their dependents residing in the State of South Dakota. The regional office is part of Service Delivery Network (SDN) 6.

Affiliation. The medical center is affiliated with the University of South Dakota Medical School.

Resources. In Fiscal Year (FY) 1999, the medical center's budget was about $60 million, and it employed 587 full-time equivalent employees (FTEE). During FY 1999, the regional office had a budget of about $1 million and employed 18 FTEE.

Workload. During FY 1999, medical center clinicians treated 2,347 inpatients and reported 130,433 outpatient visits. During FY 1999, the regional office administered about $59 million in C&P benefits and $3 million in VR&E benefits to veterans and their dependents.

Objectives and Scope of the Combined Assessment Program Review

The purposes of the Combined Assessment Program (CAP) review were to evaluate selected clinical, financial, and administrative operations in both the medical center and the regional office, as well as to provide fraud and integrity awareness training to VAM&ROC employees.

Patient Care and Quality Management (QM). Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and measures to ensure staff competence. The QM program is a set of integrated procedures designed to monitor and improve the quality of patient care and to identify, evaluate, and correct conditions that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities.

To achieve the review objectives, we inspected patient care areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. As part of the review, we used questionnaires and interviews to survey employee and patient opinions about quality of care, timeliness of service, and satisfaction with care received. The review covered the following clinical operations and monitoring functions:

Contract Nursing Home Care
Credentialing and Privileging
Environmental Management
Extended Care and Rehabilitation
Infection Control
Mental Health Services
Pain Management Services
Patient Advocacy
Pharmacy Services
Primary Care Services
Quality and Risk Management
Specialty Care Services
Utilization Management

Financial and Administrative Management. We reviewed selected financial and administrative activities to evaluate the effectiveness of management controls. These controls were 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 review, we inspected work areas, interviewed managers and employees, and reviewed pertinent administrative, financial, and clinical records. Specifically, we assessed:

Accounts Receivable
Agent Cashier
Construction Planning
Controlled Substances Accountability
Decision Support System
Employee Travel
Enhanced Use Lease Potential
Equipment Accountability
Government Purchase Card Program
Hazardous Materials Inventories
Information Technology Security
Inventory Management
Medical Care Collection Fund
Printing Practices
Radiology Equipment Purchases
Surgical Consent
Undelivered Orders

Regional Office Operations. Our review of controls over the benefits delivery processes at the regional office was comprised of analyses of general building security and of policies and procedures and included the following areas:

Benefits Delivery Network Software Security
Claims Authorizations
Claims Backlog
Claims Timeliness
Fiduciary Files and Schedules
Files Security
Information Technology Security
Medical Examination Timeliness
Payments Over $15,000
Payments to Hospitalized Beneficiaries
Returned Mail
Vocational Rehabilitation and Employment Quality Assurance

Fraud and Integrity Awareness. We conducted 4 fraud and integrity awareness briefings for 72 employees. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of CAP Review. The CAP review covered VAM&ROC operations for FY 1999 and the first quarter of FY 2000. The review was performed in accordance with the Office of Inspector General (OIG) "Standard Operating Procedures for Combined Assessment Program Reviews."

Results, Suggestions, and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

Overall, we concluded that VAM&ROC Sioux Falls' patient care and QM programs were generally well managed and that clinical activities were operating effectively. Areas reviewed that represented organizational strengths included:

VAM&ROC managers created an environment that supported high quality patient care and performance improvement (PI). The VAM&ROC had a comprehensive QM program, including PI, that resulted in effective oversight of the quality of care using national and local performance measures, risk management, utilization management, occurrence screening, and peer reviews. There was a defined reporting mechanism for administrative and clinical issues through the Quality Resource Council (QRC), chaired by the Director, and the Medical Executive Committee (MEC), chaired by the Acting Chief of Staff. A review of QRC and MEC minutes substantiated communication of PI initiatives throughout the VAM&ROC.

Ongoing quality of care monitors included:

- Infection control
- Restraint use
- Psychotropic medication use
- Operative procedures
- Waiting times for primary care
- Preventive health measures
- Clinical guidelines

Generally, QM managers appropriately analyzed and trended data and initiated actions on recommendations resulting in improvements in patient care services. For example, a clinical practice guideline reference book, developed by clinicians, was available to all clinicians and was helpful in improving compliance with chronic disease performance measures. We also reviewed all the administrative boards of investigation and focused-review analyses that VAM&ROC employees had conducted over the previous 12 months. We found these review processes to be sound and the conclusions and corrective actions relevant. For example, an unexpected death in the operating room was internally and externally peer reviewed, and top management appropriately approved the conclusions.

In 1998, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performed its most recent triennial survey of the VAM&ROC. JCAHO did not

make any Type I recommendations, and all supplemental recommendations had been corrected by the time of our visit.

High quality patient care was the VAM&ROC's top objective. Many environment of care improvements were underway or planned for the future. The Director had ensured that aesthetically pleasing patient care areas were provided and was implementing space consolidation efforts to provide increased space for the provision of patient care services.

Clinical and administrative managers and employees reacted positively when asked about their jobs and about the care provided by VAM&ROC staff. This feeling was demonstrated by employees' responses to a survey question with 89 percent responding affirmatively to the question of whether they gained personal satisfaction from their jobs.

Management had established an effective management structure. The facility had a collaborative management structure with positive communication between employees and veterans service organizations (VSOs). VSO representatives described management's open door policy for addressing veteran issues as creating a friendly environment for both veterans and employees. Also, VAM&ROC managers met formally with VSO representatives to address issues and answer questions. The meetings had documented minutes and evidence of actions taken to address issues. The Primary Care Product Service Line (PSL) had thorough PI initiatives, which were documented in monthly employee meetings focusing on findings, actions taken, and follow-up. PI data was benchmarked with the Institute for Healthcare Improvement, Veterans Health Administration (VHA), External Peer Review Program/Clinical Guidelines, and Preventive Health measures. Management had ensured that the Medical Care Collection Fund (MCCF) office business hours were changed so that veterans' questions concerning billing issues could be answered timely.

Dialysis services were effective. Dialysis services were provided through a contractual arrangement with a community-based group. The contract included medical management, nursing services, and quality control monitoring for the overall dialysis process for acute cases 24 hours per day, 7 days per week. Routine dialysis was scheduled three times per week. We reviewed credentialing and privileging files for physicians, competency files for nurses, and quality control documents related to bacterial monitoring of dialysis cultures and did not identify any deficiencies. Overall management of the dialysis program was thorough, and comprehensive PI monitors were in place.

The TCU had a comprehensive and well-documented PI process. The TCU was a 41-bed unit that assisted patients' transition from acute care to long-term care by providing nursing, rehabilitation, medical, and related psychosocial services. The TCU had a defined scope of care, a screening process for admissions, and a PI program that addressed high-risk, high-volume, and problem-prone areas. TCU managers provided documentation of PI indicators and data, which consistently supported the indicators'

results. Employees in the TCU were able to articulate an accurate understanding of the PI process. Examples of TCU PI initiatives included admission appropriateness, unintended weight loss of more than 5 percent within 30 days of admission, acquired pressure ulcers, and polypharmacy.

