Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center St. Louis, Missouri

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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.
- 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.

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 period August 9–17, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center St. Louis, MO. 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 284 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 15.

Results of Review

The CAP review covered 13 areas. The following organizational strength was brought to our attention by medical center management:

- Telehealth outpatient substance abuse treatment services were effective.

We identified 13 areas that needed additional management attention. To improve operations, the following recommendations were made:

- Improve controls over controlled substances and complete inspections.
- Improve inventory management and reduce excess inventory.
- Improve controls over patient waiting times.
- Improve information technology (IT) security.
- Strengthen collections and billings for the Medical Care Collections Fund (MCCF).
- Complete training requirements and revise policy for cardiopulmonary resuscitation (CPR).
- Correct safety and environmental deficiencies.
- Strengthen controls over part-time physician time and attendance.
- Comply with the Veterans Health Administration's (VHA's) Patient Safety Alert for the bulk oxygen utility system.
- Strengthen QM leadership, peer reviews, and credentialing and privileging (C&P).
- Strengthen Supply Processing and Distribution (SPD) controls for infection and environment.
- Improve contract administration and documentation.
- Collect duplicate fee basis payments.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Mark Collins, Audit Manager, Chicago Audit Operations Division.

VISN 15 and VA Medical Center Director Comments

The VISN 15 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 23-41, 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

Medical Center Profile

Organization. VA Medical Center (VAMC) St. Louis is a two-division, tertiary care medical center. The John Cochran Division is located in downtown St. Louis, and the Jefferson Barracks Division is located in south St. Louis County. VAMC St. Louis also has community-based outpatient clinics (CBOCs) located in St. Charles, MO; Belleville, IL; and at the Missouri State Veteran's Home in north St. Louis. Additional CBOCs are jointly operated with other VA medical facilities in Effingham and Springfield, IL.

Programs. With 116 acute care beds, the John Cochran Division provides acute medical and surgical programs and a wide range of specialty care**,** including hematology-oncology, cardiology, and hemodialysis. The Jefferson Barracks Division provides primary care and has 102 acute beds (70 psychiatry and 32 spinal cord), a 50-bed domiciliary, and a 71-bed nursing home.

Affiliations and Research. The medical center has affiliations with the St. Louis University and Washington University Schools of Medicine. It supports 115 medical residents. An affiliation with the University of Missouri-St. Louis School of Optometry provides educational experiences for 12 students annually.

In fiscal year (FY) 2003, the medical center's Research Service reported expenditures of approximately $4 million in support of basic biomedical, clinical, and health services research. As of June 30, 2004, the medical center had eight VA-funded basic biomedical research programs and four VA cooperative studies. In total, 51 principal investigators directed 100 active projects.

Resources. The medical center's operating budget for FY 2003 was approximately $235 million, and for FY 2004 was approximately $240 million. Staffing for FY 2003 was 1,840 full-time equivalent employees (FTE). Staffing for FY 2004 was 1,866 FTE, including 121 physician FTE and 595 nursing FTE.

Workload. VAMC St. Louis treated 47,400 unique patients in FY 2002 and 50,781 unique patients in FY 2003. Inpatient workload totaled 8,470 admissions in FY 2003. In FY 2003, the average daily census was 151 for the medical center and 64 for the nursing home. Outpatient workload totaled 406,266 visits for FY 2002 and 447,290 visits for FY 2003.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services. On February 12, 2004, the Commission on Capital Asset Realignment for Enhanced Services issued a report to the Secretary of Veterans Affairs making its recommendations for the improvement or replacement of VA medical facilities. The Secretary published his decisions relative to the commission's

recommendations in May 2004. As a result of the Secretary's decisions, VISN 15 has seven new CBOCs targeted for priority implementation by 2012. The medical center will provide oversight of the CBOC planned in Sullivan, MO.

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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information health care facilities use to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 13 activities:

Bulk Oxygen Utility System	Moderate Sedation
Contracting	Part-Time Physician Time and Attendance
Controlled Substances Accountability	Patient Waiting List
Environment of Care	Quality Management
Fee Basis Payments	Supply Inventory Management
Information Technology Security	Supply Processing and Distribution
Medical Care Collections Fund	

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all medical center employees who had Internet access, and 336 employees responded. We also interviewed 30 patients during the review. Significant issues identified through the employee and patient surveys were discussed with medical center management.

During the review, we also presented five fraud and integrity awareness training sessions for the medical center's employees. A total of 284 employees attended these sessions, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered facility operations for FYs 2003 and 2004 through June 30, 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strength

Telehealth Outpatient Substance Abuse Treatment Services Were Effective. Medical center managers brought this initiative to our attention. The medical center's Substance Abuse Treatment Program (SATP), located at the Jefferson Barracks Division, is an intensive 14-day, group-based outpatient treatment program with a 25-bed lodger unit. Although the John J. Pershing VA Medical Center (JJPVAMC) in Poplar Bluff, MO had appropriate patients for the program, it was not feasible to have those patients treated at the Jefferson Barracks Division. Employees decided to use videoconferencing to allow JJPVAMC patients access to the SATP group treatment program.

Tele-SATP was implemented in June 2004 and the first 2 months of operation yielded 202 Tele-SATP patient contacts. Case management is performed at JJPVAMC using local resources, and treatment plans are co-signed by VAMC St. Louis treatment managers. A weekly schedule of anticipated group therapy session content is sent to JJPVAMC employees and about 20 hours of programming is provided each week. JJPVAMC generally has one to three patients attending each group therapy session. SATP employees noted that group members from both sites actively participate in the discussions and patient feedback regarding the group therapy sessions has been positive.

Opportunities for Improvement

Controlled Substances Accountability — Controls Needed To Be Strengthened and Inspections Completed

Condition Needing Improvement. VHA policy requires Pharmacy Service staff to maintain accountability of all controlled substances. Our assessment of pharmacy controls, inspection procedures, and security identified six deficiencies that needed improvement.

