



Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program
Review of the
Kansas City VA Medical Center

Office of Inspector General Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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

Contents

	Page
Executive Summary	i
Introduction	1
Medical Center Profile	1
Objectives and Scope of CAP Review	1
Results of Review	3
Organizational Strengths	3
Opportunities for Improvement	4
Supply, Processing, and Distribution Areas	4
Environment of Care.....	5
Medical Record Privacy	6
Primary Care for Mental Health Patients.....	6
Part-Time Physician Timekeeping	7
Narcotics Inspection Program	9
Pharmacy Security	11
Medical Care Collection Fund	13
Communicating Test and Procedure Results	14
Information Technology Security	15
Background Investigations	17
Government Purchase Cards	18
Angioplasty Contract	19
Appendices	
A. Monetary Benefits in Accordance with IG Act Amendments	21
B. Kansas City VA Medical Center Acting Director Comments	22
C. Report Distribution	35

Executive Summary

Introduction

During the week of June 25–29, 2001, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Kansas City VA Medical Center (KCVAMC). The purpose of the review was to evaluate selected health care system operations, focusing on patient care administration, quality management (QM), financial and administrative controls. During the review, we also conducted fraud and integrity awareness training briefings for about 100 employees.

Results of Review

KCVAMC patient care administration and QM activities reviewed were generally operating satisfactorily. The QM Program, referred to as the Performance and Patient Care Improvement (PPCI) Program, provided effective oversight of the quality of care. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, KCVAMC management needed to:

- Correct infection control and safety problems in the Supply, Processing, and Distribution (SPD) areas.
- Correct environmental deficiencies that compromised the safety of patients.
- Secure patient information and computer workstations throughout the medical center.
- Specify guidelines for ensuring timely access to Primary Care services for Mental Health (MH) patients.
- Strengthen time and attendance controls for part-time physicians.
- Account for all controlled substances, resolve any discrepancies noted during monthly inspections, and report any controlled substances losses to appropriate authorities and officials.
- Enhance pharmacy security by restricting access, securing keys, performing 72-hour inventories, and securing pharmaceutical items stored in patient ward areas.
- Ensure Medical Care Collection Fund (MCCF) employees pursue unpaid accounts receivable, collect and document health insurance information, and make follow-up telephone calls.
- Notify providers and patients of abnormal results of tests and procedures.
- Improve information technology (IT) security by requiring employees to log-off unused computers and training all employees in computer security.
- Request background investigations for all new clinicians and previously hired clinicians as needed.

- Improve controls over approval of Government purchase card transactions, discontinue the practice of splitting purchases to avoid exceeding spending limits, and have the program coordinator resume monthly audits.
- Ensure that existing medical service contracts are used at all times, and that any contracts due to expire are renewed or replaced as needed.

KCVAMC Acting Director Comments

The KCVAMC Acting Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix B, pages 22–34, for the full text of the Acting Director's comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Kansas City, Missouri, the KCVAMC is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics (CBOCs) located in Nevada, Belton, and Whiteman Air Force Base in Missouri and in Paola, Kansas. The KCVAMC is part of Veterans Integrated Service Network (VISN) 15 and serves a veteran population of about 210,000 in a primary service area that includes 14 counties in Missouri and 5 counties in Kansas.

Programs. The KCVAMC provides medical, surgical, mental health, and advanced rehabilitation services. The KCVAMC has 125 hospital beds and operates several regional referral and treatment programs, including substance abuse, geriatric care, oncology, vascular diseases, and infectious diseases. In addition, the KCVAMC has sharing agreements with the University of Kansas Medical Center (KUMC) and contracts with Health Midwest and Truman Medical Center for additional medical services.

Affiliations and Research. The KCVAMC is affiliated with the University of Kansas School of Medicine and supports 76 medical resident positions in 20 training programs. In Fiscal Year (FY) 2001, the KCVAMC research program had 170 projects and a budget of \$1.4 million. Important areas of research include digestive, kidney, cardiovascular, alcohol/drug addiction, and neurological diseases.

Resources. In FY 2000, KCVAMC medical care expenditures totaled \$107.3 million. The FY 2001 medical care budget is \$116.8 million, 8.9 percent more than FY 2000 expenditures. FY 2001 staffing is 511 full-time equivalent employees (FTEE), including 73.8 physician and 240.7 nursing FTEE.

Workload. In FY 2000, the KCVAMC treated 27,067 unique patients, a 3.8 percent increase from FY 1999. The inpatient care workload totaled 6,353 discharges, and the average daily census was 121 patients. The outpatient workload was 242,235 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to enhance employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

Performance and Patient Care Improvement Program	Part-Time Physician Time and Attendance
Supply, Processing, and Distribution Areas	Controlled Substances Accountability
Ambulatory Care Clinics	Information Technology Security
Inpatient Care Units	Service Contracts
Medical Record Privacy	Government Purchase Card Program
Mental Health Primary Care	Medical Care Collection Fund
Communicating Test and Procedure Results to Providers and Patients	Background Investigations on Selected Clinicians

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with patient care services and the quality of care. The survey results were provided to KCVAMC management.

During the review, we also conducted three fraud and integrity awareness training briefings for KCVAMC employees. About 100 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered KCVAMC operations for FYs 2000 and 2001 through May 2001 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strengths

KCVAMC management created an environment that supported high quality patient care and performance improvement. The patient care administration, QM, financial, and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective, as illustrated by the following examples.

The PPCI Program Identified Performance Improvement Opportunities. The KCVAMC established a QM program, referred to as the PPCI Program, to monitor the quality of care using national and local performance measures, patient incident reporting measures, and utilization review. Data from the measures were analyzed, trended, and used to identify performance improvement opportunities. Administrative investigations and focused reviews were appropriately conducted and recommended corrective actions were implemented.

Patients Generally Expressed Satisfaction with the Quality of Care. We interviewed 15 inpatients and 15 outpatients to obtain their opinions about timeliness of services and quality of care. All 30 patients felt that their treatment needs were addressed satisfactorily and that they were generally involved in decisions about their medical care. Of the nine patients who responded that they had pain during their inpatient admission, all said that they received medications or treatments that effectively reduced their pain. All 15 outpatients stated that the same primary care providers (PCPs) saw them for scheduled primary care visits. Twelve of the 13 outpatients who had requested appointments with their PCPs were able to schedule appointments within 7 days after the dates of their requests. Ninety-three percent (28 of 30) of the patients interviewed said that they would recommend the KCVAMC to eligible friends or family members and rated the quality of care as good, very good, or excellent.

Service Contracts Were Effectively Monitored. We reviewed contract oversight for 6 clinical services contracts and 4 ambulance contracts valued at about \$8.9 million. All 10 contracts had contracting officer technical representatives appointed who were effectively monitoring contractor performance and ensuring compliance with contract terms.

Opportunities for Improvement

Supply, Processing, and Distribution Areas – Infection Control Risks Require Immediate Management Attention and Oversight

Conditions Needing Improvement. Our tour of the SPD areas revealed significant deterioration of the physical environment. Employees had not initiated needed repairs and had not adequately cleaned areas to maintain Veterans Health Administration (VHA) infection control standards required for the processing and storage of sterile supplies. Employees told us that repairs were requested through work orders, but the work had not been completed. We found the following examples of unacceptable conditions:

- Paint was peeling and crumbling from the ceiling and walls. There were paint chips on clean and sterile instrument packs, on supply storage shelves, and on the floors throughout the area.
- The ceiling leaked in several places despite evidence of prior repairs. For example, a leak in the ceiling of a sterile storage room was diverted into a large bucket using plastic sheathing fashioned into a funnel. Further, the bucket contained dirty water, even though it had not rained for several days.
- Most of the ceiling panels in the sterile package preparation area were damaged.
- The ventilation system fan had rusted metal, peeling paint, and dirty blades.
- Dust covered shelves, floors, and doors.
- Broken medical equipment was stored in various rooms in the SPD areas.
- Trash had accumulated on desktops, counters, and storage shelves.

The KCVAMC had insufficient space for storage of clean and sterile instruments and supplies. Clean medical equipment that was to be returned to patient care areas was stored in decontamination areas with dirty equipment, such as a used crash cart (a portable cart with medications and equipment used during a cardiac arrest) and intravenous pumps that had been returned for cleaning. We also noted a dirty fly swatter hanging on the wall of this room. Clean or sterile medical instruments should be stored in pest free areas. Exposed electrical cords and steam pipes that had peeling foam wrapping were in one of the two rooms where medical equipment and instruments are decontaminated. In the other decontamination room, cleaning fluid from the steam sterile processing unit had leaked on the floor. This room also had dirty floors, walls, and equipment.

