Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Tomah, Wisconsin

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

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

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Executive Summary

Introduction

During the week of August 4-8, 2003, the OIG conducted a CAP review of the VA Medical Center Tomah, WI, which is part of Veterans Integrated Service Network (VISN) 12. The purpose of the review was to evaluate selected medical center 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 248 medical center employees.

Results of Review

The medical center effectively monitored part-time physician time and attendance and effectively managed the Government purchase card program. Unliquidated obligations were properly monitored and Agent Cashier operations were sound. Medical center management involved employees in QM decision-making. To improve operations, VISN and medical center management needed to:

- Screen motor vehicle operators for valid driver's licenses and provide safe driver training to staff and volunteers who transport patients.
- Secure sharp instruments and hazardous chemicals in patient areas and correct environmental deficiencies in Veterans Canteen Service, Nutrition and Food Service, and Supply Processing and Distribution.
- Analyze Utilization Management data for trends, establish criteria for measuring patient care improvement actions, and use quality of care scales when conducting peer reviews.
- Strengthen controlled substances mail-out procedures, include all controlled substances in ward shift-change inventories, conduct random monthly inspections, and research credits due from vendors for returned drugs.
- Verify that Community Residential Care facility employees are not also employed at the medical center and determine if patients who have fiduciaries are receiving the care they need.
- Improve follow-up on Medical Care Collections Fund receivables and reduce the number of invalid insurance bills.
- Establish procedures to detect non-VA medical center staff that no longer need access to automated data systems and evaluate the cost effectiveness of relocating the alternate data processing site to a more distant location from the main site.
- Improve documentation of contracting actions.

VISN 12 Director Comments

The VISN 12 Director agreed with the CAP findings and provided acceptable implementation plans. (See Appendix B, pages 15-24, for the full text of the Director's comments.) We will follow up on the implementation of recommended improvement actions.

This report was prepared under the direction of Mr. Fred Howell, Director, and Mr. William Gerow, Jr., CAP Review Coordinator, Chicago Audit Operations Division.

(original signed by
Michael G. Sullivan
Deputy Inspector General)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in Tomah, WI, the medical center is a primary and long-term care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at community-based outpatient clinics (CBOCs) in LaCrosse, Loyal, Wausau, and Wisconsin Rapids, WI. The medical center is part of VISN 12 and serves a veteran population of about 62,000 in a primary service area that includes 14 counties in Wisconsin and 1 county in Minnesota.

Programs. The medical center provides acute medical and psychiatric inpatient services. Specialty programs include speech and audiology, neurology, podiatry, dermatology, dental, physical medicine, optometry, and a variety of mental health programs.

Affiliations. The medical center is not affiliated with a school of medicine, but has affiliations with Viterbo University, Western Wisconsin Technical College, University of Wisconsin–Eau Claire, University of Wisconsin–LaCrosse, and Winona State University for nursing, social work, psychology, and other programs.

Resources. The medical center has 26 acute care beds, 45 residential care beds, and 260 nursing home beds. In Fiscal Year (FY) 2003, the medical center's budget was $63.3 million, an 11 percent increase from the FY 2002 budget of $57 million. Staffing through July 12, 2003, was 674 full-time equivalent employees (FTEE), including 22 physicians and 256 nursing FTEE.

Workload. In FY 2002, the medical center treated 16,715 unique patients, a 25 percent increase from FY 2001. The FY 2002 average daily census (ADC) was 19 inpatients, 35 residential care patients, and 172 nursing home patients. In FY 2003 through July 2003, the ADC was 12 inpatients, 39 residential care patients, and 178 nursing home patients. Outpatient workload totaled 116,514 visits in FY 2002, and the projected FY 2003 outpatient workload was 132,000 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 medical center 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 of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FYs 2001, 2002, and 2003 through July 2003, 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; met with veteran service organization and union representatives; and reviewed clinical, financial, and administrative records. The review covered the following 14 activities:

Agent Cashier	Information Technology Security
Community Residential Care Program	Medical Care Collections Fund
Contracting	Part-Time Physician Time and Attendance
Controlled Substances Accountability	Patient Transportation Services
Enrollment and Resource Utilization	Quality Management Program
Environment of Care	Supply Processing and Distribution
Government Purchase Card Program	Unliquidated Obligations

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–13). 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 Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and quality of care. We invited medical center employees to complete an on-line electronic questionnaire, 100 of whom did so. We also interviewed 30 patients. The questionnaire and interview results were provided to VISN and medical center management.

