Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Chillicothe, Ohio

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and 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.

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Introduction

During the week of February 23-27, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center Chillicothe, Ohio (the medical center) which is part of Veterans Integrated Service Network (VISN) 10. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 137 employees.

Results of Review

This CAP review focused on 12 areas. As indicated below, there were no concerns identified in four of the areas. The medical center complied with selected standards in the following areas:

- Government Purchase Card Program
- Means Tests
- Pharmacy Security
- Quality Management

Based on our review of these four areas, the following organizational strength was identified:

- Means tests procedures were effective.

We identified eight areas which needed additional management attention. To improve operations, the following recommendations were made:

- Correct environment of care deficiencies.
- Improve information technology (IT) security.
- Enhance billing procedures and improve physician documentation of care provided.
- Reduce excess supply inventories and strengthen inventory management controls.
- Strengthen monthly controlled substances inspections.
- Aggregate and analyze moderate sedation outcome data.

Suggestions for improvement were made in the following areas:

- Fully document price reasonableness determinations and ensure services are validated in accordance with contract terms prior to payment.
- Ensure computer equipment inventories are completed timely, inventory lists are updated when needed, and the local policy on loaning laptop computers is revised.

This report was prepared under the direction of Mr. William H. Withrow, Director, Kansas City Audit Operations Division, and Mr. Joseph T. Janasz, Jr., CAP Review Coordinator, Kansas City Audit Operations Division.

VISN 10 and Medical Center Directors' Comments

The VISN 10 Director and Medical Center Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendices A and B, pages 14-22 for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

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

Introduction

Facility Profile

Organization. Located in Chillicothe, Ohio, the medical center provides acute and chronic mental health services, primary and secondary medical services, and a wide range of nursing home care services. Outpatient care is also provided at four community-based outpatient clinics (CBOCs) located in Athens, Lancaster, Marietta, and Portsmouth, Ohio. The medical center is part of VISN 10 and serves a veteran population of about 71,000 in a primary service area that includes 15 counties in southeastern and south central Ohio.

Programs. The medical center provides medical, surgical, and mental health services and maintains 35 acute medical care; 25 acute psychiatric; 25 psychosocial residential rehabilitation treatment; 50 domiciliary; and 162 nursing home beds. The medical center also has 17 sharing agreements with 12 provider organizations to provide various services such as ophthalmology, diagnostic radiology, and mammography.

Affiliations and Research. The medical center has affiliation agreements with Ohio State University, the University of Cincinnati, and the University College of Osteopathic Medicine in Athens for the purposes of education, training, and research with major emphasis on psychiatric services. There are 38 other program affiliations with 19 institutions, representing various health care programs.

Resources. The medical center's Fiscal Year (FY) 2003 medical care budget was $94.1 million, a .3 percent increase over the FY 2002 budget of $93.8 million. FY 2003 staffing was 1076.2 full-time equivalent employees (FTEE), including 41.5 physician and 332.7 nursing FTEE. FY 2002 staffing was 1090.9 FTEE, including 40.2 physician and 351.9 nursing FTEE.

Workload. In FY 2003, the medical center treated 17,392 unique patients, a 5.5 percent increase over FY 2002. The patient care workload for FY 2003 totaled 4,335 inpatients treated and 199,378 outpatient visits, which represented a 8.1 percent decrease and a 4.5 percent increase, respectively, from FY 2002 workload.

Objectives and Scope of the 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 increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity 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. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FYs 2003 and 2004 through January 2004, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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:

Contract Award and Administration	Means Tests
Controlled Substances Accountability	Medical Care Collections Fund
Environment of Care	Moderate Sedation Practices
Equipment Accountability	Pharmacy Security
Government Purchase Card Program	Quality Management
Information Technology Security	Supply Inventory Management

As part of the review, we used questionnaires and interviews to survey patient satisfaction with the timeliness of service and the quality of care. We also interviewed 15 inpatients and 15 outpatients during the review. The full survey results were provided to medical center management.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 137 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

An activity that was particularly effective or otherwise noteworthy is recognized in the Organizational Strength section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-13). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Organizational Strength or Opportunities for Improvement sections, there were no reportable deficiencies.

Results of Review

Organizational Strength

Means Tests Procedures Were Effective. Means tests are administered to obtain income information from certain veterans in order to determine whether they are subject to medical co-payments. Veterans Health Administration (VHA) facilities are required to retain signed means test forms in patients' administrative records. We reviewed means test forms for 30 veterans and found that all were completed and signed appropriately.

Opportunities for Improvement

Environment of Care – Areas Needed Management Attention

Condition Needing Improvement. We inspected inpatient units, outpatient primary care and specialty clinic areas, dining areas, and the gymnasium of the medical center and found the environment of care to be generally acceptable. However, we identified several areas requiring corrective action. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors. The following areas required management attention.

Housekeeping and Maintenance. We found unlocked dirty utility rooms, dirty employee refrigerators and microwave ovens, food in a procedure room in the Surgery/Urology Clinic, Asian beetles throughout the medical center, hallways damaged by motorized carts used to transport items, areas in need of painting and ceiling tile replacement, and an unsafe loading zone near the Building 24 smoking hut.