Most patient and employee survey results were positive. We surveyed employees and patients through questionnaires and interviews. The employee questionnaires were mailed prior to our arrival onsite and included questions on job satisfaction, staffing, and quality of care. We mailed 231 employee questionnaires, and 154 employees returned completed forms (67 percent). The patient questionnaires requested patients to comment on timeliness, access to care, and employee courtesy. Eighty-five patients, including inpatients, long-term care patients, and outpatients completed these questionnaires.

The overall results of both surveys showed a high degree of patient and employee satisfaction. For example, 85 percent of inpatients, 100 percent of outpatients, 100 percent of long-term care patients, 88 percent of employees, and 100 percent of managers reported that the quality of care provided was good, very good, or excellent. In addition, 92 percent of inpatients, 96 percent of outpatients, 95 percent of long-term care patients, 83 percent of employees, and 100 percent of managers stated that they would recommend the care provided at the facility to a family member or a friend.

Recommendation for Improving Patient Care Management

An opportunity to improve the delivery and quality of patient care was noted in the following area:

Oversight of the Contract Nursing Home (CNH) program needed to be improved. VA medical staff did not document physician approval of final CNH contracts required in JCAHO policy. During FY 1999, only 3 of the 12 required monthly patient visits were completed, and the reports of these visits were not reviewed by top management as required.

Recommendation 1. The VAM&ROC Director should ensure that:

a. CNH contracts are approved by the medical staff, as required by JCAHO.

b. Monthly visits by clinicians are conducted.

c. Documentation of monthly visits is reviewed by management.

<u>VAM&ROC Director Comments</u>

a. Concur with this recommendation. Action already completed for all locally initiated contracts; Medical Staff Executive Committee is approving. Regional community nursing home contracts are completely handled by HQ with no local involvement.

b. Concur with this recommendation. Monthly visits by clinicians are conducted.

c. Concur with recommendation. Monthly visits will be done as outlined in the 11/2000 Network policy on Community Care Program Evaluation and Ongoing Monitoring. The monthly visits are reviewed by the Extended Care and Rehabilitation PSL Site Director and Associate Director Patient Services and/or Chief of Staff.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider these issues resolved, although we may follow up on implementation actions.

Suggestions for Management Attention

We noted several issues for which we suggested greater management attention. Managers agreed to evaluate these issues and to take corrective actions.

- Management of chronic pain
- Prevention counseling for sexually transmitted diseases
- Nurse staffing
- Environment of care
- Results of patient and employee interviews and surveys
- Documentation of informed consents for surgery
- Documentation of patient signatures

Management of chronic pain required increased coordination. The VAM&ROC did not have a mechanism in place to identify patients affected by chronic pain. Also, since the facility had not implemented the Computerized Patient Record System (CPRS), communication between health care providers caring for chronic pain patients was inhibited. Alternative pain treatment modalities, such as biofeedback and whirlpool therapy, although available at the VAM&ROC, were not fully utilized. In fact, several VAM&ROC health care providers were not even aware that biofeedback services were available.

We conducted a survey of psychiatric patients who were prescribed medications for chronic pain in the preceding year and identified several areas requiring improvement. Medical records lacked adequate documentation regarding the reasons medications were prescribed, there was inadequate documentation indicating that alternative pain treatment modalities had been tried, and there was no indication that patients' pain had been evaluated by health care providers other than psychiatrists in the preceding year.

Clinicians also stated that slow turnaround times for urine drug screens adversely affected the overall management of chronic pain patients. At the time of our review, urine drug screens were sent to another VA medical center within the VISN, and the results were not available until approximately 1 week later. More timely urine drug screen results would help providers determine more quickly if a patient is

inappropriately using controlled substances prescribed for pain or is taking them in conjunction with non-prescription or illegal substances. Health care providers indicated that conducting urine drug screens at the VAM&ROC or in the community would result in more rapid and reasonable turnaround times and would greatly assist them in providing care for chronic pain patients.

VAM&ROC managers had recently appointed a physician to be responsible for the pain management program at the facility. They also told us that they would initiate efforts to raise health care providers' awareness of alternative pain treatment modalities available at the VAM&ROC.

Prevention counseling for sexually transmitted infections (STIs) was not always provided when indicated. We reviewed five medical records of patients who were treated for STIs in the previous year. Only one record contained documentation that clinicians had provided any prevention counseling. None had documentation that condom use was discussed or condoms were provided for veterans. Likewise, none of the medical records indicated that clinicians had informed patients that an external agency would contact them regarding partner notifications. This was a concern because one patient had been treated twice for the same STI within a 3-month period, and another patient was undergoing treatment for two STIs simultaneously.

VAM&ROC managers recognized that the Infection Control Program was undergoing a variety of changes in light of the recent retirement of the Infection Control physician. The Infection Control nurse practitioner agreed that the facility needed a comprehensive, formal, multidisciplinary plan for STI prevention counseling and for health care provider training regarding this sensitive area.

A nurse staffing methodology was not utilized at the VAM&ROC. We reviewed the VAM&ROC's methodology to determine appropriate nurse staffing levels. This review used information provided by nurse managers. We concluded that the VAM&ROC did not have a clear or consistent method for determining appropriate nurse staffing levels. Nurse managers had established an informal process whereby they met daily to discuss staffing levels. However, they did not maintain documentation concerning staffing or actions taken to address variances. The Nurse Executive did not participate in these meetings.

VAM&ROC nurse managers should consider implementing a formal process for documenting planned versus actual staffing levels, recording the variances between the two, and communicating actions taken to address any identified variances to VAM&ROC management. This process should include all nursing employees facility-wide. Also, managers should require the Nurse Executive to be involved in the determination of nurse staffing levels.

The environment of care needed minor improvements. Examples of areas that needed to be improved were:

- Building 1 had sprinkler heads that were not of the breakaway type, which presented a suicide risk.
- Building 5 had ceiling tiles that were missing and others that were cracked.
- There was no thermometer on Ward 2 South to indicate temperature variations, and the nutritional refrigerator's temperature was not recorded daily in a temperature log.
- Building 16 did not have signage indicating how veterans might contact the Patient Advocate.

We provided a complete list of areas that were in need of management attention to the responsible VAM&ROC employees. They developed an action plan that appropriately addressed the identified environment of care issues.

Some patient and employee interview and survey results indicated a need to improve patient care and employee morale. Some employee and patient responses to questionnaires and interviews highlighted facility strengths. However, other responses identified areas in need of improvement. Employees expressed dissatisfaction with the recognition and awards process. Only 39 percent of employees surveyed said that recognition and awards reflected performance. Employees also expressed concern about the adequacy of staffing to meet the needs of all patients. Although most employees stated that they would recommend care at the medical center to a family member or friend (see page 6), only 45 percent of employees surveyed said that the VAM&ROC had adequate staffing to meet patient care requirements.

VHA policy requires that a single physician be in charge of each inpatient's care, but only 69 percent of inpatients surveyed responded that one physician was in charge of their care. Eighty percent of outpatients surveyed reported that they waited more than 30 minutes for prescriptions from the pharmacy, and 49 percent reported that they were unable to schedule appointments with their primary care providers within 7 days.

Informed consents for surgery were not always obtained. VHA policy requires documentation that patients signed informed consents before any surgical or invasive procedures are performed. VA policy for informed consents provides elements that must be present in every instance when informed patient consent is required. The policy states that it is the responsibility of the practitioner to obtain and fully document informed consent for any episode of care where it is required.