During the review, we also presented 6 fraud and integrity awareness briefings that were attended by 248 employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strengths

Scheduling Clinic Appointments Had Improved. Procedures for scheduling initial patient appointments were effective. From June 2002 to July 2003, the average time to an initial appointment decreased from 38 to 20 days for primary care clinics and from 58 to 7 days for specialty clinics. There were no patients waiting for appointments to be scheduled.

Part-Time Physician Time and Attendance Was Effectively Monitored. The medical center employed three part-time physicians. These physicians signed attendance records at the beginning and end of their tours, and their presence was accounted for. Fiscal staff audited the physicians' timecards at least twice a year and initiated appropriate corrections when warranted.

Government Purchase Card Program Was Effectively Managed. Medical center staff complied with VA policy on the use of Government purchase cards. Cardholders and approving officials performed reconciliations and approvals in a timely manner, and controls were adequate.

Unliquidated Obligations Were Properly Monitored. Fiscal Service staff reviewed unliquidated obligations monthly, contacted the appropriate services to determine the continued validity of obligations, and promptly cancelled obligations that were no longer needed.

Agent Cashier Operations Were Sound. An OIG-requested audit of Agent Cashier funds on August 7, 2003, identified no discrepancies. The amount of the Agent Cashier advance was appropriate, and physical security for employees and funds was adequate. Medical center staff properly conducted unannounced audits of Agent Cashier funds.

Employees Were Involved in Medical Center Quality Management Decisions. Medical center management involved employees in strategic planning processes and in medical equipment procurement decisions. As a result, more than half of employee suggestions to improve patient care services were incorporated into the medical center's strategic plan, and top management was better able to prioritize equipment purchases.

Opportunities for Improvement

Patient Transportation Services – Internal Controls Needed Strengthening

Conditions Needing Improvement. Human Resources Management Service (HRMS) staff and service line supervisors needed to ensure that employee motor vehicle operators were properly screened and that annual safe driver training was provided to everyone who operated VA vehicles for official business. Medical center employees and volunteers regularly transported patients for a variety of reasons and activities. VA regulations require that motor vehicle operators and volunteers who transport patients possess valid driver's licenses, have safe driving records, receive annual safe driver training, and undergo health examinations. In addition, other employees who transport patients must also receive safe driver training each year.

Driver Screening. Records showed that volunteer drivers were appropriately screened. However, personnel records did not document that employee motor vehicle operators had valid driver's licenses or that their driving records were reviewed before they were hired. In addition, records showed that only one employee motor vehicle operator had received a health examination, which is required at least once every 4 years.

Driver Training. Personnel records showed that employee motor vehicle operators had completed annual safe driver training. However, there was no documentation to show that other persons who transported patients, such as recreation therapists, social workers, and volunteers, had completed the training.

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the medical center Director requires that:

(a) Motor vehicle operators are screened for valid driver's licenses and safe driving records, and receive health examinations.
(b) Volunteers and others who transport patients receive annual safe driver training.

The VISN Director agreed and reported that by December 1, 2003, a log will be in place to track such information as license verification, driving record, annual safe driving training, and health examinations for motor vehicle operators and other employees and volunteers who transport patients. In addition, as of September 1, 2003, the medical center had entered into an agreement with the State of Wisconsin for obtaining information on motor vehicle violations. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Environment of Care – Safety and Environmental Deficiencies Needed Correcting

Conditions Needing Improvement. Service line supervisors needed to ensure that cleaning products and sharp instruments in patient care areas are secured and that safety and maintenance deficiencies in the Nutrition and Food Service (N&FS) are corrected. Veterans Canteen Service (VCS) and Supply Processing and Distribution (SPD) supervisors needed to ensure that safety vulnerabilities are corrected.

Veterans Health Administration (VHA) regulations require that the hospital environment be clean and in good repair to minimize risk of injury and infection to patients, employees, and visitors. We inspected inpatient and outpatient areas, the N&FS patient dining room, food preparation and storage areas, the VCS retail store, kitchen, and food service cafeteria, and SPD areas.

Security of Cleaning Products and Sharp Instruments. There were unsecured cleaning products in a medical ward patient shower as well as in an unlocked housekeeping closet. There were also unsecured needles, syringes, hemostats, and scissors in outpatient examination rooms. Cleaning products and sharp instruments need to be secured to prevent accidental or purposeful injury to patients, visitors, or staff.

N&FS Safety and Maintenance. In the N&FS food preparation area, there were four electrical cords with exposed wires protruding from the ceiling of a walk-in refrigerator. There was also a build-up of ice on the ceiling and floor of a walk-in freezer. These conditions created safety hazards. There was mold growing on areas surrounding the doors of two walk-in freezers, which could indicate malfunctions and the need for maintenance and cleaning.