Outdated Supplies. Supply Processing and Distribution (SPD) staff cleans, processes, stores, and distributes sterile and non-sterile supplies, instruments, and medical equipment for clinical use. SPD staff are responsible for ensuring that all necessary supplies and equipment are sterilized and readily available for operative procedures. We inspected seven sterile supply items and found that all items were outdated. VHA policy requires outdated sterile supply items be reprocessed to ensure sterility and reduce the risk of hospital acquired infection.

Patient Confidentiality. Federal law requires the safeguarding of confidential patient information. Confidential patient information was found in a hallway adjacent to a Specialty Care Unit and in a clinic hallway in Building 210.

Handicap Access. Federal law prohibits discrimination against individuals with disabilities in such areas as public accommodations, recreation, health services, and access to public services. Based on a patient interview and an inspection of the gymnasium in Building 247, we found that the female locker room and showers were inaccessible to wheelchair-dependent female veterans.

While we were onsite, managers took immediate steps to correct deficiencies and the Medical Center Associate Director submitted a plan of action to address the unresolved issues.

Recommended Improvement Action(s) 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: a) the Medical Center Associate Director's action plan for housekeeping and maintenance issues is implemented, b) SPD supplies are reprocessed when outdated, c) confidential patient information is secured, and d) access to the female locker room and showers in the gymnasium in Building 247 is provided for wheelchair-dependent female veterans.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that corrective actions are being taken for housekeeping and maintenance issues, SPD instituted an Outdate Checklist for daily checks of sterile supplies, patient information was secured and discussed with staff while we were onsite, and the barrier identified by the review team has been removed and a project to make the entire building handicap accessible has been submitted for FY 2005. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Improvements Needed To Comply With VA and Local Policies

Condition Needing Improvement. Medical center managers needed to strengthen IT security. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, and misuse. We found that annual security awareness training was provided, password controls were adequate, and critical data were backed up on a regular basis. However, we identified three areas that required management attention.

Security Plans. The Veterans Health Integrated Systems and Technology Architecture (Vista) and telecommunications security plans were adequate. However, the Local Area Network (LAN) Security Plan needed improvement. This plan discussed certain potential physical security risks associated with the computer room, which are normally found in risk assessments. It did not follow Government standards for a security plan. For example, the plan did not include items such as system identification, rules of behavior, assignment of security responsibility, system environment, sensitivity of information handled, or management controls.

Contingency Plans. The medical center's contingency plans for Vista, LAN, and telecommunications needed improvement. These plans did not properly address the annual

testing requirements, contact information for key personnel, or storage of backup tapes. Government IT standards require contingency plans to be tested at least annually. The annual test requirement was included in the VISTA and telecommunications contingency plans, but was omitted from the LAN Contingency Plan.

Contact information for key personnel in the case of an emergency was incomplete. Personnel were listed without phone numbers or with only their extension numbers. In some cases, alternate contact numbers were not provided. Also, the "Notification Cascade," which listed contact information for key personnel and identified staff responsible for notifying personnel, had not been updated since August 2001.

The Vista Contingency Plan required that the backup tapes be stored in the basement of the same building where the computer room is located. VHA policy requires that data be backed up and stored in a location physically separate from the computer room so as to not be affected by the same contingency or threat. While the VHA policy does not provide a specific distance requirement for the backup storage location, the medical center Information Security Officer (ISO) agreed that storage in the basement of the computer room building did not satisfy VHA policy. After our review, managers in the Chief Information Officer (CIO) Office updated the contingency plans to require annual testing of the plans and to include full contact information for key personnel. Also, they initiated plans to move the backup tapes to a location away from the computer room building.

Physical Security. Physical security and access controls needed improvements in the following areas.

- VHA policy states that there will be no signs informing the public that an information system is located in a particular building or area. We found that communication closets and computer storage rooms had signage identifying their contents.

- During our tour of the outpatient clinics with the medical center ISO, we found five unattended computers that were on and not locked. On one computer, patient information was on the screen. The ISO immediately locked the computers and left notifications of the security violations.

- The computer room did not have smoke detectors as recommended by VA policy. Smoke detectors can serve as an early warning detection prior to activation of the sprinkler system, which could cause water damage to the equipment. Medical center management had smoke detectors installed while we were onsite.

- New computers were initially stored in Building 35 until they were configured and deployed to a using service. The room in which the computers were stored was kept locked. However, the building was located on one end of campus and the storage room was on the ground level with windows that had no protective barriers. Also, the room did not have an alarm system. On a regular basis, new computers valued from $100,000 to $200,000 were stored in this room.

- CIO Office management identified potential physical security risks in the computer room. In the LAN Security Plan, CIO Office management noted that the air conditioning unit was leaking and did not work properly causing the computer room to be shut down four times in 2003 due to the excessive temperatures. Also, the uninterruptible power supply (UPS) system is easily overloaded. Medical center management stated that these deficiencies will be remedied as part of a project to relocate the computer room from the second floor to the first floor of Building 18. The expected completion date for this project is June 2005. In the interim, Engineering Service staff has installed new compressors to the air conditioning unit and is currently reviewing options to repair the UPS system.