We reviewed medical records for 20 surgical procedures taken from logs detailing surgical cases for the month of April 2000 to determine if clinicians were adhering to VHA policy. We found four instances in which informed consents were not adequately documented in medical records. On three occasions, the responsible practitioners had not signed the consent forms as required. In the fourth instance, the consent form was not dated or witnessed. Improvements needed to be made in documentation of informed consents.

Documentation of patient signatures needed improvement. During our review of medical records, we identified one instance in which a patient demonstrated by use of a personalized signature stamp that he had received instructions for steps to be taken in preparation for a surgical procedure. This occurred despite the fact that the patient had signed other forms in the medical record on prior dates, as well as on the date in question.

Medical center employees familiar with this case informed us that the stamp was the patient's own property, and that he had requested to use the stamp on this occasion because he was having problems signing his name. We were further informed that the patient used this stamp for other purposes such as endorsing and signing checks. Regardless of the patient's condition and preferences on that given day, medical center managers should ensure that a local policy is generated that outlines procedures for staff to follow on those occasions when patients are unable to sign documents that are to be placed in VA records.

At a minimum, medical center staff should provide a signed and dated note for the medical record indicating clearly that the patient was unavailable or unable to sign a given document, but that the document had been discussed with the patient, his representative, or his next-of-kin. These measures will serve to protect both VA staff and patients.

VAM&ROC Director Comments to Suggestions

The Director provided positive comments in response to our suggestions. These comments are contained in the full text of the Director's comments in Appendix III.

Medical Center Financial and Administrative Management

Overall, we concluded that the medical center maintained an effective system of internal controls. As discussed in more detail below, we reviewed and tested controls in 17 areas and found that controls were generally working effectively.

Management Controls Were Working Effectively in Several Areas

We reviewed selected management controls in the areas of construction planning, Decision Support System (DSS), employee travel, enhanced use leasing, printing practices, and planned purchase of radiology equipment and found that internal controls were in place and working effectively, as follows:

Construction Planning. Medical center managers had identified the facility's space needs and were in the process of working with VAM&ROC and VISN 13 management to revise and prioritize construction plans to better address medical center needs in light of fiscal constraints.

DSS. DSS had been implemented, processing was current, and DSS was used daily in medical center operations and in the planning process. We were informed by VHA headquarters staff responsible for DSS that this medical center, in concert with the VISN 13 DSS initiative, was well ahead of most VHA facilities.

Employee Travel. Adequate internal controls had been implemented to monitor reimbursement for employee travel. In one instance, an employee was reimbursed for the full amount of a travel voucher without offsetting the advance. However, medical center staff later identified this case and recovered the advance from the employee.

Enhanced Use Leasing. There were no enhanced use leases in force at the time of our review. However, medical center staff were aware of VA policies governing these leases and were open to using them if the opportunity should occur.

Printing Practices. Medical center staff adhered to Government Printing Office restrictions on obtaining printing from private vendors. With rare exceptions, publications and presentations were prepared in-house, and no out-sourced printing jobs exceeded the $1,000 limitation imposed by Public Law 90-62.

Planned Purchase of Radiology Equipment. A planned purchase of radiology equipment was being properly evaluated and justified as part of the local planning process involving construction and major equipment purchases.

Recommendations To Improve Financial and Administrative Management Controls

Areas reviewed which required greater management attention included:

Discrepancies found during monthly controlled substances inspections were not resolved or reported. We requested that an unannounced controlled substances inspection be performed and reviewed the written reports of the preceding six monthly controlled substances inspections. While inspections were being conducted monthly as required, we found that VAM&ROC staff did not address instances of missing documentation and questionable pharmacy inventory practices. Therefore, the accuracy of reported medical center controlled substances inventories could not be verified.

We reviewed the reports of six monthly narcotics inspections that were conducted from January to June 2000. On five occasions during that time, designated medical center narcotics inspectors could not find VA Forms (VAF) 10-2320, Controlled Substance Administration Record. Because VAF 10-2320 is the inventory record that establishes and documents the levels of controlled substances that should be on hand, the correct inventory levels could not be determined from those five inspections. Thus, all accountability for the controlled drugs listed on the missing forms was lost. We could find no evidence that facility inspectors had resolved any of these instances of lack of accountability.

With the exception of an e-mail message between Pharmacy Service staff and Nursing Service staff that referred to one of the five missing VAFs 10-2320, there was no documentation of effort by facility staff to verify that the inventory records in question had ever been located. We also found other instances of interrupted or lax accountability that were identified by monthly inspectors, but which had not been addressed:

- On six occasions, area clinicians had physically received drugs but had not established accountability for them by documenting the receipts in medical center records.
- Inspectors were told that VAF 10-2320 sheets were “in transit” while inspections were being conducted and, thus, were unavailable for review.
- Identification numbers for drugs and controlled substances records were changed without adequate explanations by ward personnel.

We found no evidence that these conditions had been addressed by the narcotics inspectors, making inventory counts suspect.

The facility did not have an established, codified protocol for reporting and resolving discrepancies such as those described above. Had such a process been in place, these issues could have been identified and resolved. We contacted staff in the

Pharmacy Benefits Management Strategic Healthcare Group in VHA and were informed that, at a minimum, management should have conducted root cause analyses and corrected any systemic problems that were found to have lead to the discrepancies.

VHA requires notifying, among others, the Drug Enforcement Administration (DEA) and the OIG when controlled substances cannot be accounted for. Because adequate follow-up was never performed on deficiencies found in monthly inspections, medical center managers could not have known if the discrepancies should have been reported to the DEA and the OIG.

We believe that medical center managers should resolve all discrepancies detailed above and ensure that proper notifications are made in all instances where such notifications are required by VHA policy.

Recommendation 2. The VAM&ROC Director should:

a. Establish a process whereby discrepancies identified in monthly narcotics inspections are recognized and addressed expeditiously and effectively.

b. Review monthly narcotics inspections for a 1-year period and, as far as possible, resolve identified problems.

c. Notify appropriate authorities on those occasions where accountability for controlled substances cannot be restored or reconstructed.

VAM&ROC Director Comments

a. Concur with recommendation. The monthly inspection process has been strengthened by mandatory education for the narcotic inspection team, pharmacy and nursing staff. Center Circulars, Inspection of Controlled Substances and Controlled Substances in Non-Pharmacy areas were updated and part of the education. Timely follow-up has been received for inspections from 9/00 forward. Immediate notification and follow up is expected when any discrepancies are identified. This has been firmly reinforced. Narcotics were removed from the research building. In addition, inpatient narcotic usage was evaluated by a Pharm.D. and nursing. This review resulted in a 40% decrease in ward stock of controlled substances. Significant improvements are seen with this process.

b. Concur with recommendation. This review was initiated the week of the OIG on site visit. A complete report with attachments was submitted to OIG on August 18, 2000. All issues were resolved and closed. This review identified process issues with nursing and pharmacy that led to improving our current process.

c. Concur with recommendation. Updated policy and education focused on priority and necessity to report to OIG and appropriate DEA officials.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider these issues resolved, although we may follow-up on implementation actions.

Information technology (IT) security measures should be improved. We tested facility compliance with Office of Management and Budget and VHA criteria and found that improvements needed to be made in IT security. Prior to the onsite phase of our review, we requested that OIG staff at the Austin Automation Center provide us with a list of all individuals who had access to the facility's Veterans Information System Technology Architecture (VISTA) computer system, but who were not listed as current employees in the VA payroll system. The result was a listing of 556 such individuals.