VCS Safety Issues. Equipment and light fixtures in the VCS kitchen and storage rooms were located near sprinkler heads creating inadequate clearance. National Fire Protection Association Life Safety Codes require an 18-inch clearance around sprinkler heads. Equipment blocked a fire extinguisher in the VCS kitchen. An eyewash station in the VCS food preparation area was too small, required a multi-step process to activate, and, because the jets were misaligned, would not direct water into an employee's eyes. The Occupational Safety and Health Administration (OSHA) requires that properly functioning eyewash stations be located in areas where employees can be exposed to eye injuries from chemicals or corrosive materials.

VCS Infection Control Practices. VCS employees did not fully cover their hair with hairnets or caps and did not consistently use gloves when preparing and serving food. VCS policy requires that food handlers wear hairnets or caps to prevent hair from falling into food and beverages and requires that employees wear gloves when handling food without utensils.

Material Safety Data Sheets. Material Safety Data Sheets (MSDSs) for potentially hazardous chemicals in VCS were not current. OSHA requires that MSDS information be current for all chemicals used in an area.

Defective Equipment in SPD. Defective equipment needed to be repaired in SPD. Trays on the back of two scope-cleaning machines in the cleaning room were cracked. The cracked trays allowed chemicals to overflow onto countertops, exposing staff to a safety hazard.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the medical center Director requires that:

(a) Cleaning products and sharp instruments are secured.
(b) Safety and maintenance issues in N&FS are corrected.
(c) Safety issues in VCS are corrected.
(d) VCS employees adhere to infection control policies.
(e) MSDSs are current.
(f) Defective equipment in SPD is repaired.

The VISN Director agreed and reported that as of October 14, 2003, most of the noted deficiencies had been corrected. The Director anticipated that corrective action on sprinkler head clearance in VCS would be completed by December 10, 2003 and work on installing a new eye wash station in VCS would be completed by November 7, 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Quality Management Program – Data Analysis and Peer Review Processes Needed Improving

Conditions Needing Improvement. QM supervisors needed to ensure that Utilization Management (UM) data was tracked, trended, and reported, that outcome criteria was established to evaluate the effectiveness of performance improvement activities, and that the peer review process was consistent with medical center policy. VHA policy requires that health care facilities establish QM programs to monitor the quality of patient care services and performance improvement.

UM Data Analysis and Reporting. A comprehensive QM program includes UM reviews that assess inpatient admissions to determine their appropriateness and inpatient stays to ensure timely discharges. Documentation showed that UM employees collected admission and continued stay data and contacted medical care providers if the data revealed any concerns. However, UM data was not tracked, analyzed for trends, or presented to medical center management. Consequently, top management did not have complete information that would have helped them identify problems or opportunities to improve resource utilization.

Root-Cause Analysis Evaluation Criteria. Two of four Root-Cause Analysis (RCA) reports reviewed did not contain criteria for measuring the effectiveness of recommended performance improvement actions. The RCA process requires that resulting recommendations have measurable outcome goals so that medical center management can evaluate the effect of improvement actions on patient care services.

Peer Review Quality of Care Scale. Medical care staff assigned to review the quality of care delivered by peers did not complete a practitioner quality of care scale in four of seven peer reviews. This scale helps the reviewer assess whether the patient's diagnosis and treatment was appropriate and whether most other practitioners would have handled the case similarly. Medical center policy requires that medical staff assigned to review the quality of care delivered by a peer complete this scale. Regular use of the scale would prevent inconsistent documentation of peer review outcomes.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the medical center Director requires that:

(a) UM data is analyzed for trends and reported to medical center management.
(b) Criteria is established to measure patient care improvement actions.
(c) Peer reviewers use the practitioner quality of care scale.

The VISN Director agreed and reported that beginning in October 2003, UM data is tracked, trended, and reported monthly to providers, to medical center management through the Performance Improvement Council, and to the VISN 12 Utilization Management Service Line Manager. A retrospective review of past RCAs was completed in September 2003, and future RCA goals will be evaluated by the Performance Improvement Council for measurable goals before the medical center Director's approval. In addition, the Director anticipated that a revised medical center memorandum reflecting use of the quality of care scale in peer reviews would be issued by November 14, 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Controlled Substances Accountability – Certain Security and Control Procedures Needed Improving

Conditions Needing Improvement. Accountability and security of controlled substances in Pharmacy Service were generally effective. Physical security was adequate, and the number of staff accessing the vault room was within permitted limits. Pharmacy Service staff maintained a perpetual inventory of controlled substances and conducted required Drug Enforcement Administration biennial inventories. Monthly controlled substances inspections were properly conducted. Since May 2002, Pharmacy Service staff had conducted required quarterly destructions of expired and unusable drugs. However, there were four conditions that needed corrective action.