Recommended Improvement Action(s) 2. We recommended that the VISN Director ensure that the Medical Center Director takes the following actions to improve IT security: a) revise the LAN Security Plan and medical center contingency plans in accordance with Government IT standards, b) store backup tapes in a location away from the computer room building, c) remove signage identifying the locations of sensitive information and automated systems, d) remind employees of the need to secure patient information by ensuring computers are properly locked or logged off when left unattended, e) upgrade the physical security of the new computer storage room, and f) ensure plans to remedy potential risks associated with the air conditioning unit and the UPS system for the computer room are carried out timely.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the LAN Security Plan has been revised. Backup tapes have been moved to a separate building, signs identifying the location of sensitive information and automated systems have been removed. Further, instructions were sent to all employees for securing computers when left unattended. Interim measures are being taken to upgrade the physical security of the existing new computer storage room and the medical center Space Committee is developing plans for a new location for new computer storage. The new location will include all required security features and a construction project has been submitted to address concerns with the air conditioning and the UPS system. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Third Party Billings Needed Improvement

Condition Needing Improvement. The medical center increased Medical Care Collections Fund (MCCF) collections from $4.5 million in FY 2002 to $5.3 million in FY 2003 and met its MCCF collection goal both years. Our review of a judgment sample of outpatient visits and inpatient discharges for November 2003 found that MCCF staff issued bills appropriately. However, medical center management could further improve MCCF program results by strengthening billing procedures for fee-basis care, establishing procedures to ensure bills for outpatient and inpatient care provided prior to July 2003 are processed before insurance filing deadlines expire, billing for optometry services, and ensuring physicians adequately document care provided in the medical records. We found additional billing opportunities totaling at least $27,000 with estimated collections of $13,095 ($27,000 x 48.5 percent medical center historical collection rate).

Fee-Basis Care. From October 1, 2003, to December 31, 2003, the medical center paid 84 fee-basis claims totaling $76,363 to non-VA providers who provided medical care to veterans who had health insurance. Payments included claims for outpatient care, inpatient care, and ancillary services related to inpatient care. To determine whether the fee-basis medical care was billed to patients' insurance carriers, we reviewed a judgment sample of 32 claims totaling $57,295. Of these 32 claims, 23 were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions or the care was not billable under the terms of the insurance plans. The remaining nine fee-basis claims were for care that was billable to the insurance carriers. MCCF staff had appropriately issued bills totaling $5,246 for five claims. However, we found additional billing opportunities totaling $13,297 for the other four claims. MCCF staff took immediate action as a result of our review and issued bills for these four claims.

Unbilled Care Report. The *Unbilled Care Report* dated February 18, 2004, covering the time period of October 1, 2002, through December 31, 2003, listed 242 outpatient visits prior to July 1, 2003, with potential billable care totaling $42,214 that had not been billed. We reviewed 10 of these visits and found that 7 involved medical care totaling $2,876 that should have been billed. The medical care for six of these visits was still billable; however, medical care totaling $328 for the other visit was no longer billable because the deadline to file a claim with the insurance carrier had expired.

MCCF managers explained that these bills had not been issued when the care was provided because, at that time, the billing software had not identified these cases as billable. For example, in some cases the veterans' insurance status may not have been determined until after the care was provided. In other cases, updates to the reasonable charges in the billing software package can create new billing opportunities for care previously provided. MCCF staff prints the *Unbilled Care Report* each month to identify potential bills for care previously provided. However, current care was their first priority and in most months the older care cases listed on the *Unbilled Care Report* were not reviewed. With the filing deadlines imposed by insurance carriers, the older bills needed to be processed before deadlines expire.

Reasons Not Billable Report. The *Reasons Not Billable Report* dated February 2, 2004, covering the time period of July 1, 2003, through December 31, 2003, listed 166 potential billable cases totaling $35,904 that were unbilled for 1 of 3 reasons – insufficient documentation, no documentation, or non-billable provider (resident). We reviewed 24 potential billable cases totaling $18,222 and found that 12 were not billable because the care was for service-connected conditions or was not billable under the terms of the insurance plans. However, the other 12 potential billable cases were billable as discussed below.

In nine cases totaling $7,870, billings for optometry services were missed. MCCF staff had not issued bills for these cases because they considered care provided by optometry residents as non-billable. However, VHA's Revenue Office provided guidance stating that optometry residents are considered to be licensed practitioners. As long as they are licensed in the State in which the services are performed and they are authorized to perform such services in that State, their services are billable as physician services. MCCF staff agreed and began issuing bills for these

services. MCCF staff is also reviewing all cases identified as non-billable provider (resident) to identify any other bills that needed to be issued.

In three cases, MCCF staff could have billed $2,957 for the care provided but medical care providers did not provide adequate documentation in the medical records. This occurred because providers did not complete progress notes in two cases or sign a cardiology report in the other case.