Information Resource Management (IRM) employees informed us that many of those included on our list could have been temporary or intermittent employees, volunteers, or resident physicians. Others could have been individuals employed by the affiliated university in research or other positions that required occasional access to VISTA. We were also informed that medical center staff could not identify which of these situations, if any, pertained to any of the 556 individuals on our list.

We did identify 58 individuals with VISTA access who had been employed by VA at one time, but who had been terminated. Managers should immediately review the need for VISTA access for these 58 individuals and terminate VISTA access that is not needed. Medical center IRM staff should also determine how many of the remaining 498 individuals should also have their access terminated.

The large number of non-employees with VISTA access appears to be excessive, given this facility's size and mission. Facility managers should develop and enforce policies and procedures to reduce this number considerably, thereby significantly reducing the risk of unauthorized access to sensitive information.

We also found that 15 individuals, including the Information Security Officer (ISO), the Assistant ISO, and 13 IRM employees, should have had security clearances documented in facility records, as required by VHA policy. For 7 of the 15 individuals (47 percent), such clearances had not been obtained. One of those without a documented clearance was the facility ISO.

Recommendation 3. The VAM&ROC Director should:

a. Ensure that only those individuals with an established need be granted access to facility VISTA data.

b. Obtain and document security clearances for those individuals with high-level access to facility automated data systems.

VAM&ROC Director Comments

a. Concur with recommendation.

b. Concur with recommendation. Requests for security clearance were prepared for identified individuals and forwarded July 28, 2000 to: Department of Veterans Affairs, Deputy Assistant Secretary for Security and Law Enforcement, Washington, DC 20420. That office acknowledged receipt of requests September 1, 2000 and has initiated the security clearance process.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider these issues resolved, although we may follow up on implementation actions.

Timely billing of third party accounts receivable would enhance facility collections. As of July 3, 2000, there were 3,355 unbilled episodes of inpatient and outpatient care provided to Category "C" veterans. These consisted of 3,300 outpatient visits and 55 inpatient episodes of care. Some cases had remained unbilled for up to 7 months.

At the time of our review, MCCF staff processed current bills first and worked on backlogged cases as workload and time permitted. However, because billings to providers were not being processed timely, accounts receivable were established for these patients because they were shown as Category "C" veterans in medical center records. We were informed that many veterans contact MCCF staff on receipt of these notifications to try to resolve the issues, thereby creating a significant drain on the limited staff resources and further inhibiting efforts to reduce the backlog in MCCF.

We were also informed by MCCF staff that the backlog initially occurred when VHA and VISN 13 promulgated the requirement for a 100 percent medical record review of all billed cases. Further, we were informed that this requirement was initiated at a time when staffing in MCCF was being reduced, but that some progress had been made at reducing the backlog over time.

Utilizing the average billed amount shown on the Unbilled Amounts Report, we determined that the average bill for an inpatient episode of care was $4,734, as of July 3, 2000. The amount billed for outpatient care averaged $226 per visit. Based on these average billed amounts, we calculated the value of the backlog for unbilled third party cases to be approximately $1 million.

As the medical center's demonstrated recovery rate for third party cases was 23 percent, we estimate that the medical center could recover about $230,000 if the current MCCF backlog were eliminated. As VISN 13 management has in the past allowed this medical center to retain the amounts recouped from third party carriers, this would likely mean that facility management would have an additional $230,000 to address medical center needs.

Recommendation 4. The VAM&ROC Director should take action to address billing backlogs in the MCCF program.

VAM&ROC Director Comments

Concur with recommendation.

Corrective action plans:

- Two temporary FTEE have been hired to assist in the billing backlog (8/00). Permanent employees for billing practices is not being pursued as contracting for a portion of the billing activities would be more cost effective. Implementation date for contracting is October 2001.
- Billing staff in concert with validators/coders bill Category C inpatient and outpatient care continually. Implementation date – September 2000.
- A slight modification has been made to the "Management Report for Ambulatory Procedures" to include whether or not the veteran has third party insurance. MCCF staff identified which clinics in the facility were high cost and high return for billing and collections. These clinics were targeted for the first run of the report. We implemented a process (12/00) where the biller sets up a bill for the event identified on the Ambulatory Procedure report along with all other billable events for the individual veteran. Notification is made to the validator/coder that all bills have been established in VISTA. The validator/coder reviews the CPT and ICD-9 codes to ensure proper documentation and coding. The validator/coder then releases the bill for mailing. Implemented – December 2000.
- Once the institution is using CPRS in all outpatient areas a contract for remote validation of encounters through VISTA will be sought. The contractor would be responsible to set up the bill in VISTA with the hard copy document printed in the MCCF unit. This will shift current staffing and workload from outpatient to inpatient the result being more timely inpatient billing. Implementation date – October 2001. Contract language is being drafted.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider this issue to be resolved, although we may follow-up on implementation actions.

Inventory management controls needed strengthening. Internal controls over receipt and accountability for items maintained in Supply Processing and Distribution (SPD) and in the general warehouse needed strengthening. Issues that required management attention were:

- Warehouse employees did not inspect items received in the warehouse from vendors when Government purchase cards were utilized for procurement of the

items. We were informed that in most cases credit card purchasers did not process their purchase orders timely or did so only after items had been received. Therefore, warehouse employees had no documentation on which to base inspections to accept or reject items delivered. Additionally, credit card purchases were often processed on a simplified purchase order that did not identify the requesting service, give a detailed description of items purchased, or identify the individual and service making the purchase. Because of these issues, medical center employees often encountered problems with vendors when unacceptable or damaged items were delivered.

- Inventory levels recorded for SPD were not accurate. SPD had 857 medical supply line items on hand, valued at $135,494. We selected a random sample of 5 line items with a value of $4,317 and reviewed inventory records for accuracy. We found that in three instances, our physical inventory count did not agree with the quantity on hand shown in the Generic Inventory Package (GIP). Further review showed that inaccuracies in inventory records occurred because employees failed to maintain accurate inventory records of stock on hand in secondary distribution points.
- Emergency levels of stock on hand were not being maintained. To test the exception occurrence rate, we reviewed the Emergency Stock Level Report (ESLR) for SPD. We found that 98 line items were listed on the report as of July 25, 2000. Of these 98 items, 68 (69 percent) had inventory levels that were unknown or below emergency levels. Medical center staff informed us that stocks had fallen below emergency levels because, in some cases, emergency levels shown on the ESLR needed to be revised. In other instances, they conceded that emergency levels were not being maintained.
- Some items on hand exceeded the 30-day stock level recommended by VHA policy. In SPD, 712 of the 857 primary inventory points (83 percent) had stocks on hand that exceeded the recommended 30-day level. This excess stock had a value of about $96,476. In the warehouse, there were 306 primary inventory points that included medical supply items with a total value of approximately $132,367. A total of 286 of these primary inventory points (93 percent) included stocks that exceeded the 30-day level. This excess stock had a value of about $96,948. Improved inventory controls would result in better use of about $193,424 ($96,476 + $96,948) tied up in excessive stock in the warehouse and in SPD.

Medical center employees responsible for inventory activities voiced a need for additional training, particularly pertaining to the more technical aspects of GIP. The results of our review confirmed that additional training was needed. Medical center managers should ensure that employees responsible for control over inventories are adequately trained. While such training is being undertaken, deficiencies identified by our review should be addressed.