Reported Discrepancies. From July 2003 to June 2004, VA Police investigated 15 reported incidents of missing controlled substances. Management did not implement controls to reduce continued discrepancies identified in the monthly controlled substances inspection reports and did not report missing controlled substances to the VA OIG Office of Investigations as required.

- Eleven of the 15 VA Police reports referred to controlled substances missing from the pharmacy vault and wards during monthly controlled substances inspections. The Pharmacy Service Manager adjusted the counts to agree with inventory records, and no further actions were taken. When there are suspicious, recurring shortages of controlled substances, VHA policy requires the medical facility Director to immediately report the shortages to the VA OIG Office of Investigations.

- Three of the 15 VA Police reports pertained to controlled substances mailed via Federal Express to patients who subsequently reported that they had not received the drugs. In two instances, the Federal Express tracking numbers confirmed that the hydrocodone was delivered to the veterans' residences. However, according to the VA Police reports, the veterans stated that the Federal Express packages were stolen from their mailboxes. Both veterans were advised to report the incidents to the local sheriff's department. In the third instance, the veteran reported receiving his morphine tablets in sealed containers that did not appear to have been tampered with. However, upon opening the Federal Express package, he discovered that 10 tablets were missing. VA Police advised him to file a complaint with the Patient Affairs Representative and the Pharmacy Manager.

- One of the 15 VA Police reports referred to a discrepancy in the count for a bottle of chlordiazepoxide awaiting destruction. The inventory records showed the bottle contained 100 tablets. The pharmacist assumed the bottle was full, but discovered at the time of the destruction that it contained only 65 tablets. The inventory records were later adjusted to reflect 65 tablets.

The following chart shows the 15 reported discrepancies by type of controlled substance and the quantity missing.

VA Police Reports on Missing Controlled Substances

	Location	Controlled Substance	Quantity Missing
1	Veteran's Residence	Hydrocodone 500 mg	120 tablets
2	Ward 6	Morphine 2mg	1 injectable
3	Veteran's Residence	Morphine 200 mg	10 tablets
4	Ward 7 South	Roxanol Morphine	3 ml
5	Inpatient Pharmacy	Tylenol #3	4 tablets
6	Main Pharmacy	Hydrocodone 500 mg	1200 tablets
7	Pharmacy Destruction	Chlordiazepoxide 25mg	35 tablets
8	Ward 7 South	Lorizipam 2mg injectable	1 injectable
9	Ward 6 North	Percocet and Tylenol #3	8 tablets
10	Veteran's Residence	Hydrocodone 500mg	90 tablets
11	Inpatient Pharmacy	Vicodin 500mg	30 tablets
12	Ward 53S2	Percocet 5mg	16 tablets
13	Pharmacy Vault	Vicodin 500mg	7 tablets
14	Surgical Intensive Care Unit	Tylenol #3	2 tablets
15	Ward 7 South	Morphine 15 mg	1 tablet

Expired Controlled Substances. VHA policy requires that all excess, outdated, and unusable controlled substances be returned to the pharmacy for proper disposal. An OIG-observed inspection on August 9, 2004, found 10 expired controlled substances that had not been returned to the pharmacy for destruction. From April 2003 through July 2004, controlled substances inspectors reported 25 incidents of expired drugs on the wards and in the pharmacy vault. Nursing Service staff stated that they made repeated calls to the pharmacy, but none of the expired drugs were picked up. According to inspection reports, one of the expired drugs (Versed) was returned to the pharmacy for destruction. However, there was no evidence that it had been destroyed.

Inventory Accuracy. VHA policy requires medical facilities to conduct monthly unannounced inspections to properly account for controlled substances. The OIG-observed inspection revealed that a Schedule III controlled substance was listed twice in the inventory records, causing us to question the integrity of the inventory. According to the Pharmacy Service Manager, the drug was recorded twice: once as a Schedule III controlled substance and then incorrectly as a Schedule II controlled substance.

Receipt of Controlled Substances. VHA policy requires VA staff to verify the count of controlled substances received from the Prime Vendor or other distributors before signing for the deliveries. In November 2003, a pharmacist accepted and signed for a delivery of hydrocodone. The invoice showed the shipment included six boxes of hydrocodone. However, Pharmacy Service staff only accounted for five boxes after the delivery driver had left. A VA Police investigation discovered that pharmacy staff had not verified the delivery count before signing for delivery of the five boxes.

Improper Destruction. VHA policy requires the appropriate disposition of outdated and surplus controlled substances in accordance with the Drug Enforcement Administration

procedures. Nurse managers and other patient care managers are responsible for identifying all unusable or expired controlled substances and requesting pharmacy staff to collect them for destruction. The "Controlled Substances Inspection Report" for October 2003 showed six controlled substances had expired, and some were inappropriately destroyed on the ward. The quantities were not indicated on the destruction report, and we are not certain how many controlled substances the ward nurse destroyed. According to the Chief, VA Police, their investigation was unable to determine if the controlled substances were diverted. Subsequently, the Chief, Pharmacy Service verbally instructed Pharmacy Service and Nursing Service staff not to destroy controlled substances on the wards.

Incomplete Inspections. According to the Controlled Substances Coordinator (CSC), inspectors were notified at the end of each month of the upcoming required inspections. From August 2003 to July 2004, 7 (58 percent) of 12 monthly unannounced inspections did not include all areas containing controlled substances. The CSC stated this occurred because some inspectors did not inspect all areas assigned to them.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) implement controls to investigate, report to the VA OIG Office of Investigations, reconcile, and reduce controlled substances discrepancies; (b) remove expired controlled substances from the pharmacy vault and wards; (c) ensure controlled substances are properly recorded and inventoried; (d) ensure delivery counts are verified before signing for them; (e) ensure drugs requiring destruction are returned to the pharmacy; and (f) ensure inspectors include all areas containing controlled substances in the monthly unannounced inspections.