Management was aware of these conditions. In August 2000, the KCVAMC Industrial Hygienist cited multiple deficiencies and made specific recommendations in a “Safety, Health, Environmental, and Fire Protection Evaluation Report.” The recommendations were not implemented. Management planned to relocate the SPD area into a new building addition that was under construction, but no funding was available to accomplish this move.

Recommended Improvement Action 1. We recommended that the KCVAMC Acting Director take immediate action to correct infection control and safety concerns in the SPD areas.

The KCVAMC Acting Director concurred with the recommendation. Work began September 15, 2001, to correct infection and safety concerns in SPD. Further, a project to construct a new SPD had received approval with activation scheduled for FY 2003. The implementation actions are acceptable, and we consider the issues resolved.

Environment of Care – Medical Center Cleanliness Needs Immediate Management Attention and Oversight

Conditions Needing Improvement. In addition to the infection control and safety concerns in the SPD areas, we identified multiple environmental issues throughout the medical center during our tours of inpatient units and ambulatory care areas. Many areas needed repairs that had been neglected for years. For example, employees told us a faucet in the dialysis area had been leaking for 14 years.

Environmental and infection control concerns posed hazards or potential threats to safe, high quality patient care. We found the following examples of unacceptable conditions:

- Dust covered all horizontal surfaces, such as bedside tray tables, bedside lockers, and bedrails in rooms prepared for new patient admissions on Units 8E, 3W, the Medical Intensive Care Unit (MICU), and the Surgical Intensive Care Unit (SICU). Dust also covered the cardiac monitors in the MICU and the SICU.
- Unsecured cleaning chemicals were stored in unlocked storage rooms or on unattended housekeeping carts.
- An unlocked storage room on Unit 4E contained needles, syringes, and blood drawing supplies.
- An oxygen tank was left unsecured on top of a meal cart in the hallway on Unit 3W.
- Intravenous stands, treatment carts, and other equipment items were stored in the hallway on Unit 3W.
- There were cracked and dirty seats on portable shower/commode chairs.
- There were dirty countertops in patient nourishment kitchens and medication rooms.
- Clean and dirty items were stored in close proximity in storage rooms in the MICU and the SICU.
- Construction sites were not properly sealed to restrict unauthorized traffic in the areas, creating a potential hazard for wandering patients.
- Rodent traps were found in several patient rooms. We observed rodent droppings in one device in a patient room, creating a potential infection control hazard.
- An electronic insect killing device that did not appear to be in working order was found in the MICU. Employees told us that there was an ongoing pest problem.

Recommended Improvement Action 2. We recommended that the KCVAMC Acting Director take immediate action to correct all of the environmental and infection control deficiencies noted by our review.

The KCVAMC Acting Director concurred with the recommendation. The Acting Director of Facilities moved most housekeeping staff to the day shift to improve cleanliness and removed the rodent traps from all patient care areas. KCVAMC management also had begun to fill housekeeping vacancies, approved overtime pay for housekeeping staff as needed, established a temporary work leader position to assist with supervision within housekeeping, and planned to implement improved performance measures for housekeeping. The implementation actions are acceptable, and we consider the issues resolved.

Medical Record Privacy – Patient Information and Computer Workstations Need to be Consistently Secured

Conditions Needing Improvement. VHA policy requires that patient information must be protected against deliberate or inadvertent misuse or disclosure. The positions of computer monitor screens in the dialysis area and Unit 8E allow the public to view sensitive information. Also, employees on Unit 8E have discovered family members or visitors accessing the Internet at computer workstations in the hallway near patient rooms. Medical center employees in the Primary Care Silver and Gold Clinics left unsecured computer terminals on during evening hours. A VA Police officer reported to us that during his patrol of the Silver Clinic area after clinic hours, he pressed the space bar on a keyboard, which immediately accessed the entire list of patients who had appointments in the clinic for that day. We also noted several breeches in patient confidentiality during our tour of the medical center. For example, we found index cards with patient information taped to the doors of patients' rooms on Unit 4E; charts with patient information hanging from the handrails in the hallway outside patients' rooms on Unit 3W; and sign-in sheets with patients' names and social security numbers in public view in the Learning Center. Additionally, a VA Police officer brought us a manila folder containing patient information that he found on top of a trash cart in a hallway.

Recommended Improvement Action 3. We recommended that the KCVAMC Acting Director ensure that computer workstations and patient information are secured throughout the medical center.

The KCVAMC Acting Director concurred with the recommendation and agreed that VA Police would check areas for improper computer usage and weekly environmental rounds would include a review of patient information privacy. The implementation actions are acceptable, and we consider the issues resolved.

Primary Care for Mental Health Patients – Improve Written Policies for the Provision of Primary Care and Examine Waiting Times for Service

Conditions Needing Improvement. The medical center policy governing patient care services defined procedures for PCPs to refer Primary Care patients for MH Care, but does not define procedures for the referral of MH patients to Primary Care. When we interviewed 11 MH patients enrolled in Primary Care, 8 told us they could not schedule appointments with their

PCPs within 7 days if they had pressing medical needs. In contrast, they were able to see MH providers on a walk-in basis.

KCVAMC ambulatory care employees enrolled MH patients in Primary Care for their medical conditions, but there were delays of 3-8 weeks before PCPs could see the MH patients to evaluate their medical conditions. There were no guidelines for prioritizing the urgency of the MH patients' medical conditions so that those who needed immediate care could obtain a Primary Care appointment within days rather than weeks.

Recommended Improvement Action 4. We recommended that the KCVAMC Acting Director ensure that:

- (a) Facility policies be updated with specific guidelines about referring MH patients for Primary Care services for their medical conditions.
- (b) MH patients can schedule appointments with their PCPs to meet their pressing medical needs within 7 days.

The KCVAMC Acting Director concurred with the recommendations. Mental Health revised the Mental Health Scope of Care to include referral of mental health patients to primary care, including Primary Care Day Clinic or the Emergency Room (ER) as needed, and would continue efforts to assist mental health patients to schedule appointments with their PCPs within 7 days for non-emergent care and within 30 days for routine appointments. The implementation actions are acceptable, and we consider the issues resolved.

Part-Time Physician Timekeeping – Strengthen Controls On Time and Attendance

Conditions Needing Improvement. KCVAMC management needed to ensure that part-time physicians were on duty when required and that their time and attendance was appropriately documented. Part-time physicians are hired to work less than the normal 40-hour duty week. These physicians can work either fixed or adjustable hours. Physicians working adjustable hours must work a minimum number of scheduled core hours each pay period, but their remaining hours may be worked outside the core hours, provided their total work requirements are met.

VA policy requires that timekeepers ensure that timecards accurately reflect the hours that physicians are present for duty. Timecards should show the part-time physician's assigned tour of duty, the actual hours worked, and any charges to leave. After the timekeepers complete the timecards, approving officials must certify that the hours worked and the hours charged to leave are correct.

To evaluate part-time physician timekeeping controls, we attempted to locate 15 physicians during their tours of duty. When we checked, 12 of the 15 physicians either were on duty or approved leave. However, the remaining three physicians were not on duty or on approved leave at the time of our visit.

One of the physicians had submitted a request for annual leave for 5 days beginning June 28, but could not be located on June 26. The timekeeper assumed that the physician had started annual leave earlier than planned and agreed to obtain an amended leave request upon the physician's return.

Clinic employees reported that they did not know the locations of the other two physicians when we checked. Neither physician had requested leave for the day of our review, but both later submitted leave requests for the time they were absent on that date. As a result of our review, a physician who was on approved leave the day of our review submitted 14 leave requests for 70 hours of annual leave that he had already taken but had not been charged for, dating back to January 1, 2001. Clinic records showed that clinic employees cancelled 98 appointments scheduled for 12 of the 14 days that this physician had taken unapproved leave.

Timekeepers told us that they often did not have personal knowledge of part-time physicians' time and attendance and relied on information from clinic employees, operating room personnel, and even phone calls or e-mails from the physicians to complete timecards. We believe that the inadequate oversight occurred because, although timekeepers and approving officials received training on the proper coding of work and leave hours, the training did not address the importance of recording and certifying timecards that reflect actual hours worked.

The Employee Accounts Section has the responsibility to perform desk audits of all timekeepers on a semi-annual basis. They should report any unsatisfactory timekeeping practices and conditions to the Acting Director and the timekeepers' supervisors. However, the Employee Accounts Section did not perform desk audits of timekeeper's records to determine whether timekeepers were properly reporting physician time and attendance. In addition, we could not determine whether part-time physicians received training on time and attendance policies.