Recommendation 5. The VAM&ROC Director should ensure that:

a. Procedures for receiving items procured with Government purchase cards provide for appropriate administrative and financial controls.

b. Inventory records are accurate.
c. Emergency levels of critical medical supply items are maintained.
d. Excessive levels of stocks are avoided.
e. Staff are adequately trained.

VAM&ROC Director Comments

a. Procedures for receiving items procured with purchase cards provide appropriate administrative and financial control. Concur with recommendation.
b. Inventory records are accurate. Concur with recommendation.
c. Emergency levels of critical medical supply items are maintained. Concur with recommendation.
d. Excessive levels of stock are avoided. Concur with recommendation.

   The CAP OIG external assessment review was instrumental in expediting the management inventory program for the facility. A full time materiel manager was hired in December 2000 to oversee, direct and organize the centralization and management of inventories and funding of inventories. Establishment of a centralized G.I.P. inventory program is in process. Consolidating into a primary inventory will eliminate 153 inventory line items, provide usage and cost information for each functional area, reduce costly emergent procurements, track costs more efficiently and effectively, reduce and lower holding costs and allow for few stock outages by automating the replenishment process. We are transitioning from 4.6 annual turnover to 12 turnover rate.

   All posted stock is currently being bought out or eliminated to comply with VHA Standard of 30 days on hand levels. A projected one-time saving of $300,000 is expected with implementation.

e. Staff is adequately trained. The newly selected manager attended a weeklong Intra VA Detail (12/00) at a highly functioning program. We have embarked on an ambitious and active training program for materiel management employees to include recruitment of two additional support staff. Training is being formulated for staff to include: cross training of all staff to provide back up and support when necessary, C.I.P./M.I.C. program training, Cluster Training SPD certification for materiel manager, warehouse materials handlers training, and Intra VA detail for materiel management in inventory/SPD training.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider this issue to be resolved, although we may follow up on implementation actions.

The Government purchase card program lacked required oversight. In 1995, use of Government purchase cards for purchases under $2,500 was made mandatory by the Under Secretary for Health. We reviewed 2,050 transactions totaling approximately $1.2 million made using Government purchase cards in the 3rd quarter of FY 2000. We found that the internal controls for this program needed strengthening. Problems identified by our review were as follows:

- 173 of 2,050 transactions (8 percent) were not reconciled by cardholders within 5 days as required by VHA. Exceptions ranged from 1 to 46 days delinquent.
- Approving officials did not certify purchases within 14 days as required, on 40 occasions (2 percent). Exceptions ranged from 2 to 23 days delinquent.
- On 125 occasions (6 percent) purchases were not approved by the appropriate officials.
- In one instance, a purchase of $9,630 was split into 4 smaller purchases to avoid the purchase card limitation of $2,500 per purchase.
- Required audits of cardholders and approving officials were not performed by the Government purchase card coordinator as required.
- Financial Service Center random monthly quality reviews of credit card purchases had not been verified and signed by Fiscal Service staff to ensure accuracy.

To ensure that Government purchase cards are utilized appropriately, staff should comply with VHA policy for relating to reconciliations and approvals. In addition, VHA requirements for systematic audits and reviews should be adhered to in order to timely identify those occasions when corrective actions are warranted.

Recommendation 6. The VAM&ROC Director should ensure that staff comply with VHA policy governing the use and oversight of Government purchase cards.

VAM&ROC Director Comments

Concur with the recommendation. The following items are being addressed. Staff developed training (1/01) for all credit card holders and approving officials. The training is being conducted in February, and stresses the timely reconciliation of credit card purchases. Currently monthly reminders are sent to all staff involved with the credit card purchases to insure compliance with reconciliation and documentation procedures. Monthly reporting to VACO is being accomplished; recent reports reflect an improvement in the timely reconciliation of credit card purchases (last quarter). Currently Financial Service Center random quality reviews are being reviewed by the Chief Financial Officer and signed. Random audits of cardholders will begin in late February following the mandatory training.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider this issue to be resolved, although we may follow up on implementation actions.

Suggestions for Management Attention

We also noted several other administrative issues that warranted management attention. We made suggestions for improvements in the following areas:

Documentation for hazardous materials needed improvement. Inventories of hazardous chemicals were not accurate. VHA policy requires that facility employees develop and maintain an inventory listing of all hazardous chemicals to include their purchase, storage, use, and disposal.

We examined inventory records for three items shown as "in stock" and found that no inventories were on hand in two instances. These discrepancies were due to miscommunications between the program coordinator and users on how to describe stocks that had been depleted through normal use.

Inaccurate inventory records do not allow responsible medical center employees to effectively monitor the use, location, and levels of hazardous chemicals. Any misunderstandings in the methods used to report inventories should be addressed and all reported inventory levels of these chemicals verified.

Collection efforts for two accounts receivable were not performed timely. VA policy requires that facilities establish and initiate timely collection efforts for accounts receivable. We reviewed the 5 largest non-federal accounts receivable, which totaled $35,686, and all 8 employee accounts receivable, which totaled $7,945. These accounts ranged from 2 to 20 months old.

In one instance, a private vendor had owed VA $3,146 since October 1998, and no collection efforts had been initiated. Fiscal Service staff responsible for initiating collection activities informed us that they were unaware of the existence of this particular accounts receivable. In another instance, a physician who had resigned did so owing $1,382 in unearned special pay. Although Fiscal Service staff had completed all collection efforts possible at the local level, more aggressive action needed to be taken, as a review of this account showed no collection activity for about 6 months. In this instance, staff should refer the case to the Department of Justice (DOJ) for further action.

Agent Cashier activities could be improved. Responsibility for the principal Agent Cashier's advance was not fully transferred to another employee. VHA requires that the principal Agent Cashier be removed from all activities involving the advance for a period of 2 weeks each year.

We found that during a scheduled 2-week absence by the principal Agent Cashier, part of which coincided with our visit, the principal Agent Cashier was actually still involved with Agent Cashier activities. This included administrative and record keeping functions and retaining a working advance of $2,000. Management should ensure that the

principal Agent Cashier is assigned duties completely divorced from Agent Cashier activities during these 2-week long breaks. This will improve opportunities for training alternate Agent Cashiers, as well as improve internal controls over the advance.

Equipment inventories should be conducted. VHA policy states that equipment should be inventoried on a yearly basis. We selected 40 medical center Consolidated Memorandums of Receipt (CMRs) with a value of approximately $12 million, to determine if they had been inventoried as required. We found that 18 CMRs, representing approximately $10 million, had not been inventoried within the specified yearly time frame. The lengths of time that these inventories were delinquent, when finally completed, ranged from 4 to 97 days.

At the time of our review another six CMRs with a value of about $661,231 had not yet been inventoried and were past due about 2 months. One CMR with equipment valued at about $5,600 had not been inventoried for over 2 years.

Medical center management should take measures to ensure that all CMRs are inventoried yearly.

VAM&ROC Director Comments to Suggestions

The Director provided positive comments during the CAP review in response to our suggestions.

Regional Office Operations

Overall, regional office management controls over benefits delivery processes were effective. As discussed in more detail below, we reviewed and tested controls and found that they were generally working effectively.