The VISN Director agreed with the findings and recommendations and reported that medical center policy has been modified to include reporting to the OIG Office of Investigations each controlled substance discrepancy upon completion of the medical center's internal investigation. Pharmacy Service has implemented the PYXIS[1] automated drug dispensing system to increase control over controlled substances. With this system, discrepancy reports are immediately generated. Pharmacy Service surveyed all areas with controlled substances and initiated a monthly review of all inventories for removal of outdated controlled substances. Pharmacy Service staff will also run PYXIS reports to identify drugs with upcoming expiration dates. The medical center has counseled the employee who improperly accounted for a controlled substances delivery and has discontinued the practice of receiving controlled substances in multiple delivery containers. The listing of a substance in the pharmacy inventory as both a Schedule II and Schedule III narcotic has been corrected. Additional inspectors have been selected and trained to ensure that all areas with controlled substances are included in the monthly

[1] The PYXIS Medstation is a computerized storage and dispensing device used for dispensing medication.

inspections. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management — Inventory Management Needed To Be Improved and Excess Inventory Reduced

Condition Needing Improvement. VHA policy requires medical facilities to establish stock levels that do not exceed 30-days stock on hand. Medical facilities are required to use the Generic Inventory Package (GIP) for most types of supplies. Inventory managers can use GIP to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and help conduct physical inventories.

Medical center staff used GIP to manage medical supplies and the Prosthetics Inventory Package (PIP) to manage prosthetics supplies. To determine the accuracy of the quantities and values of supplies reported in the two systems and to test the reasonableness of inventory levels, we reviewed inventory data and judgment samples of 20 line items recorded in GIP and 10 line items recorded in PIP.

Reported Stock. There were no inaccuracies in our PIP sample. However, information recorded in GIP did not accurately reflect supply levels on hand for medical supplies. There were inaccuracies ranging from 1 to 1,880 items for 15 of the 20 sampled line items. For 10 line items, GIP recorded levels were 1,926 items over the physical counts, and for 5 line items, GIP recorded levels were 41 items under the physical counts. According to inventory managers, staff returning or taking items and not adjusting the GIP inventory records caused the inaccuracies. Inaccuracies in inventory data can lead to unexpected shortages of needed supplies or premature purchases.

Use of GIP. Medical center staff had not implemented GIP to manage engineering supplies. Implementation of GIP for engineering supplies was scheduled for August 31, 2004. The Engineering Program Manager stated that the implementation deadline had been extended to February 2005, but did not provide documentation to support his statement. There was no inventory system, either automated or manual, to account for engineering supplies. Engineering Service staff relied on their judgment and experience to determine the type and quantity of supplies to order. VHA policy requires an annual wall-to-wall inventory, but Engineering Service staff had not conducted an annual inventory for engineering supplies and could not recall when the last inventory had been conducted.

Excess Inventory. Medical center staff needed to monitor supply usage rates and adjust stock levels to achieve 30-day stock levels. As of August 10, 2004, the "Days of Stock on Hand Report" showed 1,107 medical supply line items valued at $172,570 were in excess of 30 days. However, because of inaccuracies found in our sample, these figures may not be reliable. The report also showed that there were 164 prosthetics line items valued at $58,373 in excess of 30 days. Excess supply inventories make funds

unavailable that could be put to other uses. Medical center staff stated that some excess inventory was due to items being packaged in greater amounts than needed, while some ordered items were in greater amounts due to the lag time between the ordering and receiving dates.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) improve the accuracy of GIP by ensuring that transactions are correctly recorded into the system and that recorded levels are accurate, (b) implement GIP for engineering supplies and conduct annual wall-to-wall inventories, and (c) reduce excess inventory levels to a 30-day supply.

The VISN Director agreed with the findings and recommendations and reported that the medical center has implemented new receiving report procedures, a complete inventory has been scheduled, staff has received additional training on using GIP, and stock is now posted by inventory managers instead of supply technicians. A GIP primary inventory point consisting of 390 engineering items was completed, and more items are being added as they are identified. All engineering items are now inventoried monthly. The VISN Logistics Department is in the process of identifying and removing inactive items and items with excess supplies. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Patient Waiting Times — Management Controls Needed To Be Improved

Condition Needing Improvement. Medical center schedulers were not scheduling appointments within 30 days of the desired appointment dates for new patients and consultations. VHA policy states that new enrollees requesting an appointment will be scheduled for an initial evaluation and assignment to a Primary Care Panel within 30 days of application. The policy also states that patients will be able to schedule follow-up appointments within 30 days of the desired date, and that patients will have appointments scheduled with a specialist (consultations) within 30 days of the desired date. In addition, appointments for established patients must be scheduled within 30 days of the clinically appropriate appointment date. If an appointment cannot be scheduled within the 30-day time frame, the patient can be treated at another VA medical facility, on a fee basis, or under a sharing agreement. The medical center's scheduling system was deficient in two areas that require management's attention.

Next Available Appointments. Medical center schedulers did not schedule the next available appointments correctly. VHA policy defines a next available appointment as an over-book (no available appointment for the desired date), a new patient appointment, or a consultation (excluding follow-up). Through observations and interviews we found that 53 of the 62 schedulers were trained to not use "the next available appointment option" in the Veterans Health Information Systems and Technology Architecture (VistA) scheduling module. Instead of using the patient's actual desired date, staff used a date

that was within 30 days of an appointment opening in order to appear to meet VA's 30-day performance standard. The scheduling records for nine new patients and five patient consultations erroneously showed that patients received appointments within 30 days of the desired appointment dates, instead of the actual 42 to 143 days.

Training. Medical center schedulers needed training on the proper use of the VistA scheduling module. Schedulers had no formal training other than on-the-job training. For primary care, the Chief of Staff provided scheduling guidance, but non-primary care schedulers learned their duties by trial and error and from other schedulers.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director: (a) implements local scheduling procedures that comply with VHA policy, and (b) develops a training program for schedulers.