Controlled Substances Mail-Out Procedures. The medical center needed to improve security controls of mail-out prescriptions. Pharmacy Service staff relinquished control of controlled substances to mail room and warehouse staff before private parcel delivery companies picked them up. Pharmacy Service staff marked packages containing controlled substances and separated them from packages containing only non-controlled substances. Both groups of packages were delivered to the medical center's mailroom for sorting and metering. They were then delivered to the warehouse for pickup by delivery companies.

Medical center police told us there had been no reported thefts or losses of controlled substances awaiting pickup. However, the risk of loss or theft when these substances are being sent to patients could be reduced if Pharmacy Service staff maintained control of these packages until picked up by the parcel delivery companies. The companies should be instructed to pick up the packages directly at the pharmacy.

Ward Inventories of Controlled Substances. An OIG-caused unannounced inspection of controlled substances on August 5, 2003, at 14 locations in the medical center identified an overage of lorazepam on 1 ward. According to ward inventory records, two vials of lorazepam were administered to an inpatient on July 31, 2003, but the patient's medical record showed only one vial administered. The discrepancy was not discovered during the 13 shift-change counts that occurred between July 31, 2003, and the date of our inspection. Lorazepam vials were stored in a locked drawer in a refrigerator. Based on interviews with ward staff and on our review of ward drug activity records, we concluded that the contents of that drawer were not included in shift-change counts of controlled substances. Ward staff made the appropriate inventory adjustment during the inspection. By not counting all controlled substances on hand during shift changes, the risk of diversion was increased.

Randomness of Monthly Unannounced Inspections. The timing of monthly controlled substances inspections established a predictable pattern and potentially reduced their effectiveness in detecting and preventing loss or theft of controlled substances. Medical center staff properly conducted these inspections. However, they performed 11 of the last 13 inspections during the last 2 weeks of each month. We believe the effectiveness of unannounced inspections will be improved if their timing is less predictable.

Credits for Returned Drugs. Pharmacy Service staff did not know if vendors' credits were due or received for two recent returns of out-dated drugs. In June 2003, Pharmacy Service staff had established a procedure to follow up on credits for drugs returned to vendors. The procedure allowed them to track the status of an estimated $16,300 in drugs returned to vendors in June 2003. However, they were not aware of the status of credits for drugs returned to vendors prior to that. For example, the status of an estimated credit of $9,100 for drugs returned in January 2003 and May 2002 was unknown. The status of these earlier returns should be researched to determine if the medical center received the credits it was due.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the medical center Director take action to:

(a) Have mail-out controlled substances picked up at the pharmacy by parcel delivery companies.
(b) Include controlled substances stored in ward refrigerators in shift-change counts of controlled substances.
(c) Establish more random timing of monthly controlled substances inspections.
(d) Research the status of credits due for the return of drugs to vendors prior to June 2003.

The VISN Director agreed and reported that parcel delivery companies have started picking up mail-out controlled substances at the pharmacy. On October 7, 2003, nurse managers were

informed of revised procedures designed to insure that all controlled substances are included in shift-change verification counts. Beginning with a controlled substance inspection in September 2003, inspectors began more randomly timing inspections. In addition, the Director expects that research into the status of credits for returned drugs will completed by November 28, 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Community Residential Care Program – Program Areas Needed Improving

Conditions Needing Improvement. Community Residential Care (CRC) program supervisors needed to ensure that residential care facility employees were not also employed by the medical center. Veterans Benefits Administration (VBA) field examiners and medical center clinicians needed to meet once a year to evaluate if CRC patients who had fiduciaries were receiving sufficient funds from their fiduciaries. The CRC program is for patients who do not require hospitalization or nursing home care but need to live in supervised settings. We reviewed program policies, files for each CRC facility, and the medical records of 10 CRC residents. We also interviewed program supervisors and visited two CRC facilities.

CRC Employee Status. Because of potential conflicts of interest, VA policy prohibits medical center employees from being CRC facility operators or providers. Program files did not show that supervisors had verified that CRC facility employees were not also employed by the medical center.

VBA and Medical Center Annual Reviews. VA regulations require that VBA field examiners and medical center clinicians communicate annually to assess if VA funds paid to CRC residents with fiduciaries are used to meet patient needs. A review of 10 medical records of CRC residents showed that 9 had fiduciaries, but their medical records did not show that VBA field examiners and clinicians had determined if their needs were being met.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the medical center Director requires:

(a) Verification that CRC facility employees are not also employed by the medical center.
(b) Annual assessments by clinicians and VBA field examiners to determine if patients who have fiduciaries are receiving the care they need.