Management Controls Were Working Effectively in Several Areas

We reviewed selected management controls in the areas of the automated medical information exchange system, VR&E quality assurance (QA), processing of VR&E claims, C&P adjudication, establishment of pending C&P claims, performance of C&P medical examinations, and security of locked files and found that internal controls were in place and working effectively, as follows:

Regional office staff effectively used the Automated Medical Information Exchange system. VA is required to reduce C&P benefits of veterans receiving Aid and Attendance (A&A) benefits when the veterans are also receiving hospital, domiciliary, or nursing home care at VA expense. A review of 10 cases in which veterans were receiving A&A and were also receiving medical care at VA expense showed that regional office staff were properly reducing A&A benefits.

The VR&E QA program was effective. There were two types of VR&E QA programs in place at the facility. One was directed through VA Central Office, and the second was performed through SDN reviews. The VR&E's national QA program was in transition. VA Central Office staff were implementing a new QA program and distributing a new manual in early FY 2001. In the meantime, regional office staff were instructed to perform local reviews. Our review of the most recent QA reports showed that the facility was the highest rated of all regional offices in its SDN, with a composite score (timeliness, accuracy, and customer satisfaction) of 67.4. Additionally, at the national level, the regional office's score was well above the 55.7 national average.

Regional office staff processed VR&E claims timely. We reviewed 10 cases to determine whether VR&E claims were properly controlled and whether proper "dates of claim" were used to establish claims. In all 10 cases, VR&E employees properly established benefits timely, with proper dates of processing actions.

Management controls for C&P adjudication were effective. We reviewed 10 claims files to determine the appropriateness of VA benefit payments that veterans were receiving. Our review showed that payments were appropriate and that regional office employees were following correct authorization procedures. This included third signature approvals on the award documents for large payments.

Pending C&P claims were properly established. As of July 27, 2000, the work-in-process report showed a total of 1,513 pending C&P claims, with 316 (21 percent) pending over 180 days. Of the 316 older claims, 130 represented appeals of prior

decisions and 186 were original or reopened claims for service-connected disabilities. We evaluated 10 randomly selected claims files and found that the claims were properly established or cleared in each case with proper dates of claim.

VAM&ROC staff performed C&P medical examinations timely. We reviewed 10 claim files for compensation benefits to determine the timeliness of C&P examinations. In 7 cases, medical center clinicians completed the examinations and made them available for Veterans Benefits Administration (VBA) use within 14 days of the requests for examinations, as required by policy. In two cases, the veterans did not show up for examinations. In only 1 case did the examination take longer than 14 days to complete.

Locked files were properly secured. Locked files are claim files of veterans who are also VA employees. We found adequate locked file procedures in place at the VAM&ROC. We also found that facility staff were properly trained in this area. The files were placed in separated locked file cabinets. Also, active C&P veteran-employee claims files for employees of this facility were sent to another regional office for additional security.

Recommendations To Improve Management Controls

During our review, we noted two administrative issues that warranted formal recommendations:

The Fiduciary and Field Examination program needed management attention. A fiduciary is a person or legal entity charged with the duty of managing the estate of an incompetent beneficiary. Field examinations are to be performed once a year to ascertain the needs of the beneficiary, to assess the competence of the beneficiary, to assess the abilities of the fiduciary, and to determine whether funds have been properly spent. Accountings detail money received, money spent, and assets remaining. Regional office staff were responsible for overseeing the Fiduciary and Field Examination program. Primary responsibilities included conducting field examinations and ensuring that required accountings were completed.

As of July 2000, regional office staff were supervising 609 fiduciary cases. We reviewed 10 randomly selected fiduciary cases to determine whether required field examinations and accountings had been conducted. Our review revealed a critical backlog of pending field examinations due to a shortage of staff. For the previous 3 years, only one field examiner had been working on fiduciary cases regularly, receiving assistance from two veterans benefits counselors, one each from the VA medical centers at Ft. Meade and Hot Springs, South Dakota.

We found that 7 of 10 field examinations were not completed by their due dates. One veteran beneficiary had not been seen by a field examiner since 1994. Of the other 6, 2 were overdue 9 months, 2 were overdue 5 months, and 2 were overdue 4 months. Accountings were required in 3 of the 10 cases, but only 1 was completed timely. The other 7 cases had custodian fiduciaries, and accountings were not required.

This condition provides potential for abuse and also creates vulnerability for fraud. Lack of VA oversight also increases the risk that incompetent beneficiaries may not be receiving proper care.

Recommendation 7. The VAM&ROC Director should provide enough staff to ensure that field examinations and accountings are completed timely.

VAM&ROC Director Comments

Concur with recommendation. One full time employee was hired in July 2000 as a field veterans service representative. Staffing in the field section doubled from one to two examiners with this new hire. Last July, there were 97 pending follow-up examinations of which 66 or 68% of them were overdue. This is consistent with OIG findings that 7 out of 10 (70%) examinations were not timely. Over the last 6 months good progress has been made in reducing the pending examinations. As of January 2001, 15 follow-up examinations are currently pending, a reduction of 84% since July 2000, with only one of these (6.7%) beyond the suspense dates. Similar improvements were achieved with initial appointments of 14 pending in July 2000 to 3 currently pending in 2001. Total accountings were reduced from 26 to 17, but improvement in timely completion of these is still needed. During the next 2 months, we anticipate reducing pending accountings significantly.

Office of Inspector General Comments

The Director's comments and implementation actions are acceptable. We consider this issue resolved, although we may follow up on implementation actions.

Physical security of claim files needed improvement. Regional office staff stored about 26,000 claim files. During our tour of the regional office we observed that the rooms where the claim files were stored contained no fire protection devices, such as sprinkler systems. In fact, the entire ground floor of the regional office was not protected by a sprinkler system.

The record room containing claim files was also not secured against unauthorized access, and claim files were not maintained in a safeguarded area when not in use. Files that were in transit from file cabinets were stacked in open areas. Although the records room had doors with locks and a warning sign against unauthorized access, we observed that these doors were open all day.

Recommendation 8. The VAM&ROC Director should improve security of veterans' claim files by providing fire protection, securing the records room from unauthorized access, and ensuring that claim files are safeguarded in transit.

VAM&ROC Director Comments

Concur with recommendation. Keyless entry access to the main claim folder storage area has been installed in 2000 and all service center employees have been briefed on maintaining security of records. We will ensure that this area is made to comply with all National Fire Protection Association codes for non-medical areas. We are currently exploring the feasibility of installing cameras in the front foyer area of the building and in the corridor adjacent to where the claim files are stored. It is felt that this will allow supervision of building access and monitor potential unauthorized access to the records storage area.

Office of Inspector General Comments

The Director's comments and implementation plans are acceptable. We consider this issue to be resolved, although we may follow up on implementation actions.

Suggestions for Management Attention

In three administrative areas, while we did not make formal recommendations, we do suggest greater management attention:

Physical security of the computer room needed improvement. The regional office's computer room contained telecommunications equipment and Benefits Delivery Network (BDN) computer servers. The computer room could be accessed through a door that contained a glass panel. The glass panel could easily be broken, and unauthorized access to the room could then be obtained by simply reaching in and turning the doorknob. The Director should improve computer room security by ensuring that the door is replaced with a steel or solid wood core door without a glass panel.

Multiple BDN user identifications for individual employees should be eliminated. A supervisor in the regional office had more than one BDN access code. As back-up authorizer for VR&E claims, this employee was given an additional access code because the commands for the VR&E claims fell under a different BDN series.