Recommended Improvement Action 5. We recommended that the KCVAMC Acting Director ensure that:

- (a) Timekeepers and approving officials accurately record in timekeeping records all part-time physicians' on-duty time and leave.
- (b) The Employee Accounts Section personnel conduct semi-annual audits of timekeepers.
- (c) All timekeepers and approving officials receive training on the importance of recording and certifying timecards that reflect actual hours worked.
- (d) All part-time physicians and their supervisors receive training on VA time and attendance policies.

The KCVAMC Acting Director agreed with the recommendations. Management had reviewed all current scheduled tours and core times for these physicians and planned to conduct spot reviews of part-time physician timekeeping over the next 6 months. They agreed that Employee Accounts Section personnel would conduct semi-annual audits of timekeeper records and provide the results to the Chief of Staff. All current timekeepers and approving officials would receive refresher training, and all part-time physicians would receive a memorandum regarding the timekeeping and leave process. The implementation actions are acceptable, and we consider the issues resolved.

Narcotics Inspection Program – Improved Procedures Could Increase Accountability

Conditions Needing Improvement. KCVAMC management needed to improve narcotics inspection procedures to ensure that all controlled substances are accounted for accurately and that any narcotic drug losses are identified and reported to the proper authorities. VHA policy requires facility Directors to create comprehensive inspection programs to ensure the safety and control of Schedule II-V drugs and to report any suspected theft, diversion, or suspicious loss of Schedule drugs to the OIG, VA Police, and through the Regional Directors to the Chief, VA Central Office (VACO) Pharmacy Service.

For the 12-month period May 2000 to April 2001, we reviewed records of the narcotics inspections conducted, VA Police reports, Pharmacy and Therapeutics (P&T) Committee minutes, and interviewed inspectors and both the current and former Controlled Substance Inspection Coordinators. The inspectors performed all required monthly inventory counts and the narcotics inspection program met most VHA policy requirements. However, the following areas needed improvement.

Program Policy and Procedures. VHA policy requires that inspectors inventory all outdated and unusable controlled substances that are stored in the pharmacy vault pending destruction and compare a sample of dispensing entries to doctors' orders and patients' records to verify the amounts removed from perpetual inventories for all applicable areas inspected. Local policy and written inspection procedures did not comply with VHA policy.

Monthly Inspections. KCVAMC management should replace two nurses on the inspection team and document inspection procedure training for all inspectors. VHA policy requires that facility Directors appoint inspectors, who are not pharmacists, nurses, or physicians, as controlled substances inspectors and that they must maintain documentation on all orientation and training provided. Two of the approved inspectors were nurses, and orientation and training was not documented for 6 of the 30 inspectors.

In addition, inspectors did not include the following procedures in their monthly narcotics inspections:

- Inventory controlled substances awaiting destruction in the inpatient pharmacy vault.
- Compare a sample of dispensing entries to doctors' orders and patients' records in all wards, clinics, and research areas.
- Inspect all areas that had stocks of controlled substances each month.
- Inspect all areas on the same day.
- Conduct inspections at random times during the month.

Documenting Resolution of Inspection Discrepancies. VHA policy requires that narcotics inspectors report discrepancies to the accountable official, who will determine the causes to the

satisfaction of the inspectors and make a report of findings to the facility Director. At the KCVAMC, the Chief, Pharmacy Service, was the accountable official.

The Inspection Coordinator summarized the narcotics inspection results in a monthly report to the facility Director, which was also given to the Chief, Pharmacy Service for follow up on discrepancies. The report did not include all discrepancies, the steps the inspectors or the accountable official took to resolve the discrepancies, and whether the discrepancies indicated losses. Many of the explanations for inspection discrepancies were hand-written notations made by a pharmacy technician in the margins of the monthly report. In our opinion, this is not adequate documentation to show how the discrepancies were resolved. For example, the August 2000, inspection report showed a discrepancy between the inspector's count and amounts recorded in the perpetual inventory record for three 10-packs of midazolam vials. The inspector matched the receiving report to an entry on the perpetual inventory record for the three 10-packs, but the count was off by 30 vials. The pharmacy technician noted that the inventory count was corrected (changed to match the amount the inspectors found), but did not explain why the perpetual inventory record was in error, since the record matched the receiving report. The narcotics inspector and the Inspection Coordinator accepted the explanation and considered the discrepancy resolved. Without further explanation or documentation, we could not determine whether the discrepancy represented an input error when the midazolam was entered into the perpetual inventory record or whether it represented an unexplained loss of 30 vials.

Reporting Losses of Controlled Substances and Missing Inventory Records. VHA policy requires that any suspected theft, diversion, or suspicious loss of controlled substances must be immediately reported by the facility Director, to the OIG Office of Investigations, VA Police, and VACO Pharmacy Service officials. We identified five discrepancies in inventory counts and a missing perpetual inventory record in narcotics inspectors' reports, but could not determine from the documentation whether the discrepancies and the missing perpetual inventory record were resolved or not. If the discrepancies indicated suspicious losses, the facility Director should have reported them to VA Police and other authorities as required.

There were four VA Police reports regarding losses of controlled substances, but none were for the discrepancies discussed above. The four VA Police reports included two instances of suspected thefts from the pass/discharge area.¹ The former Director reported all four of these losses to the OIG, but had not reported any of them to VACO Pharmacy Service officials as required.

Trending of Monthly Inspections. VHA policy requires that the facility Director trend inspection results to identify potential problem areas for improvement. Trending could identify a pattern of potential illegal diversion of controlled substances that should be reported by the facility Director to VA Police. The former Director delegated responsibility for trending the inspection results to the P&T Committee.

The committee reviewed 9 of 12 inspection reports from April 2000 through May 2001, and identified a trend due to the number of errors inputting dispensing data into perpetual inventory

¹ The pass/discharge area is where medications are dispensed to discharged patients, and patients leaving the hospital for weekends or for emergencies.

records and one unresolved drug loss in the pass/discharge area. The Chief, Pharmacy Service addressed these two issues by reassigning Pharmacy Service staff and placing stricter controls over the keys to the narcotics cabinets in the pass/discharge area.

The three inspection reports that the P&T Committee did not review included the discrepancy with the three 10-packs of midazolam, the five unresolved discrepancies in the inpatient vault counts, and the missing perpetual inventory form mentioned previously. In our opinion, these three reports showed significant problems that should have been trended but were not because the P&T Committee did not review all of the inspection reports.

Recommended Improvement Action 6. We recommended that the KCVAMC Acting Director ensure that the narcotics inspection program complies with VHA policy by:

- (a) Updating local policy and procedures on inspecting controlled substances awaiting destruction and verifying a sample of dispensing entries to doctors' orders and patients' records.
- (b) Replacing two nurse inspectors with employees who do not handle drugs as part of their duties.
- (c) Documenting inspector training.
- (d) Ensuring that narcotics inspectors review all areas on the same day, verifying a sample of dispensing entries, and selecting random inspection dates.
- (e) Resolving all discrepancies between perpetual inventory records and inspection counts, including documenting the steps taken to resolve the discrepancies.
- (f) Reporting any controlled substances losses and missing perpetual inventory records to the appropriate authorities and officials.
- (g) Trending all inspection results to identify potential problem areas.

The KCVAMC Acting Director concurred with the recommendations. The local policy memorandum concerning inspection of controlled substances was rewritten. The Acting Director replaced the nurses previously on the inspection teams with new inspectors and prepared forms to document inspector training. Top management plans to stress inspection of all areas on the same day and resolution of discrepancies in all future training. All discrepancies and missing inventory records would be reported to the appropriate officials and would be trended by the P&T Committee. The implementation actions are acceptable, and we consider the issues resolved.

Pharmacy Security – Improved Security Could Enhance Accountability

Conditions Needing Improvement. Improvements were needed to enhance pharmacy security and accountability of controlled substances.

Access to Pharmacy Areas by Non-Pharmacy Employees. VHA policy requires restricted access to pharmacy areas. Each medical center and outpatient clinic must install electronic control systems in pharmacies to monitor access to controlled substances. At the KCVAMC, the electronic system provided access by punching codes into a keypad. Each individual allowed access has a unique electronic code so that the system can track access by door and area for each user. Four non-pharmacy employees had access to the pharmacy areas. One person left the KCVAMC Pharmacy Service to take a position with VISN 15, which is co-located at the medical center. The other three individuals were clinical faculty from the University of Missouri at Kansas City. Two assisted as part of the Pharmacy Service residency program and one assisted with drug utilization reviews. None of the four filled or dispensed medications.