The VISN Director agreed with the findings and recommendations and reported that local procedures have been established to comply with the VHA policy for scheduling outpatient appointments. A training program has been established for all clerical and clinical staff who schedule appointments. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Information Technology Security — Security Controls Needed To Be Improved

Condition Needing Improvement. We reviewed IT security to determine if controls adequately protected automated information system (AIS) resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security of the computer room and backup, recovery, and storage of critical data were adequate, and an uninterrupted power supply supported the AIS. However, we identified six issues that required management attention.

Background Investigations. Three employees who held high-risk positions did not have appropriate security clearances for their positions. These employees included a Nuclear Medicine employee with programmer privileges, the Chief of Staff, and the Chief, VA Police. High-risk positions involve duties that are critical to VA. VHA and local policies require appropriate security clearances for specific positions based on the sensitivity and importance of information used by staff in those positions. Security clearances require background investigations. The type of investigation should match the sensitivity designation assigned to the position. For high-risk positions, a full background investigation covering a 10-year period is required and should be renewed every 5 years.

Position Description Security Clause. VHA and local policy require that all high-risk position descriptions include an information security clause. Position descriptions for 20 (87 percent) of 23 Information Resource Management (IRM) employees did not contain the required security clause. The clause describes the security responsibilities associated

with the position. The Information Security Management Plan designated IRM positions (excluding clerical) as high-risk.

Contingency Plans. The contingency plans for telecommunications and the local area network (LAN) had not been updated to include recent changes and did not designate an alternate processing site. VHA policy requires contingency plans to be tested and reviewed annually. IRM staff last updated the telecommunication contingency plan on April 18, 2003, and the LAN contingency plan on March 19, 2002. The VistA contingency plan did not have the home telephone numbers of key personnel. VHA policy states that the contingency plans need to be documented, updated, and copies stored at the alternate processing site.

System Access. IRM staff did not remove user access and privileges as required by VHA and local policies for 15 former employees and 3 contractors who held programmer privileges. The 15 former employees had been separated from the medical center from 49 to 215 days. The programmer privileges logs showed that the accounts of two contractors had been inactive for more than 7 months. The third contractor had access even though his contract had expired. During our review, the Information Security Officer removed user access and privileges of the three contractors. VHA and local policies require timely review of user access and privileges every 90 days. In addition, the policies require that a process be established to immediately remove access and privileges when the need for the access ends (e.g., transfer, resignation, retirement, termination, or change of job).

Annual Security Training. The "FY 2003 Training History Summary" report showed that 559 (25 percent) of the 2,210 medical center employees had not completed their annual security training. As of August 16, 2004, 1373 (62 percent) of the 2,210 employees had not completed the training for FY 2004. VA, VHA, and local policies require that each employee complete annual security training.

Communication Closets. Communication closets were not adequately secured. There were security problems with 10 (29 percent) of the 34 communication closets. To comply with Federal physical access controls, closets must be inconspicuous with the interiors concealed. The entranceways to three communication closets were equipped with doors with Plexiglas windows. Communication equipment was visible and vulnerable to unauthorized access. In addition, another communication closet had a solid door, but security was compromised by a separate Plexiglas window. Communication equipment in one closet was located underneath leaking water and sewer pipes. VA, VHA, and local policies require physical safeguards to protect controlled and restricted areas such as communication closets.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) obtain appropriate

background investigations for all personnel in high-risk positions, (b) include the information security clause in all IRM position descriptions, (c) update contingency plans annually to include a designated alternate processing site and a complete listing of home and work telephone numbers for key personnel, (d) establish a process to review and immediately remove former employee and contractor access and privileges, (e) enforce employee compliance with the requirement to complete annual security awareness training, and (f) install physical safeguards to secure and protect communication closets.

The VISN Director agreed with the findings and recommendations and reported that appropriate background investigations have been initiated for all personnel in high-risk positions. An information security clause has been added to all IRM position descriptions. The contingency plans have been updated to address alternate processing sites and listings of home and work telephone numbers for key personnel. A procedure has been established to review and remove former employee and contractor access privileges. Employee security training will be monitored monthly to ensure that everyone has completed training by the end of each fiscal year. Physical safeguards have been installed to correct the security deficiencies of communication closets. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Medical Care Collections Fund — Collection Efforts Needed To Be Strengthened and Billing Delays Reduced

Condition Needing Improvement. MCCF staff verified patient insurance, identified billable episodes of care, and billed appropriate amounts. However, collection efforts for third-party accounts receivable needed improvement, and unbilled episodes of outpatient care needed to be reduced.

Collection Efforts. As of July 1, 2004, the medical center had 14,557 third-party accounts receivable, ranging from less than 30 days to 365 days old, valued at $6,907,857. Fifteen percent (2,122 of 14,557) of the third-party receivables exceeded 90 days and had a value of $1,893,872. Third-party receivables exceeding 90 days have a decreased potential for collection.

VHA policy requires follow-up 45 days from the initial bill and again in 30 days. Our review showed MCCF staff was not meeting these standards. We evaluated the effectiveness of third-party collection efforts by reviewing a judgment sample of 20 third-party receivables (valued at $3,073) generated during the third quarter of FY 2004. There were eight receivables (40 percent) with a value of $1,148, ranging in age from 46 to 147 days that had no follow-up. We found follow-up for one of the receivables was 92 days after MCCF staff sent the initial bill. Follow-up for the remaining 11 third-party receivables was satisfactory.

Billing Delays. There was a backlog of unbilled outpatient cases. As of June 30, 2004, the medical center had 3,085 unbilled outpatient episodes of care valued at $1,620,079. During the third quarter of FY 2004, MCCF staff took an average of 107 days to initiate a bill, 52 days more than the VISN standard of 45 days. According to the Patient Accounts Manager, position vacancies and the training of newly hired, inexperienced medical coders caused the backlog. Our analysis showed that 25 percent, or $405,020 (1,620,079 x 25%), of the outpatient episodes were not billable. Using the medical center's third quarter collection rate for FY 2004 of 30 percent, the Patient Accounts Manager agreed that the lack of timely billing for these cases delayed the availability of $364,518 [($1,620,079 - $405,020) x 30%] in additional resources to the medical center.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) improve the timeliness of follow-up collection efforts for third-party receivables, and (b) reduce the backlog of unbilled third-party episodes of care.