The VISN Director agreed and reported that, in October 2003, medical center staff had completed a review of all existing CRC owners and providers to ensure that they were not also medical center employees and that a process had been established to obtain and review new CRC owners and providers for the same purpose. In addition, in October 2003, a log was created to monitor annual assessments by clinicians and VBA field examiners. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Medical Care Collections Fund – Follow-Up on Insurance Receivables Needed To Be Strengthened and Billing Delays Reduced

Conditions Needing Improvement. Medical Care Collections Fund (MCCF) staff verified patient insurance, identified billable episodes of care, and billed appropriate amounts. The collection rate for insurance receivables exceeded VHA's goal for the third quarter of FY 2003. Improvement was needed in following up on outstanding insurance receivables, avoiding establishing invalid bills, and promptly establishing receivables.

Follow-up on Outstanding Insurance Receivables. Follow-up on outstanding insurance receivables could be improved. The VISN 12 Customer Service Collection Center (CSCC) was responsible for VISN-wide collection of MCCF receivables including those for VA Medical Center Tomah. As of July 25, 2003, the medical center had 7,694 outstanding insurance receivables valued at approximately $1.2 million, excluding those referred to the VA Regional Counsel. Of those, 2,409 were more than 90 days old (31 percent valued at $404,653).

We evaluated collection potential for MCCF receivables by reviewing 30 insurance bills (valued at $16,651) that were outstanding for more than 90 days. Of the 25 valid insurance receivables in our judgmental sample (valued at $14,965), 8 required more aggressive follow-up (32 percent, valued at $1,812). CSCC staff had not followed up at all on three receivables, beyond the first 90 days, and had not followed up on five others since December 2002. CSCC management agreed that more aggressive follow-up could increase the collection rate by as much as 25 percent. This would provide the medical center with estimated additional revenue of $3,741 (25 percent of $14,965) for the 25 tested receivables or a total of $101,616 (25 percent of the $406,465 in insurance receivables more than 90 days old).

Invalid Bills. Some MCCF insurance billings for outpatient care were not valid. Five of the 30 insurance receivables we reviewed (17 percent, valued at $1,686) should not have been billed. Four were invalid because the veterans' health insurance did not cover the care provided, and one was invalid because the care was for a service-connected condition. Invalid billings waste staff resources and overstate the value of receivables.

Billing Delays. There was a backlog of unbilled outpatient cases. As of June 30, 2003, the medical center had 1,177 unbilled outpatient episodes of care (valued at $247,520). During the third quarter of FY 2003, medical center staff took an average of 59 days to initiate a bill, compared to an average of 37 days for the same period in FY 2002. According to the billing supervisor, this occurred because the training of new staff had contributed to decreased productivity that caused delays in medical record coding. Since June 30, 2003, timeliness had improved. As of August 7, 2003, the oldest unbilled episode of care was 44 days old. The supervisor informed us that as newer staff became more proficient, the coding and billing backlog would be further reduced.

Recommended Improvement Action 6. We recommend that the VISN Director take action to:

(a) Pursue MCCF receivables more aggressively by following up with insurance companies more frequently.

(b) Require the medical center Director to reduce the number of invalid insurance bills.
(c) Require the medical center Director to continue reducing the backlog of unprocessed insurance bills.

The VISN Director agreed and reported that as of October 14, 2003, formulation of a VISN-wide policy addressing all revenue generation functions was underway. The policy will address issues raised in this report. The Director expects the policy to be approved and implemented by December 31, 2003. The implementation actions are acceptable, and we will follow up on the completion of planned actions.

Information Technology Security – Certain Security Controls Needed to Be Improved.

Conditions Needing Improvement. Information technology (IT) security controls were adequate in the areas of security awareness training, risk assessment, virus protection, password controls, backup and recovery of essential data, and computer room security. The medical center had an adequate overall security plan, and its staff had identified and requested the type of background investigations that matched the sensitivity designations assigned to key staff positions. However, there were three areas where management could enhance IT security.

Access to Information Systems. Medical center procedures for terminating access to its Veterans Health Information Systems and Technology Architecture (VISTA) system worked as intended for medical center employees. However, procedures were not sufficient to terminate access for contract and VBA employees who no longer needed it. Working with the Information Security Officer (ISO), we identified 11 former contract employees and 1 VBA employee who no longer needed access to the medical center's VISTA system. The ISO immediately terminated VISTA access for these 12 individuals. Procedures should be established to identify non-medical center employees who no longer require VISTA access and to terminate their access.

Alternate Data Processing Site. The medical center's alternate data processing site was located too close to the main data processing site. An alternate processing site is a location where a facility can shift its computer operations if a disaster causes the main location to become inoperable. The medical center's main processing site was located in a building immediately adjacent to the building that housed the alternate processing site. While the two sites were in two different buildings, their proximity exposed both to the effects of the same potential disaster. Medical center management should conduct a cost benefit analysis to determine if the backup processing site should be moved to a more distant location.