Security of Controlled Substances. VHA policy requires that all controlled substances prescriptions awaiting patient pick-up be stored in a locked area. Employees having access to the locked area should be limited. In the pass/discharge area, Pharmacy Service employees stored controlled substances prescriptions waiting for patient pick-up in a locked cabinet and working stocks of controlled substances in another locked cabinet under the fill counter. Employees stored the keys in an open bin on a shelf above the fill counter where anyone with access to the pharmacy areas could find them.

Delivery of Controlled Substances to the Pharmacy. VHA policy requires that all deliveries of controlled substances be made directly to the pharmacy. The pharmacy's prime vendor delivers controlled substances directly to the pharmacy from their local warehouse unless they are out of stock and ship from their backup warehouse in Joplin, Missouri. Deliveries from Joplin arrive via Federal Express packages that are delivered to the warehouse rather than directly to the pharmacy. A warehouse employee then delivers the unopened Federal Express packages to the pharmacy. KCVAMC management said that the warehouse was the designated delivery point for all Federal Express packages. In our opinion, this practice increases the risk of loss or diversion.

Inventories of Controlled Substances. VHA policy requires that a perpetual inventory of pharmacy bulk stocks of all controlled substances be maintained and verified by Pharmacy Service at a minimum of every 72 hours. Pharmacy Service employees should document the inventories on the appropriate VA form. A sample of 45 Pharmacy Service records showed intervals between inventories ranged from 3 days to 5 months or more. A Pharmacy Service technician, recently trained in the 72-hour inventory process, considered the 72-hour inventories a low priority and only completed the counts as time permitted.

Security of Pharmaceutical Items Stored in Patient Units. Two patient units did not have refrigerated controlled substances stored in double-locking devices as required by VHA policy. In addition, one unit's self-closing medication room door did not fully close, thus leaving medications, needles, syringes, and other pharmaceuticals unsecured.

Recommended Improvement Actions 7. We recommended that the KCVAMC Acting Director enhance security over controlled substances and pharmaceuticals by:

- (a) Restricting access to pharmacy areas by canceling electronic access codes issued to four non-pharmacy employees.
- (b) Securing keys to locked areas containing controlled substances.
- (c) Designating a second Federal Express delivery point in the pharmacy areas for controlled substances packages.
- (d) Performing inventories of all bulk stock of controlled substances at a minimum of every 72 hours.
- (e) Securing pharmaceutical items stored in patient units.

The KCVAMC Acting Director concurred with the recommendations. Management removed pharmacy access for the individuals noted and secured all pharmaceutical items stored throughout the medical center. They plan to put a PYXIS unit in the pass/discharge area within 2 months to eliminate the need for keys to these areas. The Joplin, Missouri warehouse agreed to deliver controlled substances directly to the pharmacy where Pharmacy Service personnel sign for them. Pharmacy Service management reeducated the narcotic technician on the need for 72-hour inventories of pharmacy bulk stock and developed a log to document performance of the inventories. The implementation actions are acceptable, and we consider the issues resolved.

Medical Care Collection Fund – Improved Procedures Could Increase Cost Recoveries

Condition Needing Improvement. Management should maximize MCCF program results by clearing the billing backlog, identifying sources for cost recoveries, and ensuring appropriate billings and collections of funds due VA. Our review focused on FY 2001 activities and included assessments of MCCF accuracy and timeliness of billings and collections for outpatient care, and insurance identification procedures. Three areas needed improvement to maximize cost recoveries.

Billing Timeliness and Backlogs. We reviewed the medical records of 10 veterans and identified 21 bills totaling \$40,178 that had not been issued timely. The average billing lag time (date of care to date of bill) for these bills was 179 days. As a result, the KCVAMC had developed a billing backlog of 13,247 third-party reimbursement claims valued at \$2.7 million for the first 6 months of FY 2001. Based on the KCVAMC's average collection rate of 27 percent, MCCF employees could have collected about \$729,000 if they had issued bills for the care provided. VISN 15 plans to contract out billings and collections to remedy the backlog situation.

Collection Efforts. MCCF employees could increase collections from health insurance carriers by making follow-up telephone calls. KCVAMC policy requires that employees make follow-up telephone calls 15 days after issuing bills. As of March 31, 2001, the KCVAMC had 16,332 first-party receivables totaling \$111,062 and 13,530 third-party receivables totaling \$2.2 million.

We reviewed a sample of 10 first-party and 10 third-party receivables with a combined total of \$45,869 to assess the collection efforts of MCCF employees. MCCF employees did not make

follow-up telephone calls as required by local policy for 11 of the 20 bills, which included 6 first-party receivables valued at \$1,125 and 5 third-party receivables valued at \$9,241.

Unidentified Insurance. The success of the MCCF program depends on identifying veterans with health insurance coverage. Billings to health insurance carriers cannot occur unless MCCF employees identify the veterans' health insurers. At the KCVAMC, MCCF patient insurance clerks interview veterans in the intake area about their health insurance coverage and other demographic information before the veterans go to the clinics. We observed two insurance clerks at the medical center as they interviewed veterans. The insurance clerks asked veterans about their health insurance coverage, but they did not photocopy the patients' health insurance cards for their medical records as commonly practiced in private hospitals.

MCCF employees were trained in intake procedures, but employees at the CBOCs did not always request the veterans' health insurance coverage information. We contacted 10 veterans who had no recorded health insurance coverage in their medical records and who had received treatments at the KCVAMC during March 2001 to determine whether the veterans had health insurance coverage. Three of the 10 veterans had health insurance coverage and all 3 had received treatment at a CBOC. In two of the three cases, the treatments were for service-connected conditions and therefore were not billable. In the other case, treatment was for a nonservice-connected condition, so the KCVAMC billed the veteran's insurance carrier for treatment totaling \$698.

Recommended Improvement Actions 8. We recommended that the KCVAMC Acting Director take steps to:

- (a) Bill episodes of care in a timely manner to reduce billing lag times and expedite billing on the backlogged claims.
- (b) Make follow-up telephone calls on all unpaid bills.
- (c) Provide refresher training for all MCCF employees to stress the importance of health insurance coverage identification and require that MCCF employees photocopy veterans' health insurance cards for inclusion in the medical records.

The KCVAMC Acting Director concurred with the recommendations and monetary benefits. Management hired seven coders to reduce the backlog and plans to fill two vacancies in the accounts receivable section so they can resume regular telephone calls and to conduct refresher training for all intake personnel. The implementation actions are acceptable, and we consider the issues resolved.

Communicating Test and Procedure Results – Providers and Patients Should Be Notified of Abnormal Results.

Condition Needing Improvement. We reviewed the medical files for 30 patients with abnormal test or procedure results for appropriate provider and patient notification. There were 10 files each selected from Anatomic Pathology, Radiology, and Clinical Laboratory Services. Provider and patient notification were appropriate except for the following:

- One of the 10 files from Radiology Service showed no evidence of provider notification or patient follow-up. Management responded to this omission by agreeing to contact the patient and arrange an appointment as soon as possible.
- Four of the 10 Clinical Laboratory files were cases where the PCPs were different from the ordering providers. Laboratory Service employees documented that they informed the PCPs of critical values² in only one of the four applicable medical records.

We randomly selected 10 outpatients to interview and found that 5 of the 10 had abnormal test or procedure results. Four of the five patients received appropriate notifications and instructions for follow-up care. The other patient learned of his abnormal test result during his next outpatient visit.

Recommended Improvement Action 9. We recommended that the KCVAMC Acting Director ensure that:

- (a) Appropriate providers are notified of abnormal test and procedure results.
- (b) Patients are notified of abnormal test and procedure results, and are provided with instructions for follow-up care.

The KCVAMC Acting Director concurred with the recommendations and noted that Radiology Service had established two QA monitors that specifically address “abnormal” findings. These monitors provide that the individual who requested the procedure be notified of an abnormal result via an electronic "alert" message. Pathology and Laboratory Medicine notify the ordering provider of abnormal test and procedure results. These notifications are documented with an electronic flag called “critical value.” The PCP is notified of test results if the ordering provider is not available for communication or if appropriate follow-up has not been indicated. Notification of abnormal results to the patient and instructions for follow-up care are the responsibility of the clinical provider. If the tests or procedures occur on a weekend or outside normal working hours, the results are provided to the ER and the patient is contacted by the on-duty ER physician concerning the results and follow-up care.