Recommended Improvement Action(s) 3. We recommended that the VISN Director ensure that the Medical Center Director requires that MCCF staff: a) strengthen the billing process to ensure all billable fee-basis claims are identified, b) establish procedures to ensure bills are processed before insurance carrier filing deadlines expire, c) bill for optometry services provided by licensed optometry residents, d) ensure physicians adequately document care provided in the medical records, and e) prepare bills for the cases identified in our review.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that processes are now in place to ensure appropriate billing of all fee-basis claims, claims listed on the *Unbilled Care Report*, and claims for optometry services. An employee has been designated as a liaison with clinic staff to address documentation issues that impact the coding and billing of care provided. Also, all cases identified in our review have been billed. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Excess Inventory Needed To Be Reduced and Controls Strengthened

Condition Needing Improvement. The medical center needed to reduce excess inventories and make better use of automated controls to more effectively manage supply inventory. VHA established a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Inventory managers used GIP to manage and control supply inventory, but did not use GIP features to meet the 30-day supply goal. As of December 31, 2003, the 6 primary inventory control points included 4,321 line items with a reported value of $256,617.

To test the accuracy of the value of stock on hand and reasonableness of inventory levels, we reviewed 30 items (15 items in the Warehouse/Engineering, 10 items in the SPD, and 5 items in the Laboratory Service) and found 2 deficiencies. First, the GIP value of stock was overstated. We conducted a physical inventory of the 30 items and found that for 5 items (2 items in the Warehouse/Engineering and 3 items in the SPD inventories) the counts did not agree with the balances shown in GIP. For the 30 items reviewed, the GIP reported value was $51,938.

However, the actual value of this stock was $35,780, which was only 69 percent of the GIP reported value. Applying the 69 percent figure to the $256,617 value for the entire supply stock shown in GIP would yield an estimated value of $177,066.

Additionally, for 15 of the 30 items reviewed, stock on hand exceeded a 30-day supply or was no longer needed. For 13 items, the estimated value of stock exceeding 30 days was $16,578. For two items totaling $1,643, medical center staff determined that the items were no longer needed. The estimated value of stock exceeding 30 days or no longer needed was $18,221 ($16,578 + $1,643), or 51 percent of the total value of the 30 items reviewed ($35,780).

The inaccuracies in GIP and excess stock on hand occurred because medical center staff did not always record usage and in some instances recorded receipts incorrectly. Also, the Chief, Materiel Management Section and the SPD Item Manager stated that the required annual wall-to-wall physical inventory of SPD had not been performed in 3 years. Because GIP data was inaccurate, we could not determine the value of stock on hand or the value of excess stock for the entire inventory. However, by applying the 51 percent of excess stock for the 30 items reviewed to the entire stock, we estimated that the value of excess stock was $90,304 (51 percent x $177,066 estimated value of stock).

Recommended Improvement Action(s) 4. We recommended that the VISN Director ensure that the Medical Center Director requires: a) inventory managers to reduce supply inventory to the 30-day supply goal and improve the accuracy of GIP, and b) SPD to conduct and document annual wall-to-wall physical inventories.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that supply inventory levels will be reduced to a 30-day supply by March 2005, actions are being taken to resolve inventory discrepancies, and a wall-to-wall inventory has been conducted and others are planned. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Required Aspects Should Be Addressed in the Monthly Inspection Report

Condition Needing Improvement. Controlled substances inspectors reviewed all areas containing controlled substances each month and inspectors were properly rotated. However, the Controlled Substances Coordinator needed to strengthen the monthly inspections to fully comply with VHA policy and help ensure accountability of controlled substances. We reviewed the monthly controlled substance inspection reports for the 13-month period ending January 2004 and found two controls that needed improvement.

First, as part of the monthly inspections, VA policy requires the inspectors to certify the accuracy of pharmacy records for all controlled substances held for destruction, verify that controlled substances destructions are completed at least quarterly, and document this verification in the

monthly inspection reports. According to the Controlled Substances Coordinator, prior to June 2003, the inspectors did not certify the amount of controlled substances awaiting destruction or verify that controlled substances destructions occurred in the prior quarter as required. The Controlled Substances Coordinator said that since June 2003, these controlled substances were counted and controlled substances destructions were verified. However, these reviews were not documented in the monthly inspection reports for 4 of 7 months from July 2003 to January 2004.

Second, dispensing activities were not properly verified to medical records. VHA policy requires inspectors to verify a sample of dispensing activities to physicians' orders in the medical records. This policy did not address the size of the sample. VHA revised this policy on August 29, 2003, requiring inspectors to verify five randomly selected dispensing activities on each unit (inpatient ward or outpatient clinic).

We reviewed the inspections for the 13-month period ending January 2004 and found that inspectors did not consistently follow VHA policy. During the 8-month period ending August 2003, the inspectors did not verify any dispensing activities in 4 months and verified only one dispensing activity on each unit in the other 4 months. During the 5-month period after VHA revised it's policy in August 2003, the inspectors did not verify any dispensing activities in 2 months and verified only one dispensing activity on each unit in the other 3 months.

Recommended Improvement Action(s) 5. We recommended that the VISN Director ensure that the Medical Center Director provides training to controlled substances inspectors to: a) certify the accuracy of pharmacy records of controlled substances awaiting destruction, b) document in the monthly controlled substances inspection reports whether controlled substances awaiting destruction were destroyed in the prior quarter, and c) verify five randomly selected dispensing activities on each unit to the medical records during each monthly controlled substances inspection.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that medical center policy has been revised and procedures are in place to comply with VHA policy for the monthly controlled substances inspections. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Moderate Sedation – Outcome Data Needed Local Reporting and Analysis

Condition Needing Improvement. Outcome data collected by clinicians on moderate sedation needed to be reported to a medical center committee designated by medical center management to be responsible for analyzing the information.