Contingency Plans. The medical center's contingency plans for its VISTA system and local area network were generally adequate. However, the plans listed only business working hour phone numbers for key staff and did not identify the location of the backup data storage site. The ISO needed to revise the plans to include night, weekend, and holiday contact information and to identify the location of backup storage. The ISO made these revisions to the contingency plans during our review, but should continue to update the contingency plans whenever changes occur.

Suggested Improvement Action. We suggest that the VISN Director ensure that the medical center Director take action to:

(a) Establish procedures to identify non-medical center employees who no longer require VISTA access and to terminate their access.
(b) Evaluate the cost-effectiveness of relocating the alternate data processing site to a more distant location from the main computer processing location.
(c) Update contingency plans when changes occur.

The VISN Director agreed and reported that the medical center ISO had begun monthly reviews of inactive users to determine if VISTA access needed to be terminated. Medical center management has also begun plans to relocate the alternate data processing site from Building 32 to Building 408, approximately 1/3 of a mile away. The Director also reported that the ISO will review and update contingency plans when and if changes are needed. The implementation actions are acceptable.

Contracting – Contract File Documentation Needed to Be Improved

Conditions Needing Improvement. VISN 12 Great Lakes Acquisition Center (GLAC) staff needed to improve contract file documentation. GLAC staff provide contracting support for the VA Medical Center Tomah. To determine if GLAC staff complied with Federal Acquisition Regulations (FAR) in soliciting and awarding contracts on behalf of the medical center, we reviewed 10 medical center service contracts with an estimated total annual value of $8 million.

Contract File Documentation. The FAR requires that contracting files contain complete records of contracting actions and price negotiations. Three contracts valued at $1.5 million lacked some required documentation. One contract did not contain a record of price negotiations. Another lacked documented justification for an award to a sole source provider. One contract lacked evidence that a required technical review had been conducted. (A technical review is an evaluation by knowledgeable persons of the judgmental elements of a contract proposal that may include reviews of the proposed type and quantity of material, labor, processes, and other factors.)

Contract Award Decision. GLAC staff did not fully document the rationale for awarding a $4.9 million contract to operate a CBOC. The GLAC received four offers to provide CBOC services in Wausau, WI. Medical center representatives evaluated the offers using a scoring process that took into account price, past performance, and technical specifications, and GLAC staff awarded the contract based on this process. However, the scoring process and its result were not referenced in the contract's Price Negotiation Memorandum, as required by the FAR. Rather, the rationale used to justify the award compared the Government's pre-award cost estimate with the offeror's price without reference to comparisons with the other three offers. This was misleading, because the contract was awarded to the vendor with the highest offer. An explanation of the scoring process, which included price as a factor, was important and needed to be included in the rationale for the award.

Suggested Improvement Action. We suggest that the VISN Director ensure GLAC management take action to:

(a) Include required documents in contract files.
(b) Document the rationale for awarding contracts in Price Negotiations Memorandums.

The VISN Director agreed and reported that a QA program for contracting activities at the GLAC was established and implemented on October 1, 2003. The QA process includes mandatory pre-award reviews of sole source procurements exceeding $1 million and all mandatory procurements, and quarterly random reviews of remaining procurements. In addition, under this new policy, Price Negotiation Memorandums will be approved or disapproved before award. The implementation actions are acceptable.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
4d	Pharmacy Service staff need to ensure the medical center receives credits for previously returned drugs.	$ 9,100
6a	Pursuing MCCF accounts receivable more aggressively could improve collections by as much as 25 percent.	101,616
	Total	$110,716

Appendix B

VISN 12 Director Comments

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: October 14, 2003

From: Medical Center Director (00/676)

Subj: Response/Action Plan to IG CAP Report

To: Assistant Inspector General for Auditing (52)
Thru: Management Review Service (10B5)

1. I have thoroughly reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the Tomah Veterans Affairs Medical Center. I concur with the findings and have provided action plans for resolution of each finding.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

(original signed by:)

Joan E. Cummings, M.D.