Information Technology Security – Improvements Are Needed to Fully Comply with VA and Local Policies

Conditions Needing Improvement. Our review identified the following areas in which IT security could be improved to achieve full compliance with VA and local policies.

Computer Security. It is VA and KCVAMC policy that access to IT systems be controlled by passwords to ensure that only authorized individuals gain access to IT systems and that users log off computers or systems when leaving their workstations. Each KCVAMC employee was

² Critical values are abnormal laboratory test results that are damaging to the patient’s health or life threatening (medically significant). Abnormal test results are not always medically significant.

assigned a password to log on the Local Area Network, access Veterans Health Information Systems and Technology Architecture (VISTA), Outlook, and sensitive data files. Computer users were not complying with VA and local policy, as some employees had not logged off computer workstations after use, thereby potentially allowing unauthorized access to sensitive data files.

Annual Computer Security Training. VA and local policies require that all VA employees receive initial security training at orientation with annual updates, which includes the VA Security Alert Internet training course and the VA Security Alert Video. We found 1,090 (95 percent) of the 1,151 KCVAMC employees received the VA Security Alert Internet training and 1,082 (94 percent) watched the videotape.

VISTA User Access. VA and local policies require terminating VISTA access for users whose employment has terminated. At our request, IT employees reviewed the list of authorized users and identified 1,165 users whose VISTA access was disabled but not terminated. At the time of our review in July 2001, an additional 210 users were hired by the KCVAMC and given VISTA access, but never worked at the facility. Most were residents, students, or other temporary staff and access was not terminated because IT staff was not notified that the users never started work. The Information Program Manager said that new computer software loaded in May 2001 disabled users that had not logged onto the system in 90 days and that he will review the list of the disabled users to determine if their access can be terminated.

Incident Reporting. The local policy on IT security and the security plan did not include security incident reporting procedures. Two security incidents occurred and the Information Security Officer (ISO) reported he informed the former facility Director of the incidents. The incidents were not recorded on a security incident form or log, were not tracked through final closure, and copies of the incident reports were not maintained as required by VA policy. VISN 15 has recently taken corrective action in this area with a new policy, dated April 9, 2001, that established a security incident reporting system for VISN facilities.

Full-time ISO and Separation of Duties. VHA policy requires full-time ISOs in larger and consolidated facilities. The ISO should report only to the facility Director to ensure separation of duties. The facility did not comply with this policy. The current KCVAMC ISO works 50 percent of the time as the ISO and 50 percent as an application coordinator for IT. This requires him to report to the facility Director for ISO issues, but to the Information Program Manager for his coordinator duties. The former facility Director took corrective action by advertising for a full-time ISO that will report to the Director.

Recommended Improvement Action 10. We recommended that the KCVAMC Acting Director take the following actions to improve IT security:

- (a) Remind all employees of the policy to log off computers when leaving their workstations.
- (b) Require VA Police during evening and night patrols to periodically check computers to determine if they are shut down and notify the ISO of computers not shut down.
- (c) Require program managers to comply with VA and local policies to provide security training to employees who have not received the training.

- (d) Require IT staff to periodically review the list of disabled users and terminate users that no longer need computer access.

The KCVAMC Acting Director concurred with the recommendations. Management plans to conduct a Fall Education Campaign to address these information security issues and to train any employees as needed. VA Police would check areas for violations during normal off-tour rounds. Also, the KCVAMC staff was writing software to automatically terminate users with more than 60 days of inactivity. The implementation actions are acceptable, and we consider the issues resolved.

Background Investigations – Request Background Investigations for All Clinicians as Needed

Condition Needing Improvement. KCVAMC management needed to request required Office of Personnel Management (OPM) background investigations for all newly hired licensed independent clinicians, such as physicians, dentists, and nurse practitioners. Having background investigations performed reduces the likelihood that VA will employ individuals with criminal histories or medical practice debarments. We reviewed the official personnel files for a random sample of 20 of the 51 clinicians hired in the last 3 years to evaluate controls for obtaining background investigations.

Sixteen of the 20 official personnel files contained OPM certifications of completed background investigations. There were pending certifications on two of the remaining four clinicians. However, two of the files did not document either facility requests for background investigations or OPM certificates of completed background investigations. The Chief, Human Resource Management Service agreed to request background investigations for these two employees.

Background investigations are important to avoid situations such as the following example. OIG investigators performing a basic criminal history inquiry through the National Crime Information Center found that a KCVAMC physician had a criminal conviction in 1983, which was not disclosed on the physician's employment application and was not detected by KCVAMC management before the clinician's appointment in 1992. In 1983, this physician pled guilty to 20 counts of filing false claims with Medicaid and received a sentence of 4 years probation and debarment from participating in the Medicaid program in any state. KCVAMC management terminated the physician's employment effective July 12, 2001.

Recommended Improvement Action 11. We recommended that the KCVAMC Acting Director ensure that:

- (a) Background investigations are requested and completed for all licensed independent clinicians hired in the future.
- (b) A review of the official personnel files of previously hired practitioners is conducted and background investigations are requested as needed.

The KCVAMC Acting Director agreed to request background investigations on all licensed independent clinicians hired in the future. They plan to monitor the requests with an electronic tracking system. Management also planned to review the official personnel files of all previously hired practitioners to assess the adequacy and completeness of their background investigations. The implementation actions are acceptable, and we consider the issues resolved.

Government Purchase Cards – Controls Over Purchases Should be Strengthened

Conditions Needing Improvement. Approving officials did not certify Government purchase card transactions timely, cardholders split orders to stay within their single purchase limits, and monthly audits were not performed. VA requires medical facilities to use Government purchase cards for small purchases of goods and services (usually \$2,500 or less). The Government purchase card program at the facility included 85 cardholders and 30 approving officials. From October 1, 2000 to April 30, 2001, cardholders processed 10,090 transactions totaling approximately \$5.0 million.

Certifying Transactions. Approving officials did not certify 1,549 of the 10,090 transactions (15 percent), which totaled about \$685,000, within the required 14-day review and certification period. VHA policy requires each cardholder to reconcile payment charges by matching the estimated amounts of the purchases with the amounts billed, reconciling differences, ensuring receipt of the goods ordered, and providing approving officials with applicable receipt records. The approving official must then certify the reconciled payment charges within 14 days of receipt from the cardholders. The certification process ensures purchases are within the cardholders' assigned limits, purchases have applicable supporting documentation, and purchases over \$2,500 are not split to stay within single purchase limits.

Splitting Orders. Cardholders placed multiple orders to the same vendor on the same day. Federal Acquisition Regulations (FAR) prohibit splitting purchases to avoid exceeding dollar thresholds. VHA policy requires approving officials to monitor usage to ensure that purchases are not split or fragmented to stay within cardholder single purchase limits. We identified 5 instances where 3 cardholders split purchases totaling about \$24,000 into 10 orders to apparently avoid exceeding single purchase limits.

Monthly Audits. In addition, we identified a deficiency in the program coordinator's responsibilities. VHA policy requires that the coordinator perform a monthly audit of the purchase card charges. According to the acting coordinator, the monthly audit had not been done for at least 5 months because the coordinator position was in transition from one coordinator to another. The new coordinator was aware of the requirement and planned to begin doing the audits immediately.

Recommended Improvement Action 12. We recommended that the KCVAMC Acting Director ensure that approving officials review and certify transactions in a timely manner, that cardholders comply with FAR and VHA policies, and the program coordinator conducts monthly audits as required.

The KCVAMC Acting Director concurred with the recommendation and agreed to issue a memorandum to all program directors, approving officials, and purchase cardholders reiterating that prompt reconciliation and certifications must occur, that assigned cardholder dollar limits must be adhered to, and that splitting orders to circumvent the dollar limits is absolutely prohibited. The purchase card coordinator would review the timeliness of processing. Management also planned to hire two staff accountants to complete the monthly purchase card audits. The implementation actions are acceptable, and we consider the issues resolved.

Angioplasty Contract – Using an Existing Contract or Initiating a New Contract Could Have Reduced Costs

Condition Needing Improvement. KCVAMC cardiologists sent patients requiring angioplasty treatments to KUMC when the VISN had an existing contract for cardiology services, including angioplasty treatments, with another medical center. Management continued to send these patients to KUMC after a prior angioplasty contract lapsed because the two medical centers have an affiliated angioplasty fellowship program and they had an understanding that KUMC would bill the KCVAMC at the prior contract amount of \$4,950 per procedure.