The VISN Director agreed with the findings and recommendations and reported that monitors are in place to ensure that follow-up collection actions are timely completed. Staffing has been adjusted to address the backlog of unbilled third-party receivables, and billing delays have been reduced. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Moderate Sedation — Cardiopulmonary Resuscitation Training Requirements Needed To Be Completed, and Policy Revised

Condition Needing Improvement. VHA regulations require that medical facilities establish guidance for providing care to patients receiving all types of anesthesia, including moderate sedation. Moderate sedation is a drug-induced depression of consciousness used to control pain and discomfort associated with minor surgical procedures and diagnostic examinations. To evaluate the moderate sedation program, we reviewed local policy, patient medical records, and clinician training records, and we interviewed clinical employees involved in administering moderate sedation and monitoring patients.

The medical center had established appropriate controls for safe delivery of moderate sedation. However, clinical managers needed to ensure that CPR training requirements were met and that policy is revised to identify the locations where moderate sedation is to be administered.

Training Requirements. VHA regulations require that all employees who provide patient care maintain current CPR certification. We sampled training records of five clinicians involved with moderate sedation and found that two records did not show evidence of CPR certification. Additionally, the medical center did not have a policy addressing CPR requirements for patient care employees.

Moderate Sedation Policy. We reviewed the medical center's moderate sedation policy and noted that the policy did not specify the clinical locations where moderate sedation was authorized to be administered. Managers agreed to revise the policy to identify the specific clinical locations.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinical employees receive CPR certification and the medical center policy addresses this requirement, and (b) medical center policy is revised to specify the clinical locations where moderate sedation is authorized to be administered.

The VISN Director agreed with the findings and recommendations and reported that the medical center will expand the requirement for CPR education to include all medical and dental staff, and compliance will be monitored. Medical center policy has been revised to specify where moderate sedation can be administered. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Environment of Care — Patient Safety and Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. Medical center management needed to ensure that patient safety and infection control issues were corrected, computer security and patient privacy were maintained, and medications were secured.

We conducted environment of care inspections on three inpatient units and three outpatient areas at the John Cochran Division and on four inpatient units and two outpatient areas at the Jefferson Barracks Division. Managers took action to correct conditions identified during our inspections that were of immediate patient safety concern.

Patient Safety Concerns. At the John Cochran Division, pull cords on emergency call systems were missing from a patient shower area on a medical unit and in two restrooms in the Prime Clinic. We tested an emergency call system in a patient restroom and found that the system was deactivated. Clinic employees submitted a work order for repair. In a primary care clinic, emergency call systems in two restrooms activate lights over the restroom doorways; however, because there were no alarms at the nurses' station, emergency responses depended on employees being in the hallway so they could see the activated lights over the restroom doorways. The lack of audible alarms could delay responses to patients requiring assistance.

Scissors were unsecured and accessible to patients in two examination rooms in the Prime Clinic. Sharp items should be secured in patient care areas to prevent accidental or purposeful injury.

Infection Control Issues. There were open containers of body fluids, an open petroleum jelly packet, and debris on the floor in a Surgical Intensive Care Unit (SICU) patient room. The room was being held unoccupied for a patient scheduled to return from surgery. Unmarked and unlocked rooms located in hallways outside the Medical Intensive Care Unit (MICU) and SICU were used to store soiled linens and bio-hazardous trash. Bio-hazardous materials and contaminated items should be stored in locked rooms designated for such materials.

In an MICU patient room, there was a torn padded vinyl cover over a toilet seat, and the wall behind the toilet fixture had been repaired with tape. We noted two gurneys on the Spinal Cord Injury Unit and one gurney on the Nursing Home Care Rehabilitation Unit that had cracked and torn vinyl mattress covers that needed replacing. Compromised surfaces on items used by patients may present an infection control risk.

Eleven days before our inspection, the temperature log for the patient nourishment refrigerator on the Nursing Home Care Unit showed temperatures ranging between 42°F and 49°F when the posted acceptable range was between 32°F and 40°F. There was no evidence that medical center staff attempted to correct the problem. Temperatures outside the acceptable range could cause patient nourishment to spoil.

Computer Security and Patient Privacy. At the John Cochran Division, there were five instances where computers were left unattended and patient medical records were visible on the monitor screens. For example, in the SICU a portable laptop used by clinical employees was left unattended with a patient's electronic medical record displayed. The prompt on the screen indicated that an order needed approval. Federal law requires the security of patient health information.

Medication Security. On a medicine unit at the John Cochran Division, there was an unattended medication cart in the hallway with three patient medication drawers open. In the MICU, the nurse manager reported that housekeeping employees knew the electronic code to gain access to the medication room. Areas where medications are stored must be secured and accessible only to authorized employees to ensure patient safety and to prevent diversion.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) pull cords for emergency call systems are intact and audible alarms are activated, (b) sharp instruments are secured in patient care areas, (c) bio-hazardous materials and contaminated items are held in locked designated areas, (d) patient care equipment is regularly inspected and repaired or removed from service if damaged, (e) refrigerator temperatures are monitored and the correct temperature is maintained for the storage of patient nourishment, (f) patient health information is secured, and (g) medication storage areas are secured and access limited to authorized employees.

The VISN Director agreed with the findings and recommendations and reported that pull cords for emergency call systems have been replaced and audible alarms have been installed. Sharp instruments have been secured in newly installed supply cabinets, which can be locked. Locks have been placed on dirty utility rooms where bio-hazardous and contaminated items are stored. Patient care equipment in the MICU has been repaired. Staff was reinstructed to monitor refrigerator temperatures and take appropriate action when they were not within the required range. Rounds are conducted each month to ensure compliance with patient privacy requirements. Instances of unsecured patient health information are reported to supervisors and corrective actions are taken. Staff have been educated and counseled on the proper security of medications, and the punch lock code was changed. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Part-Time Physician Time and Attendance — Physicians Needed To Work Their Approved Tours of Duty and Timekeeping Controls Needed To Be Strengthened

Condition Needing Improvement. Controls over part-time physician time and attendance needed to be improved. Timekeepers, the Chief of Staff, and service chiefs were unaware that physicians were not at the medical center during their scheduled tours of duty because the physicians had not followed VHA policy.