Attachments

Appendix B

1. Patient Transportation Services

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the medical center Director requires that:		
A. Motor vehicle operators are screened for valid drivers licenses and safe driving records, and receive health examinations. B. Volunteers and others who transport patients receive annual safe driver training.	A. and B. 1. Develop a tracking log for: (a) MVO (b) Other employees (c) Voluntary Services INCLUDE: (a) Name (b) License Verification (c) Verification of driving record (d) Annual physical – employees (e) Physical every 4 years – volunteers (f) Proof of annual safe driving training (g) Volunteer drivers need to be screened. (h) Volunteer drivers need to have proof of insurance. 2. Instituted agreement with State of Wisconsin, DMV, for violations. 3. Edit Medical Center Memorandum FS-10 to reflect requirements.	1. 12/1/03 2. Completed 9/1/03 3. 12/1/03

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2. Environment of Care

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the medical center Director requires that:		
A. Cleaning products and sharp instruments are secured.	A. 1. A memo was generated to staff to secure areas and keep instruments secure in exam rooms. 2. Security of cleaning products and instruments will be checked during monthly environmental rounds performed by Nurse Managers and Zone Engineers.	A. 1. Completed 8/03 2. Beginning with October 2003 EOC rounds
B. Safety and maintenance issues in N&FS are corrected.	B. 1. Engineering checked – wires are temperature monitors, needed to monitor and record internal temperature of refrigeration unit. 2. An ice spot was found on the floor of the vegetable freezer. This was removed. Area is included in monthly Safety inspection as well as regularly scheduled EOC rounds. Employee working in the area is aware of the potential problem and monitors daily. 3. Dime size spot found of fresh mildew found on freezer door frame during inspection and was removed during the inspection. All areas are checked during monthly Safety inspections as well as regularly scheduled EOC rounds.	B. 1. Completed 8/15/03 2. Completed 8/8/03 and ongoing 3. Completed 8/8/03 and ongoing
C. Safety issues in VCS are corrected.	C. 1. Move sprinkler head for 18" clearance. WO# WO030813-006 2. Change lights to recess lighting. WO# WO030813-012 3. New Eyewash station. WO# WO030806-034 4. Fire Extinguisher moved from north wall to south wall free of all equipment.	C. 1. December 10, 2003 2. November 7, 2003 3. November 7, 2003 4. Completed 08/08/03
D. VCS employees adhere to infection control policies.	D. 1. Met with all employees and went over Infectious Control practices. 2. Sent Memo to all VCS Employees and mandated that hair net will cover all hair and gloves will be worn in food prep/serving areas.	D. Completed 8/27/03 & memo 10/08/03 ongoing

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	3. VCS Management will be walking through the areas to insure proper practice is being used weekly.	
E. MSDSs are current.	E. Contact companies for updated MSDS Sheets. Train all Employees on MSDS Sheets and review yearly.	E. Completed 8/27/03
F. Defective equipment in SPD is repaired	F. Order for replacement trays/ containers placed on 8/12/03. Cracked trays replaced 8/14/03. SPD and Biomed informed that in the future cracked/leaking trays cannot be glued or repaired and must be replaced with new tray/container.	F. 8/14/04 trays received and replaced

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3. Quality Management Program

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the medical center Director requires that:		
A. UM data is analyzed for trends and reported to medical center management.	A. 1. Beginning with October, FY 04 data collection, tracking and trending will be implemented using the Access data report system. 2. Data will be tracked, trended and reported monthly to: a) Individual providers b) Management via Performance Improvement Council c) VISN 12 Utilization Management Service Line Manager	A 1. Ongoing 2. Ongoing beginning with October FY 04
B. Criteria is established to measure patient care improvement actions.	B. 1. The Patient Safety Nurse and the Risk Manager retrospectively reviewed FY 02-03 RCAs. 2. Future RCA goals will be evaluated by the PI team for measurable goals prior to the Medical Director's approval of the completed RCA.	B. 1. Completed 9/24/03 2. Ongoing
C. Peer reviewers use the practitioner quality of care scale.	C. 1) Medical Center Memorandum has been changed to reflect use of the Quality of Care Peer review form recommended by the inspector. 2) Quality of Care form was put into use for all peer reviews in this facility.	C. 1) MCM 11-2 in approval process, 11/14/03 2) Completed 8/20/03

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4. Controlled Substances Accountability