KCVAMC cardiologists sent 58 patients to KUMC for angioplasty treatments from December 1998 through December 2000, despite not having a contract with them. During this time, the KCVAMC had a contract for cardio/thoracic services, including angioplasty with another medical center. Fee basis employees paid KUMC about \$265,000 based on the amount that would have been billed under the prior contract for these 58 patients.

In December 2000, KUMC's independent auditors found that there was no valid angioplasty contract with the KCVAMC and recommended that KUMC bill the KCVAMC for the full cost of the angioplasty treatments provided to the 58 patients. This amount totaled nearly \$832,000. They also billed some of the VA patients for the difference. As a result, the KCVAMC paid KUMC an additional \$566,000 beyond the \$265,000 already paid under the terms of the prior contract. No patients had to pay for their treatment.

The existing contract with another medical center had a higher contract rate per treatment than the prior angioplasty contract, but the KCVAMC could have saved approximately \$168,000 by using the existing contract rather than relying on the verbal understanding that KUMC would bill at the prior contract amount.

VISN 15 recently awarded a new contract to KUMC for full cardiology services, including angioplasty, to be provided to KCVAMC patients. If this contract had been awarded at the time the prior contract lapsed in November 1998, the KCVAMC could have saved approximately \$283,000.

Recommended Improvement Action 13. We recommended that the KCVAMC Acting Director ensure that existing medical service contracts are used at all times, and that any contracts due to expire are renewed or replaced as needed.

The KCVAMC Acting Director concurred with the recommendation. A new angioplasty contract with KUMC was currently in place and management plans to appoint an employee with suitable contracting experience to manage the medical care contract process and coordinate the renewal of medical care contracts with the Leavenworth Contracting Office and the Executive Committee of the Medical Staff. The implementation action is acceptable, and we consider the issue resolved.

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the Kansas City VA Medical Center

Project Number: 2001-01515-R5-0119

<u>Recommendation</u>	<u>Explanation of Benefits</u>	<u>Better Use of Funds</u>
8a	Issuing pending MCCF billings	\$729,000
8c	Bill veteran's insurance for care	<u>698</u>
	Total	\$729,698

Kansas City VA Medical Center Acting Director Comments

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
4801 Linwood Boulevard



October 5, 2001

In Reply Refer To:
589/OO

William H. Withrow
Director, Kansas City
Audit Operations Division
1100 Main St. Room 1330
Kansas City, MO 64105

Dear Mr. Withrow:

1. This letter is in response to your draft report, summarizing the results of your CAP review of the Kansas City VA Medical Center. We are providing you with our comments, including our planned or in-process actions with regard to your 13 formal recommendations. These recommendations are provided in the areas of concern where you expressed the need for management attention.

2. We have safeguarded the contents of this report to preclude any improper disclosure(s) of the information. If you have any questions regarding any of our enclosed comments, please contact Melvin Davis at (816) 922-2555. Thank you for the opportunity to provide our comments prior to the issuance of your final report.

(Original signed by:)

MATTHEW J. KELLY
Acting Director

Enclosure

Kansas City VA Medical Center Acting Director Comments

Kansas City VA Medical Center's Response To Draft Report of CAP Review Conducted by

The Office of the Inspector General

We concur with the findings, recommendations, and estimated monetary benefits and provide the following implementation plans:

Supply, Processing, and Distribution Areas – Infection Control Risks Require Immediate Management Attention and Oversight.

Recommended Improvement Action 1. We recommend that the KCVAMC Acting Director take immediate action to correct infection control and safety concerns in SPD areas.

Work began September 15, 2001 to correct infection control and safety concerns in SPD. Work will continue until all issues are corrected, with a scheduled completion date of no later than October 30, 2001. We have taken a more permanent corrective action, by submitting a project to construct a new SPD. This project has received approval and is scheduled for design and construction in FY02. The new SPD should be activated in FY03.

- Paint was peeling and crumbling from the ceiling and walls. There were paint chips on clean and sterile instrument packs, on supply storage shelves, and on the floors throughout the area.
- *On September 12, 2001, the Acting Program Director for Facilities met with employees responsible for SPD areas, the Infection Control Nurse and the Safety Manager to identify items needing correction by the Facilities Program. The Facilities Program worked with SPD staff to schedule times when the Facilities Program could correct the identified deficiencies. Work began on September 15, 2001 within the clean area of SPD, such as patching and painting of walls and ceilings. Areas containing paint chips have been clean and/or sterilized as appropriate.*
- The ceiling leaked in several places despite evidence of prior repairs. For example, a leak in the ceiling of a sterile storage room was diverted into a large bucket using plastic sheathing fashioned into a funnel. Further, the bucket contained dirty water, even though it had not rained for several days.
- *Plastic hanging from the ceiling has been removed along with the water bucket. Ceiling leak has been corrected.*
- Most of the ceiling panels in the sterile package preparation area were damaged.

Kansas City VA Medical Center Acting Director Comments

- *All damaged ceiling tiles in this area have been replaced.*
- The ventilation system fan had rusted metal, peeling paint, dirty blades.
- *Ventilation system fan has been cleaned of all dirt, rust, and peeling paint.*
- Dust covered shelves, floors, and doors.
- *All SPD areas, including shelves, floors, and doors have been thoroughly cleaned.*
- Broken medical equipment was stored in various rooms in the SPD areas.
- *Medical equipment has been either sent for repair or disposed of given extent of damage. A specific area within SPD has been established for the temporary storage of medical equipment in need of repair.*
- Trash had accumulated on desktops, counters, and storage shelves.
- *Trash has been removed. On September 12, 2001, the Acting Program Director for Facilities met with employees responsible for SPD, the Infection Control Nurse, and the Safety Manager to provide refresher training on infection control, safety, and good housekeeping habits.*

Environment of Care – Medical Center Cleanliness Needs Immediate Management Attention and Oversight

Recommended Improvement Action 2. We recommend that the KCVAMC Acting Director take immediate action to correct all of the environmental and infection control deficiencies noted by our review:

- Dust covered all horizontal surfaces, such as bedside tray tables, bedside lockers, and bed rails in rooms prepared for new admissions on Units 8E, 3W, and the Medical Intensive Care Unit (MICU), and the Surgical Intensive Care Unit (SICU). Dust also covered the cardiac monitors in MICU and SICU. Dust also covered the cardiac monitors in MICU and SICU.
- *Facilities has specific procedures for cleaning rooms and other areas. Acting Director of Facilities has moved most of the EMS staff to day shift for improved cleanliness and better communication with their customers (employees can communicate directly with EMS staff to make cleaning and stocking requests).*
- *KCVAMC has received approval to fill existing and future housekeeping vacancies without having to get VISN approval each time. We made selections to fill all existing vacancies within days of receiving this approval.*

Kansas City VA Medical Center Acting Director Comments

- *We are utilizing overtime each pay period to cover those vacancies.*
- *We are replacing carpeting in the front lobby and several waiting areas.*
- *We have contracted with the CWT Program to perform some of the moving functions. Historically, these functions have been performed by housekeeping staff, taking them away from their cleaning responsibilities.*
- *We have established a temporary work leader position within EMS to assist with supervision and problem solving relating to housekeeping.*
- *We have established a position on the evening shift that is dedicated to terminal bed cleaning (this is when the vast majority of beds are reported as needing cleaning).*
- *We are now utilizing housekeepers that are on light duty in carefully selected housekeeping functions such as horizontal dusting as their medical conditions allow.*
- *The Housekeeping supervisors have talked to the housekeeping staff about the importance of horizontal dusting.*

In addition, the following actions are being planned:

- *To obtain adequate housekeeping staff (based upon established benchmarks within and outside the VA).*
- *To increase employee and supervisor accountability by implementing a detailed procedure for housekeeping operations and for obtaining objective performance data. The objective performance data will then serve as the basis for a performance-based reward system and corrective action system.*
- *Unsecured cleaning chemicals were stored in unlocked storage rooms or on unattended housekeeping carts.*
- *The Housekeeping staff has received refresher training on the importance of not leaving cleaning chemicals or their carts unattended in unsecured areas. In addition, they have been instructed to reclaim any cleaning chemicals that have been shared with non-housekeeping staff.*
- *An unlocked storage room on Unit 4E contained needles, syringes, and blood drawing supplies.*
- *All storage rooms containing sensitive items as referenced have been secured.*