The Joint Commission on Accreditation of Healthcare Organizations requires systematic aggregation and analysis of moderate sedation outcome data. While the Tissue and Transfusion Committee reviewed the appropriateness of procedures performed under moderate sedation and

outcome data from moderate sedation were collected and reported to VISN 10, medical center management had not designated a committee to aggregate and analyze the data. This prevented medical center management from identifying patterns or trends, and recognizing areas needing improvement.

Recommended Improvement Action(s) 6. We recommended that the VISN Director ensure that the Medical Center Director designates a committee to aggregate and analyze moderate sedation outcome data and requires clinicians to report outcome data to this committee.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that outcome data is now reported to the Medical Executive Committee, with abnormal outcomes reported to and reviewed by the Peer Review Committee. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Contracts – Price Reasonableness Determinations and Contract Administration Controls Need Improvement

Condition Needing Improvement. To determine if contracts were properly awarded and administered, we reviewed 13 contracts valued at $3 million. Overall contracting activities were adequate; however, we identified two areas that needed improvement.

Price Reasonableness Determinations. The Federal Acquisition Regulation requires the contracting officer to determine that a contract price is fair and reasonable prior to awarding a contract and to document this determination in the Price Negotiation Memorandums (PNM) the contract file. We found two contracts for physician services valued at $546,308 in which the basis for the award amounts were not adequately documented in PNMs. Both contracts were awarded at higher rates than the established Federal Supply Schedule (FSS) rates. In the first contract, the FSS rate for a part-time physician was $87 per hour, but the contract rate was $103.50 per hour. In the second contract, the FSS rate for two full-time and one part-time physicians was $79.37 per hour, but the contract rate was $87.50 per hour. The contracting officer stated that the price differences were due to relocation costs, housing, malpractice insurance, travel to CBOCs, and the qualifications and experience of the physicians and that she had determined that the contract prices were fair and reasonable. However, there were no estimates for these additional costs or any documentation in the contract files showing the contracting officer's fair and reasonableness determinations. As a result of our review, the contracting officer prepared a PNM for each of these contracts.

Contract Administration. Contracting Officer's Technical Representatives (COTRs) are required to review the contractor's invoices to ensure that they accurately reflect the work completed in accordance with the requirements of the contract before certifying acceptance. For three contracts valued at $571,710, the COTRs did not properly certify acceptance. One contract was for a temporary warehouse employee at a cost of $25,402 and the other two were for physician services valued at $546,308. All three contracts stipulated that the medical center would

maintain logs for the contract employees to sign-in and sign-out. Further, the logs were to be used to certify invoices. However, we found that these logs were not maintained and the COTRs certified payments by only using time cards submitted by the contractors. This occurred because staff performing the COTR duties were not aware of the contracts' provisions. We also found that for two of these contracts, required letters designating a COTR and describing their responsibilities and duties had not been prepared.

Suggested Improvement Action(s) 1. We suggested that the VISN Director ensure that the Medical Center Director requires: a) contracting officers to document their determinations of fair and reasonable prices in PNMs, b) that sign-in and sign-out logs are maintained and used to certify invoices as required by the contracts, and c) that COTRs be designated in writing.

The VISN and Medical Center Directors agreed with the findings and suggestions and reported that PNMs have been completed for the contracts identified in the review and PNMs will be prepared for all future contract negotiations. Staff have been reminded of the requirement to maintain sign-in and sign-out logs for contract employees and to use these logs to certify invoices, and COTR designation letters have been prepared for the contracts identified in the review. The improvement plan is acceptable, and we consider the issues resolved.

Computer Equipment Accountability – Inventory Controls and Procedures For Loaning Laptop Computers to Staff Should Be Improved

Condition Needing Improvement. Medical center management needed to improve procedures for performing physical inventories and updating equipment inventory lists (EILs) of nonexpendable computer equipment. Also, procedures for loaning laptop computers to staff needed to be improved to ensure laptops were loaned only for official purposes. VA policy requires that EIL inventories be performed at least every 2 years. Acquisition and Materiel Management Service (A&MMS) and using services with nonexpendable equipment are responsible for ensuring EIL inventories are completed and EIL records are accurate. As of February 25, 2004, Information Resource Management's (IRM's) EIL contained 3,323 line items valued at $6 million. EIL inventories were performed by IRM in FYs 2001 and 2003. As a result of these inventories, computer equipment totaling $235,000 was written off because it could not be located. We identified four deficiencies with equipment accountability procedures.

Timeliness of IRM EIL Inventories. EIL inventories of IRM equipment were not performed timely. VA policy establishes timeliness standards for completing EIL inventories based on the number of items on the EILs. When an inventory is due, A&MMS staff notifies the responsible official. Based on the size of IRM's EIL, the responsible official should conduct a physical count of all nonexpendable computer equipment within 20 days after receipt of the notice that an inventory is due. We found that the last inventory took 6 months, from January to July 2003, to complete. Also, another inventory was initiated January 12, 2004, with the hiring of a new CIO. However, as of February 27, 2004, this inventory had not been completed.