VHA policy requires part-time physicians to work at VA during their scheduled tours of duty, and timekeepers are required to ensure that timecards accurately reflect the hours physicians are present. The policy requires all VA employees, including physicians, to request modifications to their tours of duty in advance of the beginning of each pay period by obtaining approval from their supervisors. A sample of 15 part-time physicians showed that 2 were not present during their scheduled tours of duty on August 10, 2004. In one instance, the physician was at the affiliated university clinic providing care to non-VA patients. Although a Medicine Service physician and the Director of QM stated that the physician had requested leave the previous week for the day of our inspection, the leave request was not forwarded to the timekeeper or entered into the Personnel Accounting Integrated Data system. There was no documentation of an approved change of tour of duty or a leave request for the day in question for the other physician.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the VAMC Director takes action to: (a) charge the two part-time physicians identified in our sample with annual leave for the hours not on duty, and (b) ensure that part-time physicians are physically present at the medical center during their scheduled tours of duty.

The VISN Director agreed with the findings and recommendations and reported that one physician was charged annual leave and the second physician with leave without pay. The medical center implemented a monitor to include all part-time physician attendance.

They have also implemented controls to ensure that part-time physicians request and receive advance written approval for leave and changes to their tours of duty. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Bulk Oxygen Utility System — Managers Needed To Comply With VHA's Patient Safety Alert

Condition Needing Improvement. Medical center management needed to ensure that bulk oxygen utility system procedures are documented in a medical center policy, qualified employees monitor oxygen deliveries, and alarm panels that monitor oxygen supply levels are operational.

Bulk Oxygen Policy. The medical center did not have a policy for ordering bulk oxygen, monitoring oxygen levels, and maintaining the bulk oxygen system. Local policy should be established to ensure that employees responsible for bulk oxygen activities are properly trained and understand the requirements for operating a bulk oxygen utility system.

Oxygen Delivery Monitoring. The medical center's bulk oxygen contract, awarded in 1999 through VA's National Acquisition Center, stated that oxygen deliveries were to be made in the evenings and on weekends, due to parking limitations at both divisions. However, VHA's Patient Safety Alert, published on April 5, 2004, requires all oxygen deliveries to be monitored by qualified employees. The Engineering Program Manager reported that up to 90 percent of the deliveries were not monitored by qualified employees, even though the contract was amended to change deliveries to weekdays between the hours of 8:00 a.m. and 4:30 p.m. Employees reported that the vendor either came during normal business hours and failed to notify appropriate staff of their arrival, or the vendor delivered during non-business hours when qualified employees were not available to monitor deliveries.

Alarm Panel Status. VHA's Patient Safety Alert requires a minimum of two constantly attended monitoring stations for all alarms related to the oxygen utility system. Alarms are required to be tested to ensure they are functional. During our inspections, we found that employees had deactivated the audible alarm at the two alarm panels at the John Cochran Division due to a problem with the oxygen supply in an area. At the Jefferson Barracks Division, the alarm panel monitoring the oxygen supplying Buildings 51 and 52 was not active, and the alarm panel monitoring Building 53 was out of service for approximately 2 weeks before our inspection due to a lightening strike. Our inspection of the Building 53 main oxygen tank gauge revealed that the quantity of 22 inches in the tank was below the reordering level of 38 inches, which was a condition that should have

activated an alarm (see the photograph below). Additionally, JEM Technology[2] conducted inspections on April 15, 2004, at the Jefferson Barracks Division and on May 1, 2004, at the John Cochran Division and reported alarm panel deficiencies in the medical center's bulk oxygen system.

Building 53 main oxygen tank gauge was at a level of 22 inches, which should have activated an audible alarm if the panel had been operational.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) procedures for ordering bulk oxygen, monitoring the oxygen levels, and maintaining the systems are documented in a medical center policy; (b) all oxygen deliveries are monitored by a qualified employee; and (c) alarm panels are fully operational.

The VISN Director agreed with the findings and recommendations and reported that policies have been consolidated into a single bulk oxygen policy. The delivery schedule has been revised. The vendor now delivers oxygen only when a qualified employee is present. Alarm panels that were being repaired have been reactivated. Measures were taken to ensure that patient care was not compromised during the repair period. Daily oxygen level checks are made to ensure that patient care is not compromised. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

[2] JEM Technology is a certified agency with the expertise to inspect the system using standard criteria and to provide a comprehensive analysis of the bulk oxygen system.

Quality Management — QM Leadership, Peer Reviews, and Credentialing and Privileging Should Be Strengthened

Condition Needing Improvement. Medical center management needed to strengthen the QM program by preparing an integrated annual QM plan and monitoring program performance during the year, ensuring that all service lines contribute to a facility-wide QM plan, and ensuring that peer reviews are properly documented. To evaluate the QM program, we interviewed key employees and reviewed policies, QM plans, committee meeting minutes, reports, C&P files, performance improvement data, and other pertinent documents. We found that QM data was adequately collected, analyzed, and trended.

QM Program Leadership and Integrated Planning. The QM program lacked adequate executive leadership and control. Each of the medical center's service lines planned and conducted their own QM activities using a format provided by the Medical Center Director. We reviewed the QM plans prepared by the service lines and found them to be acceptable. However, the medical center did not prepare a consolidated facility-wide QM plan, and there was no process for executive review and approval of the QM plans prepared by the service lines. Additionally, management did not monitor QM program performance during the year to ensure that goals were met and timely follow-up actions taken.

Without a facility-wide QM plan, medical center management could not ensure that facility-wide priorities were addressed or that QM activities were performed. Changes in policy for QM program management have been drafted that will include executive-level review and approval of the annual facility-wide QM plan and quarterly reviews of QM program performance. These changes would provide for effective executive leadership and control of the QM program.