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the medical center Director takes action to:		
A. Have mail-out controlled substances picked up at the pharmacy by parcel delivery companies.	A. 1. Change to FedEx pick up at Pharmacy for all controlled substances. We will evaluate a lease of equipment versus purchase of metering equipment (PC, printer and scale). 2. Drugs to remain locked in Pharmacy until picked up by FedEx. 3. Two pick-up times in Bldg. 400: 10 a.m. and 2 p.m. 4. Local Post Office will not pick-up onsite without an additional charge as the VAMC is a rural route.	A. 30 days to evaluate. 90 days to purchase and install.
B. Include controlled substances stored in ward refrigerators in shift-change counts of controlled substances.	B. 1. Message to all Nurse Managers. 2. Nurse Managers to run activity report in controlled substance package daily, matching balances and reviewing discrepancies and/or patterns. 3. Any discrepancies or patterns are followed up on immediately and tracked and trended through PPC monthly by the Nurse Manger.	B. Completed October 7, 2003
C. Establish more random timing of monthly controlled substances inspections.	C. 1. Inspection was held September 8, 2003 2. Controlled Substance Security Officer (CSSO) sends notification message to inspectors earlier to schedule inspection. 3. Made inspectors aware of need for randomized inspections.	C. Began in September with CSSO encouraging randomizing dates.
D. Research the status of credits due for the return of drugs to vendors prior to June 2003.	D. Effective June 03 process identified to assure credits are received for drug returns through Returns Drug Contractor. For May 02 and January 03 returns cycle: Will contact manufacturer of drugs returned or Pharmaceutical Prime Vendor to request documentation that applicable credits were received for the estimated value of outdated drugs returned	D. November 28, 2003

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5. Community Residential Care Program

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director ensure that the medical center Director requires:		
A. Verification that CRC facility owner/provider are not also employed by the medical center. B. Annual assessments by clinicians and field examiners to determine if patients who have fiduciaries are receiving the care they need.	A .& B. 1. Current informal process will be formalized. Obtain employee/provider CR home list and give to Payroll. Payroll will verify the CR home owner/providers are not also VA employees. 2. New CR home employees will be verified upon hire that they are not VA employees. 3. Social Workers routinely assess whether patient's financial needs are being met and have regular personal communication with VBA field representatives. This occurs annually or more frequently as needed. A log will be kept to monitor that this is assessed annually. If issues arise, the Social worker communicates with the Field rep or VBA examiners and it is documented in the patient record.	A. & B. Completed 1. Completed 10/8/03, there are no CR home owner/providers who are also employed at this facility. 2. Additionally verified that all CR home employees are not employed by Tomah VAMC 10/8/03. 3. Ongoing beginning 10/7/03.

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6. Medical Care Collections Fund

Subject	Corrective Actions	Target Completion Date
We recommend that the VISN Director take action to		
A. Pursue MCCF receivables more aggressively by following up with insurance companies more frequently. B. Require the Medical Center Director to reduce the number of invalid insurance bills. C. Require the Medical Center Director to continue reducing the backlog of unprocessed insurance bills.	A new VISN policy to address the all revenue generation functions has been drafted by Patient Financial Services. It has been reviewed internally and is now being review and edited by all appropriate areas i.e. Patient Administration, Health Information Management, and Compliance. The policy will be presented to the December Executive Leadership Council at the December ELC meeting for final approval. The policy includes information specific to follow-up procedures in place for outstanding 3rd party insurance bills and time intervals.	12/31/03

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7. Information Technology Security

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure that the medical center Director take action to:		
A. Establish procedures to identify non-medical center employees who no longer require VISTA access and to terminate their access.	A. The Information Security Officer (ISO) will review monthly, all users who have been DI-USERed (inactivated) in the VISTA database and determine if they need to be terminated.	A. Complete and ongoing
B. Evaluate the cost-effectiveness of relocating the alternate data processing site to a more distant location from the main computer processing location.	B. A cost benefit analysis for possible relocation of the alternate data processing site to Bldg. 408 (approximately 1/3 mile from its present location in Bldg 32) will be conducted. If the analysis shows that relocation costs are reasonable, the site will be moved as soon as sufficient funds are available.	B. 12/31/03
C. Update contingency plans when changes occur.	C. The Information Security Officer (ISO) currently reviews the contingency plan annually, but will also monitor and update the plan if and when changes are needed.	C. Complete and ongoing

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8. Contracting

Subject	Corrective Actions	Target Completion Date
We suggest that the VISN Director ensure GLAC management takes action to		
A. Include required documents in contract files. B. Document the rationale for awarding contracts in Price Negotiation Memorandums.	A. & B. 1. A Quality Assurance (QA) program has been established and implemented, effective October 1, 2003. 2. A QA team was formed to include; GLAC Management Assistant, Program Analyst and Small Purchase Center Supervisor. 3. An interim supervisory ' pre-award' QA review is **mandatory** for sole source procurements exceeding $1,000,000 and awarding to other than the lowest priced offeror/bidder when the procurement exceeds $100,000. Specifically, the Contracting Officer Supervisor will be approving/disapproving Contracting Officers Price Negotiation Memorandum **prior** to award. 4. The QA team will conduct contract reviews on all mandatory procurements subject to an interim supervisory review as well as contracts selected for a quarterly random random review. 5. QA review findings will be incorporated into a GLAC performance measure and reported quarterly to the VISN 12 Finance Council.	A. & B. Completed

Appendix C

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