Quarterly Spot Checks. A&MMS staff had not performed VA-required quarterly spot checks of the completed IRM EIL inventories to ensure the accuracy of reported information.

Accuracy of EILs. To verify the accuracy of information on the IRM EIL, we reviewed a judgment sample of 14 items with a total value of $16,199. We found that seven were not in the locations indicated on the EIL. Four items were found in other rooms; however, a search of nearby rooms did not locate the other three items. This problem occurred because the EIL was not updated when equipment was moved or excessed.

Loaning Laptop Computers to Staff. Controls over loaning laptop computers to staff to perform official duties away from the medical center needed improvement. Prior to February 2004, the medical center had no written policy or procedures for loaning laptop computers to staff. Local policy issued on February 23, 2004, provided procedures for requesting and borrowing laptop computers. However, it did not require supervisory approvals or explanations as to why the laptop computers were needed or how long they would be needed.

As of February 26, 2004, IRM maintained a pool of 68 laptops of which 34 were on loan to staff. Although IRM maintained a log showing to whom these laptops were loaned, there was no record of supervisors authorizing the need for the loans, nor any explanations as to why the laptops were needed. IRM staff stated that generally laptops were loaned to staff that travel to CBOCs or make home visits. Our review of the log of loaned laptop computers disclosed two laptop computers loaned to physicians who live and work at the medical center. Also, one social worker had two laptop computers signed out in his name.

Suggested Improvement Action(s) 2. We suggested that the VISN Director ensure that the Medical Center Director requires: a) IRM to complete EIL inventories timely, b) A&MMS staff to perform quarterly EIL inventory spot checks, c) A&MMS and IRM staff to update EIL records when equipment is moved or excessed, and d) IRM to revise local policy on loaning laptop computers to staff to ensure loans are only made for official purposes.

The VISN and Medical Center Directors agreed with the findings and suggestions and reported that an inventory management position has been created to assist in inventories, quarterly EIL inventories were initiated in May 2004, a more efficient process was developed by IRM to better track IT equipment, and new processes are in place for loaning laptop computers and medical center policy is being updated to include these changes. The improvement plan is acceptable, and we consider the issues resolved.

Appendix A

VISN 10 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 24, 2004

From: Network Director, VA Healthcare System of Ohio, VISN 10 (10N10)

Subject: **Combined Assessment Program (CAP) Review of the VA Medical Center Chillicothe, Ohio**

To: Assistanct Inspector General for Auditing (52)

1. I concur with the comments and action plans submitted by the Medical Center Director at Chillicothe, Ohio, in response to the OIG CAP Review conducted in February 2004. The staff found the review educational and appreciated the professionalism of the OIG Team.

2. If you have questions regarding the response, please contact Douglas A. Moorman, Medical Center Director, at (740)773-1141, extension 7002.

(original signed by:)

CLYDE PARKIS
Director, Veterans Integrated Service Network

Appendix B

VA Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 24, 2004

From: Director, VA Medical Center Chillicothe, Ohio (538/00)

Subject: **Combined Assessment Program (CAP) Review of the VA Medical Center Chillicothe, Ohio**

To: Director, Veterans Integrated Service Network 10 (10N10)

1. Attached is the response from the VA Medical Center, Chillicothe, Ohio, in regard to the OIG CAP Review in February 2004. I concur with the findings and recommendations/suggestions made by the review team. We found the review educational and helpful in preparation for our upcoming JCAHO Survey in August. We also appreciated the professionalism of the review team.

2. If you have any questions about the attached response, please feel free to contact me.

(original signed by:)

DOUGLAS A. MOORMAN
Medical Center Director

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

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

1. Correct environment of care deficiencies

a) The Medical Center Associate Director's action plan for housekeeping and maintenance issues is implemented.

Work orders have been submitted for button (keyless) entry for soiled utility rooms. Until new locks are installed, staff have been reminded that these doors must remain locked at all times. Staff break rooms and associated equipment (refrigerators, microwave ovens, etc.) are now included routinely in environmental and infection control rounds. Improvements have already been noted. The noted food in the procedure room was an anomaly and the incident is not standard practice. The Asian Multi-Colored Lady Beetle was introduced into the United States from Asia to control aphids, scale and other crop pests from 1978 to 1981. They are now widely distributed east of the Mississippi and have been documented in areas of the Midwest, Southwest and Pacific Northwest. Asian Lady Beetles enter homes and buildings in large numbers and although they are harmless to humans, they have become persistent over-wintering pests in buildings in some parts of the United States. They are usually recognized as typical ladybugs, but they are slightly larger than the native species. This beetle (6 to 10 mm) is also a little larger than the two-spotted lady beetle (4 to 5 mm). This species is a voracious predator of crop pests and produces several generations per year. Their tendency to aggregate and ability to enter structures may cause this insect to become a significant structural pest. They may be found in attics, wall voids, on siding and other such places and may be attracted to light. The Chillicothe VA Medical Center is a campus style facility with multiple buildings and is approximately 80 years of age. We are located in a rural setting with woods, farms and crops surrounding the facility. As stated above, there are multiple entry points in structures for this aggressive pest to enter. Their nature is to seek shelter throughout the winter months when weather transitions from warm to cold i.e., they literally swarm to buildings when this transition occurs. Our pest controllers continue to seal off entry points when observed i.e., cracks in windows, screens, doors, around ceilings, etc. Works orders are generated to replace screens on an as-needed basis and are ongoing. Employees are requested to keep windows and doors closed at all times. It should be noted that there is little, if any, food source available to Asian Beetles once they are in the medical center and they die off relatively quickly, i.e., within a few days. However, they do swarm for days at a time and require the repeated cleaning of most light diffusers throughout the facility by housekeeping personnel. In terms of the scope of the problem, please note that