Service Line QM Contributions. The medical center's Research and Education Service Line and the administrative service lines did not prepare QM plans for FY 2004. These service lines performed significant activities related to patient care, and responsibility for preparing QM plans had been specifically assigned to their employees. All service lines should prepare QM plans for FY 2005.

Peer Reviews. We reviewed documentation included in files for nine peer reviews[3] completed in the prior 12 months. Eight of the nine peer reviews had resulted in level 3 determinations that "most providers would have done things differently." One of the peer reviews had resulted in a level 2 determination that "some providers might have done things differently." We found the documentation to be deficient for seven of the peer reviews, despite the serious conclusions in these cases. In two cases, there was

[3] In a peer review, a peer clinician is asked to review the care provided. The peer clinician assigns a level 1, 2, or 3 rating to the review. Any peer review ratings of 2 or 3 should be discussed in the service where the provider works and should be discussed at the time of reprivileging.

inadequate documentation to show that peer reviews had been performed or that the conclusions were appropriate. In five cases, the peer reviews lacked adequate documentation specifying the follow-up actions that were required.

Recommended Improvement Action 10. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) finalize and implement the proposed policy changes for the QM program to include annual review and approval of the facility-wide QM plan and quarterly review of program performance, (b) ensure that all service lines contribute to the facility-wide QM plan, and (c) ensure that peer reviews are properly documented.

The VISN Director agreed with the findings and recommendations and reported that the Quality and Performance Management Council has been restructured to include service line directors and individuals responsible for key program areas. All service line directors have been notified of VISN and medical center QM goals. The medical center is redesigning the peer review process and will include a requirement for proper documentation. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Processing and Distribution — Infection and Environment Controls Needed to be Strengthened

Condition Needing Improvement. The SPD area temperature and humidity were properly controlled, and staff were using the Generic Inventory Package (GIP). However, SPD staff needed to strengthen infection and environment controls.

VA policy prohibits eating and drinking in SPD areas where sterilized equipment and medical supplies are stored. Environmental Management Service staff are required to wet mop or wet vacuum the floors in the sterile preparation area of SPD each day. During an IG-caused inspection of the sterile preparation area, we found lint and packaging debris on the floor. In addition, we found evidence of eating in the sterile preparation area. There were empty food containers and soft drink cans in two garbage cans. According to the Administrative Officer of Facilities Management Service, SPD employees working the night shift left the messy floor and empty food containers and soft drink cans in the garbage cans.

VA policy requires all personnel to wear protective clothing in the SPD decontamination area. We observed an equipment maintenance contractor working in the area without protective clothing.

Recommended Improvement Action 11. We recommended that the VISN Director ensure that the Medical Center Director requires SPD management to strengthen infection and environment controls and all personnel to wear protective clothing in the SPD decontamination area.

The VISN Director agreed with the finding and recommendation and reported that rules regarding environment controls and protective clothing in the decontamination area have been reinforced. Housekeeping personnel have been instructed to clean the sterile preparation area each morning. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Contracting — Contract Administration and Documentation Needed To Be Improved

Condition Needing Improvement. Contract prices and terms were reasonable, and contracting officers monitored contracts to ensure that payments to vendors reflected the actual services provided. The Federal Acquisition Regulation (FAR) and VA Acquisition Regulations (VAAR) require contracting officers to ensure that contract files contain all relevant documentation, including price negotiation memorandums (PNMs), certificates of insurance, and the contracting officer's technical representative (COTR) designations. Our judgment sample of 12 contracts included 9 clinical service and 3 service contracts with an estimated annual value of $14 million. We identified deficiencies in contract administration and documentation.

Contract Administration. The FAR and VAAR require that contracting officers complete PNMs. A PNM documents the facts and considerations pertaining to negotiation of the contract, including any significant differences between a contractor's and a contracting officer's negotiation positions. In addition, VHA requires a pre-award audit by the OIG for all sole source contracts with a value of $500,000 or more. Our review showed that 3 of 12 contracts had deficiencies.

- The contracting officer did not prepare a PNM for one clinical service contract (annual value of $288,737).
- Another clinical service contract (annual value of $3.36 million) had an incomplete PNM.
- Contracting staff did not request a pre-award audit by the OIG for a sole source, scarce medical specialist service contract (3-year value of $612,929).

Contract File Documentation. The FAR requires that contracting files include documentation of all contracting actions. Two (17 percent) of the 12 contract files with a combined value of $2.3 million did not have certificates of insurance as evidence of required insurance coverage.

Recommended Improvement Action 12. We recommended that the VISN Director requires contracting staff to: (a) prepare PNMs and request pre-award audits by the OIG for sole source contracts of $500,000 or more, and (b) include certificates of insurance in the contracting files as required.

The VISN Director agreed with the findings and recommendations and reported that prior to our review the Network Contracting Officer had issued a new review procedure requiring a second contracting officer to review the files for all completed contracts to ensure that all required documents are present. The Network Contracting Officer has emphasized the requirements for OIG pre-award audits for sole source contracts valued at $500,000 or more. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Fee Basis Payments — Duplicate Payments Needed To Be Collected

Condition Needing Improvement. Fee basis payments included duplicate payments for the same services. The OIG Data Analysis Section extracted a nationwide listing of potential duplicate fee basis payments from VA's Financial Management System (FMS). The time period covered was FYs 2003 and 2004 through April 2004. Data Analysis Section staff identified 14 potential duplicate payments (7 outpatient and 7 inpatient) totaling $13,065 made by the medical center and asked us to review the payments during the CAP review.

We reviewed these payments with a Fiscal Service budget analyst and found that 13 of the payments were duplicate payments. Fiscal Service staff had already collected one overpayment of $617.63. Fiscal Service staff had not taken action to collect the remaining 12 duplicate payments totaling $12,395.