Kansas City VA Medical Center Acting Director Comments

- An oxygen tank was left unsecured on top of a meal cart in the hallway on Unit 3W.
- *All oxygen tanks have been properly secured. The securing of oxygen cylinders is checked and reviewed during newly established Leadership Environmental Rounds conducted weekly.*
- Intravenous stands, treatment carts, and other equipment items were stored in the hallway on Unit 3W.
- *All items being stored in hallway area on Unit 3W have been relocated to appropriate storage areas.*
- There were cracked and dirty seats on portable shower/commode chairs.
- *Portable shower/commode chairs on the units have been cleaned and/or replaced as appropriate.*
- There were dirty countertops in patient nourishment kitchens and medication rooms.
- *While housekeeping staff does not have access to medication rooms, they are responsible for cleaning the exterior surfaces within patient nourishment kitchens. We have assigned a housekeeper that is on light duty to police these kitchens for more consistent cleaning. We are in the process of scheduling a time where EMS staff can, under observation, be allowed to clean the Medication rooms.*
- Clean and dirty items were stored in close proximity in storage rooms in the MICU and SICU.
- *Equipment that is no longer in use for patients will be placed in the Soiled Utility room for pick-up and cleaning by SPD.*
- Construction sites were not properly sealed to restrict unauthorized traffic in the areas, creating a potential hazard for patients who wander.
- *All construction sites were reviewed and proper locking devices installed to restrict unauthorized traffic as necessary. In addition, a new medical center policy was implemented that requires the safety manager review and approve all construction barriers to reduce potential hazards to patients and staff.*
- Rodent traps were found in several patient rooms. Rodent droppings were observed in one device in a patient room creating a potential infection control hazard.
- *Rodent traps will be removed from all patient rooms by October 8, 2001. These traps will only be placed in administrative office areas. They will not be placed in food preparation areas. Also by October 8, 2001, we will assign a*

Kansas City VA Medical Center Acting Director Comments

housekeeper, who is on light duty, to check rodent traps in these administrative areas on a regular basis to reduce any infection control hazards.

- An electronic insect killing device that did not appear to be in working order found in the MICU. Employees told us that there was an ongoing pest problem.

- *The referenced electronic insect killing device was replaced just a few days after the visit by the OIG. Due to the amount of construction activity occurring within the vicinity of the MICU, we have had to deal with an increased number of pests, primarily flying insects. Consequently, we have implemented a program involving the placement of electronic insect killing devices near patient care areas affected by construction activities and within construction areas. These devices have now been added to our computerized preventative maintenance program to be checked for proper operation.*

Medical Record Privacy – Patient Information and Computer Workstations Need to be Consistently Secured

Recommended Improvement Action 3. We recommend that the KCVAMC Acting Director ensure that computer workstations and patient information are secured throughout the medical center.

- *We are in the process of developing a Fall Publicity Campaign dealing with patient confidentiality. In addition, the VA Police will randomly check areas for improper computer usage and our weekly environmental rounds will include a review of patient information privacy.*

Primary Care for Mental Health Patients - Improve Written Policy for the Provision of Primary Care and Examine Waiting Times for Service

Recommended Improvement Action 4. We recommend that the KCVAMC Acting Director ensure that:

- Facility policy should be updated with specific guidelines on referring MH patients for Primary Care services for their medical conditions.

- *Mental Health will follow facility policy for referring mental health patients for Primary Care services for their medical conditions. Mental Health will assist patients with pressing medical needs, as necessary, to the Primary Care Same Day Clinic or to the emergency room if applicable. Mental Health has revised the Mental Health Scope of Care to include referral of mental health patients to primary care by adding the wording “Refer to Hospital Plan of Care”.*

- MH patients can schedule appointments with their PCPs to meet their pressing medical needs within 7 days.

Kansas City VA Medical Center Acting Director Comments

- *Mental Health will continue efforts to assist patients, as necessary, with the scheduling of appointments with mental health patients' PCP within 7 days for non-emergent care and within 30 days for routine appointments. Mental Health has revised the Mental Health Scope of Care to include referral of mental health patients to primary care by adding the wording "Refer to Hospital Plan of Care".*

Part-Time Physician Timekeeping – Strengthen Controls on Time and Attendance

Recommended Improvement Action 5. We recommend that the KCVAMC Acting Director:

- Ensure timekeeping and approving officials accurately record in timekeeping records all part-time physician on-duty time and leave.
- *We have communicated the names of medical center physician timekeepers and approving officials to all part-time physicians. We have also conducted a review of all current scheduled tours and core times for all part-time physicians. These actions were taken in an effort to assure that timekeeping functions are accurately recorded. A spot review/assessment of part-time physician timekeeping will be conducted in 3-month intervals over the next 6 months to assure that all timekeeping issues related to part-time physicians have been appropriately addressed and resolved.*
- Ensure that the Employee Accounts Section conducts semi-annual audits of timekeepers.
- *The employee Accounts Section will be asked to perform semi annual timekeeping audits and to provide a copy of the results to the Chief of Staff so that we can verify that timekeeping for part-time physicians are being accomplish accurately and in a timely manner.*
- Ensure that all timekeeping and approving officials receive training on the importance of recording and certifying timecards that reflect actual hours worked.
- *The Chief Operating Officer, for Medical Care will request that refresher training be provided to current timekeepers and approving officials. This training will be targeted for completion during the first quarter of FY-2002.*
- Ensure that all part-time physicians and their supervisors receive training on VA time and attendance policies.
- *A memorandum has been issued to all part-time physicians and supervisors, identifying the timekeeping and leave process. Included in this memorandum was a sample "Subsidiary Time and Attendance Report" which included each part-time*

Kansas City VA Medical Center Acting Director Comments

physician's scheduled Tour" and "Core Time". We are also assuring that more emphasis is placed on physician time keeping during the new employee orientation process.

Narcotics Inspection Program – Improved Procedures Could Increase Accountability

Recommended Improvement Action 6. We recommend that the KCVAMC Acting Director ensure that the narcotics inspection program complies with VHA policy by:

- Updating local policy and procedures on inspecting controlled substances awaiting destruction and verifying a sample of dispensing entries to doctors' orders and patients' records.
- *The local policy memorandum concerning inspection of controlled substances has been rewritten to include a policy on inspection of controlled substances awaiting destruction and the verification of a sample of dispensing entries in the medical record. The rewritten policy will be forwarded through the appropriate medical center channels for concurrence and approval by the ECMS.*
- Replacing two inspectors with employees who do not handle drugs as part of their duties.
- *Two inspectors have been named to replace the nurses who were previous members of the inspection team. The nurses have not been a part of any inspections since we became aware of this item.*
- Documenting inspector training.
- *Forms for the documentation of inspector training have been prepared, and two inspectors have been trained. Training materials are being rewritten.*
- Ensuring that narcotics inspectors inspect all areas on the same day, verifying a sample of dispensing entries, and selecting random inspection dates.
- *The importance of all areas being inspected on the same day and verification of sample dispensing entries will be stressed at future meetings and in the training of new inspectors. The inspection schedule is being rewritten so that the dates are not as predictable as the previous schedule.*
- Resolving all discrepancies between perpetual inventory records and inspection counts, including documenting the steps taken to resolve the discrepancies.

Kansas City VA Medical Center Acting Director Comments

- *The Chair Controlled Substances Inspection Team will provide detailed results and information regarding the resolution of discrepancies in the monthly inspection report.*
- Reporting any controlled substances losses and missing perpetual inventory records to the appropriate authorities and officials.
- *Discrepancies regarding the loss of controlled substances and missing perpetual inventory records are currently being reported to the appropriate officials for further investigation and action.*
- Trending all inspection results to identify potential problem areas.
- *The results of inspections will be trended by the P&T Committee, in order to identify potential problem areas. This will be noted in the revised medical center policy memorandum.*

Pharmacy Security – Improved Security Could Enhance Accountability

Recommended Improvement Actions 7. We recommend that the KCVAMC Acting Director enhance security over controlled substances and pharmaceuticals by:

- Restricting access to pharmacy areas by canceling electron access codes issued to four non-pharmacy employees.
- *The individuals identified have a close working relationship with pharmacy. They do not however perform tasks associated with the filling or dispensing of medications. The pharmacy access for these individuals has been removed.*
- Securing keys to locked areas containing controlled substances.
- *Plans are to put a PYXIS unit in the pass/discharge area within the next 2 months that would eliminate the concerns described in your report with the storage of the keys to these areas. Senior management has approved this improvement.*
- Designating a second Federal Express delivery point in the Pharmacy areas for controlled substances packages.
- *This concern is regarding the system used by our alternate warehouse in Joplin, MO that sends all controlled substances via Federal Express. Pharmacy procurement discussed this issue with management at the Joplin, MO warehouse. Joplin has agreed to follow the same delivery procedures utilized by our primary warehouse where controlled substances are delivered along with the rest of the order directly to pharmacy where pharmacy personnel sign for it.*

Kansas City VA Medical Center Acting Director Comments

- Performing inventories of bulk controlled substances at a minimum of every 72 hours.
- *The VA regulation states an inventory must be done every 72 hours for all bulk stock of controlled substance that would apply to our inpatient vault only. Pharmacy leadership has taken this one step further by requiring inspections every 72 hours in all controlled substance areas. The recently trained narcotic technician has been reeducated on these mandatory checks and this education has been documented. In addition, pharmacy leadership has developed a log for each of the three inventory areas to document of performance of the inventories. This allows us to assure the checks are accomplished and assists us with identifying trends/individuals associated with discrepancies.*
- Securing pharmaceutical items stored in patient units.
- *Action has been taken to review and secure all pharmaceutical items stored in designated storage areas throughout the Medical Center.*

Medical Care Collection Fund – Improved procedures could Increase Cost Recoveries.