you can clean a particular light diffuser and find them there again within minutes. They mostly congregate in light fixtures and around windows where warmth can be obtained. Fumigation or chemical treatments to eradicate this pest are not an option. Their continued removal requires a great deal of man-hours by housekeeping staff as the weather changes as previously noted. Staff monitor daily when weather patterns dictate, and they are targeted for immediate removal when conducting building inspections by EMS personnel. We will continue to aggressively remove this target pest when necessary. Regarding hallway damage from motorized carts, operator training is conducted by the safety manager and a card is issued to each employee who completes training. Reporting of damage is encouraged and factors leading up to the incidents are discussed for improvement of processes. Ceiling tiles have been replaced (this is a continual process) and painting is being accomplished as manpower permits (this is also a continual process). Safety procedures have been implemented in the loading area near Building 24. The lift gate has been modified to reduce the risk of carts rolling off the platform, the most level area is used for unloading, the area is closed to other traffic during loading, and employees are not permitted to ride the lift when there is a load on it.

b) SPD supplies are reprocessed when outdated

SPD routinely reprocesses outdated supplies. As a QA measure (implemented in March), SPD instituted an Outdate Checklist for daily checks of sterile supplies. This is also spot checked by the Chief, SPD and the Associate Central Hub A&MMS Manager.

c) Confidential patient information is secured

The medical center continually monitors computer terminals that are "walked away from" without being locked or logged off. Messages are left on these machines to remind the user to lock or log off the terminal before leaving. Repeat offenders are referred to the service chief/care line manager, or higher if necessary. Information was sent to all employees with complete instructions for logging off, locking workstations, shutting down, changing passwords and using the task manager.

d) Access to the female locker room and showers in the gymnasium in Building 247 is provided for wheelchair-dependent female veterans

The threshold (lip at shower entry) constituting the identified barrier has already been removed and the area tiled. A project to make the entire building ADA compliant has been submitted for FY05.

2. Improve information technology security

a) Revise the LAN Security Plan and medical center contingency plans in accordance with Government IT guidelines

Completed May 10, 2004.

b) Store backup tapes in a location away from the computer room building

A new room has been located in Building 1 (Room BA101A) and backup tapes are being moved on May 21, 2004.

c) Remove signage identifying the locations of sensitive information and automated systems

Signs have been removed.

d) Remind employees of the need to secure patient information by ensuring computers are properly locked or logged off when left unattended

See 1.c. above.

e) Upgrade the physical security of the new computer storage room

Smoke detectors were installed before the OIG team left the medical center. An appropriate location (out of Building 35) to store new computers is being developed by the medical center Space Committee and will include all required security features. An action plan is expected to be completed by June 2004. In the interim, a temporary motion detection system is being installed in the existing rooms.

f) Ensure plans to remedy potential risks associated with the air conditioning and UPS system for the computer room are carried out timely.

There is an NRM project approved to construct a new computer room on the first floor of Building 18. This will include new air conditioning systems and a new UPS. Award of the project is anticipated in September 2004. In the interim, compressors in the existing air conditioning units have been replaced for improved reliability and capacity. The existing UPS has been put under a service contract for improved response to any future repair needs. The vendor replaced the battery charging board, which has restored battery charge level to full capacity.

3. Enhance billing procedures and improve physician documentation of care provided.

a) Strengthen the billing process to ensure all billable fee-basis claims are identified

The four claims identified in the audit have been billed. Two claims were for a CNHC veteran treated at a private emergency room for G tube placement and swallowing evaluation and two claims were for services provided for labor and delivery. These were different than bills normally seen and the Lead Biller assisted in processing the claims. Processes are now in place for timely processing of all fee-basis claims.

b) Establish procedures to ensure bills are processed before insurance carrier filing deadlines expire.

Unbilled Reports are run monthly back two years to ensure that all billable episodes are reviewed for possible billing. Contracted Billers (Preferred Medical Billing and Consulting) follow up on current year cases and our billing staff review prior year cases.

c) Bill for optometry services provided by licensed optometry residents.

Are now billing and have back-billed appropriate cases.

d) Ensure physicians adequately document care provided in the medical records.

We continue to run the Reasons not Billable Report monthly to identify cases canceled because of inadequate documentation. Coding refers cases to Care Line Managers and supervisors for necessary corrective action. An employee has been detailed as a training instructor and liaison with clinic staff to address documentation issues that directly impact on our ability to code accurately and bill correctly and timely.

e) Prepare bills for the cases identified in the OIG review.

All cases identified have been billed.

4. Reduce excess supply inventories and strengthen inventory management controls.

a) Inventory managers to reduce supply inventory to the 30-day supply goal and improve the accuracy of GIP.