VBA policy states that all stations should stop the practice of issuing multiple employee identification numbers for command authorities, and that employees who currently have them should be identified and reduced to a single employee identification number. Based on this directive, the VAM&ROC Director should ensure that the supervisor's BDN access is reduced to a single employee identification number.

Controls over returned mail should be improved. VA policy states that when VA mail to a beneficiary who receives benefits via Direct Deposit/Electronic Fund Transfer is returned undeliverable, VA should contact the beneficiary's bank for an updated address. VA policy also states that non-VA records should be searched when necessary. If updated addresses cannot be obtained, VA should suspend payments to these beneficiaries.

We determined that routine mailings, such as cost-of-living allowance (COLA) notices, that are returned by the post office as undeliverable would not cause suspension of benefit payments. COLA notification letters and other routine mailings were simply filed in veterans' claim folders without action. The Director should ensure compliance with VA policy and improve controls over returned mail.

VAM&ROC Director Comments to Suggestions

The Director provided positive comments during the CAP review in response to our suggestions.

Fraud and Integrity Awareness

As part of the CAP review, we conducted four 90-minute fraud and integrity awareness briefings, which included a short film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question-and-answer opportunities. Seventy-two VAM&ROC employees attended the briefings. The information presented in the briefings is summarized below.

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 delineates VA 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 are 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 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.

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 health care-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, C&P fraud, equity skimming, and loan origination fraud. Health care-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.

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.

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review
Royal C. Johnson Memorial VA Medical and Regional Office Center
Sioux Falls, South Dakota

Project Number: 2000-02096-R4-0273

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
4	MCCF Billing Backlog	**$230,000**	
5	Reduced Inventories	**193,424**	
	TOTAL	**$423,424**	

Medical and Regional Office Center Director Comments

January 31, 2001

Center Director (00)

RESPONSE to Draft Report Sioux Falls VAM&ROC

Assistant Inspector General for Healthcare Inspections (54)

1. This is in response to your 1/11/01 memo requesting review and comment on the July 2000 combined assessment program review at Sioux Falls. There were eight recommendations in the draft report.

#1 Recommendation: The VAM&ROC Director should ensure that:

a. **CNH contracts are approved by the medical staff, as required by JCAHO.** *Comment*: Concur with this recommendation. Action already completed for all locally initiated contracts; Medical Staff Executive Committee is approving. Regional community nursing home contracts are completely handled by HQ with no local involvement.
b. **Monthly visits by clinicians are conducted.** *Comment*: Concur with this recommendation. Monthly visits by clinicians are conducted.
c. **Documentation of the monthly visits is reviewed by management.** *Comment*: Concur with recommendation. Monthly visits will be done as outlined in the 11/2000 Network policy on Community Care Program Evaluation and Ongoing Monitoring. The monthly visits are reviewed by the EC&R PSL Site Director and Associate Director Patient Services and/or Chief of Staff.

#2 Recommendation: The VAM&ROC should take steps to:

a. **Establish a process whereby discrepancies identified in monthly narcotics inspections are recognized and addressed expeditiously and effectively.** *Comment*: Concur with recommendation. The monthly inspection process has been strengthened by mandatory education for the narcotic inspection team, pharmacy and nursing staff. Center Circulars, Inspection of Controlled Substances and Controlled Substances in Non-Pharmacy areas were updated and part of the education. Timely follow-up has been received for inspections from 9/00 forward. Immediate notification and follow up is expected when any discrepancies are identified. This has been firmly reinforced. Narcotics were removed from the research building. In addition, inpatient narcotic usage was evaluated by a Pharm.D. and nursing. This review resulted in a 40% decrease in ward stock of controlled substances. Significant improvements are seen with this process.
b. **Review monthly narcotics inspections for a one-year period and, as far as possible, resolve identified problems.** *Comment*: concur with recommendation. This review was initiated the week of the OIG on site visit. A complete report with attachments was submitted to OIG on August 18, 2000. All issues were resolved and closed. This review identified process issues with nursing and pharmacy that led to improving our current process.

Medical and Regional Office Center Director Comments
(Continued)

(2) Response to Draft Report Sioux Falls VAM&ROC

a. **Notify appropriate authorities on those occasions where accountability for controlled substances cannot be restored or reconstructed**. *Comments*: Concur with recommendation. Updated policy and education focused on priority and necessity to report to OIG and appropriate DEA officials.

#3 Recommendation: The VAM&ROC Director should:

a. **Assure that only those individuals with an established need be granted access to facility VISTA** data. *Comment*: Concur with recommendation.
b. C**ause security clearances to be obtained and documented for those individuals with high level access to facility automated data systems.** *Comment*: Concur with recommendation. Requests for security clearance were prepared for identified individuals and forwarded July 28, 2000 to: Department of Veterans Affairs, Deputy Assistant Secretary for Security and Law Enforcement, Washington, DC 20420. That office acknowledged receipt of requests September 1, 2000 and has initiated the security clearance process.

#4 Recommendation – **Medical Center managers should take action to address billing backlogs in the MCCF program**. *Comment*: Concur with recommendation. Corrective action plans:

- Two temporary FTEE have been hired to assist in the billing backlog (8/00). Permanent employees for billing practices is not being pursued as contracting for a portion of the billing activities would be more cost effective. Implementation date for contracting is October 2001.
- Billing staff in concert with validators/coders bill Category C inpatient and outpatient care continually. Implementation date - September 2000.
- A slight modification has been made to the "Management Report for Ambulatory Procedures" to include whether or not the veteran has third party insurance. MCCF staff identified which clinics in the facility were high cost and high return for billing and collections. These clinics were targeted for the first run of the report. We implemented a process (12/00) where the biller sets up a bill for the event identified on the Ambulatory Procedure report along with all other billable events for the individual veteran. Notification is made to the validator/coder that all bills have been established in VISTA. The validator/coder reviews the CPT and ICD-9 codes to ensure proper documentation and coding. The validator/coder then releases the bill for mailing. Implemented – December 2000.
- Once the institution is using CPRS in all outpatient areas a contract for remote validation of encounters through VISTA will be sought. The contractor would be responsible to set up the bill in VISTA with the hard copy document printed in the MCCF unit. This will shift current staffing and workload from outpatient to inpatient the result being more timely inpatient billing. Implementation date – October 2001. Contract language is being drafted.

#5 Recommendation – The VAM&ROC Director should take steps to assure that:

a. **Procedures for receiving items procured with purchase cards provide appropriate, administrative and financial control**. *Comment:* Concur with recommendation.
b. **Inventory records are accurate**. *Comment:* Concur with recommendation.
c. **Emergency levels of critical medical supply items are maintained**. *Comment:* Concur with recommendation.
d. **Excessive levels of stock are avoided**. *Comment:* Concur with recommendation.

Medical and Regional Office Center Director Comments
(Continued)

(3) Response to Draft Report Sioux Falls VAM&ROC

- The CAP OIG external assessment review was instrumental in expediting the management inventory program for the facility. A full time materiel manager was hired in December 2000 to oversee, direct and organize the centralization and management of inventories and funding of inventories. Establishment of a centralized G.I.P. inventory program is in process. Consolidating into a primary inventory will eliminate 153 inventory line items, provide usage and cost information for each functional area, reduce costly emergent procurements, track costs more efficiently and effectively, reduce and lower holding costs and allow for few stock outages by automating the replenishment process. We are transitioning from 4.6 annual turnover to 12 turnover rate.
- All posted stock is currently being bought out or eliminated to comply with VHA Standard of 30 days on hand levels. A projected one-time saving of $300,000 is expected with implementation.

e. **Staff is adequately trained**. *Comment*: The newly selected manager attended a week long Intra VA Detail (12/00) at a highly functioning program. We have embarked on an ambitious and active training program for materiel management employee to include recruitment of two additional support staff. Training is being formulated for staff to include: Cross training of all staff to provide back up and support when necessary. C.I.P./M.I.C. program training. Cluster Training SPD certification for materiel manager. Warehouse materials handlers training. Intra VA detail for materiel management in inventory/SPD training.