Recommended Improvement Action 8. We recommend that the KCVAMC Acting Director take steps to:

- Bill episodes of care in a timely manner to reduce billing lag times and expedite billing on the backlogged claims.
- *We have already taken steps to remedy the situation. We are continuing with the implementation of our strategic plan of last year and have accomplished the following: A total of seven credentialed coders have been hired in the past 12 months. Just six months ago, our backlog was one year. As of today, we are now only eight months behind.*
- Make follow-up telephone calls on all unpaid bills.
- *We currently have two vacancies in the accounts receivable section. We will be interviewing for replacements in the near future and have every intention of resuming regular phone calls.*
- Provide refresher training for all MCCF employees to stress the importance of health insurance coverage identification and require that MCCF employees photocopy veterans' health insurance cards for inclusion in the medical records.
- *Refresher training will be conducted this fall for all Intake personnel.*

Kansas City VA Medical Center Acting Director Comments

Communicating Test and Procedure Results – Providers and Patients Should Be Notified of Abnormal Results.

Recommended Improvement Action 9. We recommend that the KCVAMC Acting Director ensure that:

- Appropriate providers are notified of abnormal test and procedure results.
- *Providers are notified of abnormal radiology results. Radiology actually has established two QA monitors that specifically address "abnormal" findings. These monitors provide the individual who requested the procedure to be notified of an abnormal result via an electronic "alert" message. In those cases that appropriate follow-up has not been indicated, a follow-up communication is sent and if necessary PPCI notified.*
- *As related to the Pathology & Laboratory Medicine findings: Appropriate providers are notified of abnormal test and procedure results. The ordering provider is considered to be the appropriate provider to be notified of abnormal test and procedure results; the primary care provider (if different from the ordering provider) is notified of the test results if the ordering provider is not available for communication. The notifications are documented through the use of an electronic flag called "critical value". The Technician enters electronic comments, which document the results, date, time, and name of the provider who was notified.*
- Patients are notified of abnormal test and procedure results, and are provided with instructions for follow-up care.
- *The requesting or ordering physician is notified of abnormal results. Notification of abnormal results to the patient is the responsibility of the clinical provider. With regard to instructions for follow-up care the provider or designee, contact s the patient to communicate this information. If there is an abnormal test or procedure result, the same process is utilized. However, if the abnormal results occur on a weekend or outside the normal working hours, they are provided to the emergency room and the patient is contact by the on duty ER physician.*

Information Technology Security – Improvements are needed to Fully Comply with VA and Local Policies

Recommended Improvement Action 10. We recommend that the KCVAMC Acting Director take the following actions to improve IT security:

- Remind all employees of the policy to log-off computers when leaving their workstations.
- *As mentioned in the previous recommendation, a Fall Education Campaign is being developed.*

Kansas City VA Medical Center Acting Director Comments

- Require VA Police during evening and night patrols to periodically check computers to determine if they are shut down and notify the ISO of computers not shut down.
- *VA Police will randomly check areas for violations during normal off-tour rounds and report their findings to the ISO.*
- Require Program Managers to comply with VA and local policies to provide security training to employees who have not received the training.
- *The remaining 5% of employees will be reminded to complete their training.*
- Require IT staff to periodically review the list of disabled users and terminate users that no longer need computer access.
- *We are writing software that will automatically terminate users with more than 60 days of inactivity.*

Background Investigations – Request Background Investigations for All Clinicians as Needed

Recommended Improvement Action 11. We recommend that the KCVAMC Acting Director ensure that:

- Background investigations are requested and completed for all licensed independent clinicians hired in the future.
- *As recommended in the Office of the Inspector General CAP review, background investigations will be requested and completed on all licensed independent clinicians hired in the future. To ensure future compliance an electronic tracking system will be developed to replace the manual tracking system currently in use.*
- A review of the official personnel files of previously hired practitioners is conducted and background investigations are requested as needed.
- *A thorough review will be conducted within the next 30 days of all previously hired practitioners to assess the adequacy and completeness of their background investigations. Immediate remedial action will then be initiated on any situations where documentation is determined to be missing or inadequate.*

Kansas City VA Medical Center Acting Director Comments

Government Purchase Cards – Controls Over Purchases Could be strengthened

Recommended Improvement Action 12. We recommend that the KCVAMC Acting Director ensure that approving officials review and certify transactions in a timely manner, that cardholders comply with FAR and VHA policies, and the program coordinator conducts monthly audits as required.

- *VAMC Kansas City recognizes the importance of ensuring that approving officials take action on those transactions, which have been reconciled and are complete within a timely manner. To reinforce this requirement a memorandum will be sent from the Acting Director to all Program Directors, Approving Officials, and Purchase cardholders reiterating that prompt reconciliation and certifications must occur. In addition, the Purchase Card Coordinator will continue to review the timeliness of processing, and will make specific reports to the Program Directors and the Acting Director if patterns of delinquent approvals are identified. This memorandum will also restate the requirements that assigned cardholder dollar limits must be adhered to and that splitting orders to circumvent the dollar limits is absolutely prohibited. Action has recently been taken to hire two staff accountants within Financial Management. Among the duties that will be assigned to these individuals is completion of the monthly Purchase Card audits. Management will monitor the timeliness and adequacy of these audits to ensure the ongoing integrity of the Purchase Card program at this medical center.*

Angioplasty Contract – Using an Existing Contract or Initiating a New Contract Could Have Reduced Costs

Recommended Improvement Action 13. We recommend that the KCVAMC acting Director ensure that existing medical service contracts are used at all times, and that any contracts due to expire are renewed or replaced as needed.

- *A new angioplasty contract is currently in place. The contract was awarded to KUMC. The Chief Operating Officer for Medical Care has assigned a specific employee, who has an extensive contracting background, to manage the medical care contract process. This will include providing information to the appropriate providers as to which services are covered by current contracts. This employee will also coordinate the renewal of medical care contracts with the Leavenworth Contracting Office and the Executive Committee of the Medical Staff.*

Report Distribution

VA Distribution

Secretary
Deputy Secretary (001)
Chief of Staff (00A)
Under Secretary for Health (105E)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Acting Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Finance (047)
Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Public Affairs (80)
Assistant Deputy Under Secretary for Health (10N)
Office of the Chief Information Office (VHA) (19)
Veterans Integrated Service Network Director (10N15)
Director, Kansas City VA Medical Center (589/00)

Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office
The Honorable Christopher Bond, United States Senate
The Honorable Jean Carnahan, United States Senate
The Honorable Karen McCarthy, House of Representatives
Chairman, Senate Committee on Governmental Affairs
Ranking Member, Senate Committee on Governmental Affairs
Chairman, Senate Committee on Veterans' Affairs
Ranking Member, Senate 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, House Committee on Veterans' Affairs
Ranking Democratic Member, House Committee on Veterans' Affairs
Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
Ranking Democratic Member, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
Chairman, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations

Appendix C

Ranking Democratic Member, Subcommittee on VA, HUD, and Independent Agencies,
House Committee on Appropriations
Chairman, House Committee on Government Reform and Oversight
Ranking Democratic Member, House Committee on Government Reform and Oversight
Chairman, Subcommittee on Benefits, House Committee on Veterans' Affairs
Ranking Democratic Member, Subcommittee on Benefits, House Committee on Veterans'
Affairs
Chairman, Subcommittee on Health, House Committee on Veterans' Affairs
Ranking Democratic Member, Subcommittee on Health, House Committee on Veterans' Affairs
Staff Director, Oversight and Investigations Subcommittee, House Committee on Veterans'
Affairs
Staff Director, Committee on Veterans' Affairs, House of Representatives

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