Each Item Manager assigned the function of managing a GIP for an area is currently working with the end user to reduce inventory to the 30 day on hand mandate. They are reviewing the past history usage, the current level, and determining where adjustments are necessary. In addition, there is a Goal Sharing team working with SPD to identify long/inactive items and make recommendations to reduce or excess items. There is also a group of Engineering staff identified to work together with A&MMS reviewing items in the Tool Room to determine if there are items being stocked which should be excessed or the level reduced.

At this time it is estimated GIP will be at a 30 day level as follows:

Environmental Management August 30, 2004
Dental September 30, 2004
Laboratory September 30, 2004
Radiology September 30, 2004
SPD September 30, 2004
Warehouse March 2005

An inventory management tool (the monthly GIP Inventory Report) was developed, which lists the various GIP inventory accounts, the inventory due dates, the date the inventory was completed, discrepancies found, and summary of actions to be taken. The report is completed by the Chief, Materiel Management, reviewed by the Associate Central Hub A&MMS Manager, and provided to the Associate Medical Center Director. Adequate number of staff are available to complete inventories in a timely fashion.

b) SPD to conduct and document annual wall-to-wall physical inventories.

An inventory was completed on March 18, with a 68 percent accuracy rate. Procedures were reviewed and adjustments made. Another inventory was conducted on April 15, 2004, with an accuracy rate of 84 percent. A third inventory was completed on May 13, 2004, with an accuracy rate of 88 percent. Another inventory is being scheduled and they will continue until an accuracy rate of at least 95 percent is achieved.

5. Strengthen monthly controlled substances inspections.

a) Certify the accuracy of pharmacy records of controlled substances awaiting destruction.

Completed. New policy was published February 23, 2004 and procedures are in place and being used.

b) Document in the monthly controlled substances inspection reports whether excess and outdated controlled substances were destroyed in the prior quarter.

Completed. New policy was published February 23, 2004 and procedures are in place and being used.

c) Verify five randomly selected dispensing activities on each unit to the medical records during each monthly controlled substances inspection.

Completed. New policy was published February 23, 2004 and procedures are in place and being used.

6. Aggregate and analyze moderate sedation outcome data.

a) Designate a committee to aggregate and analyze moderate sedation outcome data

Data go to the Medical Staff Executive Committee and any outliers are forwarded to the Peer Review Committee.

OIG Suggestion(s)

1. Fully document price reasonableness determinations and ensure services are validated in accordance with contract terms prior to payment.

a) Contracting officers to document their determinations of fair and reasonable prices in PNMs

The contracting Officer completed the Price Negotiation Memoranda (PNMs) on both contracts in question on February 27, 2004. Appropriate PNMs will be prepared on all future contract negotiations and negotiations will be documented in the contract files.

b) That sign-in and sign-out logs are maintained and used to certify invoices as required by the contracts.

All service chiefs/care line managers using contract employees have been reminded in writing of the requirement to maintain a sign-in and sign-out log at each facility where contract employees are providing services. A sheet for this purpose was developed and implemented on May 1, 2004. These sheets will be maintained and will be the only documents used to verify services performed and to certify invoices.

c) That COTRs be designated in writing.

Appropriate COTR designations were prepared on February 27, 2004 for the two contracts in question. As appropriate and as provided for under applicable FAR and VA regulations, COTR designations will be properly prepared for all future contracts.

2. Ensure computer equipment inventories are completed timely, inventory lists are updated when needed, and the local policy on loaning laptop computers is revised.

a) IRM to complete EIL inventories timely.

A&MMS has created a dedicated inventory management position to assist in IRM EIL inventories. IRM has developed a more efficient process to be used not only during the annual inventory, but daily in an effort to better track IT equipment.

b) A&MMS staff to perform quarterly EIL inventory spot checks.

This process began in May 2004. The EIL spot checks are reported through the Associate Central Hub A&MMS Manager to the Associate Medical Center Director.

c) A&MMS and IRM staff to update EIL records when equipment is moved or excessed.

A&MMS updates the EIL records after the Warehouse picks up equipment that has been turned in as excess. As mentioned above, IRM has developed a new process for tracking IT equipment when it is moved and A&MMS and IRM are meeting on May 21, 2004 to review the new process.

d) IRM to revise local policy on loaning laptop computers to staff to ensure loans are only made for official purposes.

New processes are in place for laptop loan requests to include reason for request an supervisory approval. The policy (PM 19-02, Use of Computer Laptops/Notebooks and Projectors) is in process of being updated to include these changes.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Better use of funds by ensuring all billing opportunities are realized.	$13,095
4	Better use of funds by reducing supply inventories to 30-day supply levels.	90,304
	Total	$103,399

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	William H. Withrow, Director, Kansas City Audit Operations Division (816) 426-7100
Acknowledgments	Nelson Miranda, Director, Washington Office of Healthcare Inspections Joseph T. Janasz, Jr., CAP Review Coordinator Randall Snow, Healthcare Inspections Team Leader Richard Horanski, Investigations Team Leader Jim L. Garrison C. Russell Lewis Gavin McClaren Henry Mendala Rayda Nadal Michelle Porter Carla S. Reid Oscar L. Williams

Appendix E

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