A. #6 Recommendation – **The VAM&ROC Director should ensure that staff complies with VHA policy governing the use and oversight of government purchase cards**. *Comment:* Concur with the recommendation. The following items are being addressed. Staff developed training (1/01) for all credit card holders and approving officials. The training is being conducted in February, and stresses the timely reconciliation of credit card purchases. Currently monthly reminders are sent to all staff involved with the credit card purchases to insure compliance with reconciliation and documentation procedures. Monthly reporting to VACO is being accomplished; recent reports reflect an improvement in the timely reconciliation of credit card purchases (last quarter). Currently Financial Service Center random quality reviews are being reviewed by the Chief Financial Officer and signed. Random audits of cardholders will begin in late February following the mandatory training.

#7 Recommendation – **The VAM&ROC Director should provide enough staff to ensure that field examinations and accountings are completed timely**. *Comment* – Concur with recommendation. One full time employee was hired in July 2000 as a field veterans service representative. Staffing in the field section doubled from one to two examiners with this new hire. Last July, there were 97 pending follow-up examinations of which 66 or 68% of them were overdue. This is consistent with OIG findings that 7 out of 10 (70%) examinations were not timely. Over the last six months good progress has been made in reducing the pending examinations. As of January 2001, 15 follow-up examinations are currently pending, a reduction of 84% since July 2000, with only one of these (6.7%) beyond the suspense dates. Similar improvements were achieved with initial appointments of 14 pending in July 2000 to 3 currently pending in 2001. Total accountings were reduced from 26 to 17, but improvement in timely completion of these is still needed. During the next two months, we anticipate reducing pending accountings significantly.

#8 Recommendation – **The VAM&ROC Director should improve security of veterans claim folders by providing fire protection; securing the records room from**

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unauthorized access; and ensuring that claim folders are safeguarded in transit. *Comment*: Concur with recommendation. Keyless entry access to the main claim folder storage area has been installed in 2000 and all service center employees have been briefed on maintaining security of records. We are currently exploring the feasibility of installing cameras in the front foyer area of the building and in the corridor adjacent to where the claim folders are stored. It is felt that this will allow supervision of building access and monitor potential unauthorized access to the records storage area.

2. Other suggested areas to address were discussed in the report. Significant follow-up has occurred as follows with:

A. Chronic Pain

- Chronic pain patients are being referred, evaluated and being followed by the physiatrist. This has been in place since 8/00. These patients are seen in rehab clinic and comprise 60% of the appointments. Plans are drafted to formalize a chronic pain clinic separate from rehab clinic with an interdisciplinary approach. A pain management guideline/algorithm has written by the Sioux Falls IHI pain team. It is being Network adapted for medical education interdisciplinary resource.
- A pain template for assessment is drafted and being implemented before 2/28/01. This is being expedited for priority by the new Nurse Executive.
- PM&R has whirlpool therapy and a pool program for alternative modalities for chronic pain management.
- Pathology and laboratory services completed utilization and turn around time studies on urine drug screens. They currently are sent out of community. Average turn around time for 1st Qtr. FY 2000 on 99 tests was 3.9 days; 2nd Qtr. 2000 on 162 tests was 3.3 days; 3rd Qtr. 2000 on 117 tests was 3.4 days; 4th Qtr. 2000 on 52 tests was 3.8 days and for 2001 1st Qtr. on 48 tests 3.8 days. The significant decrease in volume is due to mental health discontinuing their 'routine' use of urine drug screens. Community quotes for turn around would be 24-36 hours at a cost of 31/test. Current costs are $14/test. The Medical Staff Executive Committee did not see the cost benefit to switch all urine drug screens to local community with only a potential gain of 1-2 days in timeliness. Instead MEC recommended that tests marked as STAT would be sent locally and all routines will continue to be sent within the VA for reading. The Mental Health Medical Director, Site Mental Health PSL Director and Addictions Program Coordinator were in full agreement.

B. Sexually Transmitted Infections/Infection Control

- Dr. [ ] is the Infectious Disease Chief, program transition completed by 8/00.
- Education was provided to the primary care and medical interdisciplinary committee meetings in March, June, August, September and December 2000. The STD algorithm was distributed to each outpatient care provided by 8/00.
- On October 18, 2000 Dr. [ ] ID, Minneapolis VAMC conducted Sioux Falls city-wide grand rounds and also (x2) inservices at Sioux Falls VAMC on HIV, AIDS and or STIs.
- January 2001 all medical interdisciplinary groups were provided *The HIV Risk Assessment, a Quick Reference Guide* by the IC Practitioner.
- Condoms are stocked in Pharmacy (7/00).
- Dr. [ ] and the IC Practitioner have initiated a formal, comprehensive interdisciplinary team (MD, clinic nurse(s), case manager, psychologist, dietitian and

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pharmacist). The team meets before Infections Disease Clinic twice each month to review and plan services for individual patients with HIV, AIDS or other STI.

C. Patient Care Environment – Leadership weekly environmental rounds were initiated in 10/00. These have a follow-up tracking system. In 01/01 almost daily patient care rounds are being conducted by the new Nurse Executive. Positive results of these rounds are very evident specific to patient care environment, safety, infection control, and confidentiality of the patient and the medical record and patient focused care.
   - Repeated areas of concern are reported to the Environment of Care (Safety) Committee.
   - A work order process review by Engineering was initiated 1/01.

D. Nursing Staffing Methodology
   - Daily staffing levels are reviewed three times a day by nursing management. Staffing levels are reviewed using criteria of patient classification, complexity, admissions/discharges, activities/procedures and unscheduled leave. Effective 8/00 the worksheets that document actions taken to address variances are maintained.
   - Currently nursing restructuring is in process with the focus on the continuum for the patient. The Nurse Executive, effective, 1/01, is involved with the staffing level determinations. A more formal staffing methodology process will be developed with completion of nursing restructuring.

3. I would like to take this opportunity as the VISN 13 “One VA” coordinator to state that the CAP OIG survey was a value-added survey. In addition, as a newly appointed Director/Chief Operating Officer, I along with leadership viewed this external assessment as a valuable tool to identify areas of concern we needed to address in order to provide the best patient care services and benefits. Results from your 7/00 CAP were validated by JCAHO mock surveys also held in 2000. These external assessments were used to identify, prioritize, and “take action” for process improvements. External assessment data was also key data included in the annual leadership retreat, facility program review. This linked well with our Baldrige approach. 2000 summary data was reviewed and mission vision and strategic plan with priorities for 2001 were established.

4. The new CAP survey process was beneficial to leadership in validating needs for patient focused process improvements. As a result timely action plans were made and completed. An example is the use of CAP findings for the expeditious activation of the Management Inventory Program.

5. Thank you!

/s/

RONALD T. PORZIO

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