The budget analyst attributed the duplicate payments to batching problems. Medical center Fiscal Service staff combined (batched) the fee basis payment transactions of VAMC St. Louis with those of two other medical centers and sent them to FMS staff in Austin, TX for processing in FMS. Due to a technical problem in FMS, the transactions were not properly processed, and Fiscal Service was asked to retransmit them. However, 13 of the transactions were successfully processed the first time, and the second transmission created duplicate payments. Fiscal Service staff told us that the technical problem has been corrected.

Recommended Improvement Action 13. We recommended that the VISN Director ensure that the Medical Center Director takes action to collect duplicate payments identified in this review.

The VISN Director agreed with the finding and recommendation and reported that bills of collection were generated for all of the identified duplicate payments, and all but one of the bills has been collected. The implementation plan is acceptable, and we will follow up on planned actions until they are completed.

Appendix A

VISN 15 Director's Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2005

From: VISN Director

Subject: **VA Medical Center St. Louis, Missouri**

To: Assistant Inspector General for Audit

1. In response to the Draft Report of the Combined Assessment Program review of the St. Louis VA Medical Center, attached please find comments, corrective action plans, and completion dates for each recommendation as provided by the Medical Center Director.

2. I have reviewed the document and concur with it.

(original signed by:)
Peter L. Almenoff, M.D., FCCP

Appendix B

Medical Center Director's Comments

Department of Veterans Affairs **Memorandum**

Date: February 24, 2005

From: Medical Center Director

Subject: **VA Medical Center St. Louis, Missouri**

To: Network Director, VISN 12

1. Attached is the St. Louis VA Medical Center response and action plan to the OIG report from the Combined Assessment Program that was conducted on August 9-17, 2004.

2. If you have any questions, please contact me at (314) 289-7651.

(original signed by:)

GLEN E. STRUCTEMEYER

Medical Center 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)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) Implement controls to investigate, report to the VA OIG Office of Investigations, reconcile, and reduce controlled substances discrepancies.

Concur **Target Completion Date:** 1/31/05

All of the instances cited were previously identified by the Controlled Substances Coordinator, communicated to the Executive Management Team and investigated by the Police & Security Service. Upon completion of the internal investigation, only those incidents determined to be the result of theft or diversion were subsequently reported to the VA OIG Criminal Investigations Section. We have modified our medical center policy to include reporting of each controlled substance discrepancy upon completion of our internal investigation.

Pharmacy Service has implemented the PYXIS automated drug dispensing system to increase the control over controlled substances. This system requires the count to be verified with each and every access. Discrepancy reports are immediately generated on the unit and in the main pharmacy. The electronic reporting and a review of discrepancies has improved the monitoring of narcotic/control medication usage.

(b) Remove expired controlled substances from the pharmacy vault and wards.

Concur **Target Completion Date:** 1/31/05

The process for returning expired items to the pharmacy has been modified. Pharmacy Service surveyed all areas with inventories of controlled substances for outdated items and initiated a monthly review of all inventories for removal of outdated controlled substances. Outdated items are removed from inventories and processed per policy for destruction. Pharmacy Service implemented the PYXIS automated drug dispensing system to increase the oversight of controlled substances. Expiration date information is also retrievable in PYXIS reporting. Pharmacy staff runs reports to identify drugs with upcoming expiration dates and removes those drugs prior to the expiration date. For those areas without PYXIS pharmacy maintains the monthly review of inventories for outdated controlled substances.

(c) Ensure controlled substances are properly recorded and inventoried.

Concur **Target Completion Date:** 8/30/04

At the time of the OIG inspection, controlled substances were received in multiple delivery containers. Receipting process included the responsibility of the receipting agent to account for all controlled substances contained in a delivery. In the case cited, this process was not completed and the employee was counseled regarding this deficiency. Pharmacy and the prime vendor have agreed to have all controlled substances placed into one delivery container to improve the process of receipting of these controlled substances.

The discrepancy involving a schedule III item listed twice in the pharmacy inventory was a result of a lack of understanding of the Vista control package. The duplication happened when the national classification was reduced from a schedule II to a schedule III narcotic. When the schedule status in VISTA was changed, a new location code entry was entered without deleting the previous location code. This led to the duplication. The location codes have been corrected. No other instances have been identified.

(d) Ensure delivery counts are verified before signing for them.

Concur **Target Completion Date:** 8/30/04

Pharmacy management and the prime vendor have agreed to have all controlled substances placed into one delivery container to improve the process of receipting of these controlled substances.

(e) Ensure drugs for destruction are returned to the pharmacy.

Concur **Target Completion Date:** 1/31/05

Outdated items are removed from inventories and processed per policy for destruction. Pharmacy Service implemented the PYXIS automated drug dispensing system to increase the control over controlled substances. Expiration date information is retrievable in PYXIS reporting. Pharmacy staff runs reports to identify drugs with upcoming expiration dates and removes those drugs prior to the expiration date. For those areas without PYXIS, pharmacy maintains the monthly review of inventories for outdated narcotic/controls.

and (f) Ensure inspectors include all areas containing controlled substances in the monthly unannounced inspections.

Concur **Target Completion Date:** 9/30/04

The Executive Management Team authorized a request for additional controlled substance inspectors. Additional inspectors were trained and are in place to complete the assigned inspection areas. A monthly report to the Medical Center Director via Quality Management includes completed and missed inspections.

Recommended Improvement Action 2. We recommend the VISN Director ensure that the Medical Center Director takes action to: (a) improve the accuracy of GIP by ensuring that transactions are correctly recorded into the system and that line item totals are accurate.

Concur **Target Completion Date:** 4/30/05

Excess items were immediately removed. The VISN Logistics Manager has implemented new receiving report procedures so that items are not shelved before the receiving report is actioned in as 100%. Inventory is scheduled for the weekend of April 16-17, 2005. Staff has been trained not to take or put back anything from shelves without input into GIP. Picking tickets are now posted by inventory managers (GS-9) instead of supply technicians (GS-5). Prime vendor contract pending award. This will reduce stock on hand and lessen inventory errors.

(b) implement GIP for engineering supplies and conduct annual wall-to-wall inventories.

Concur **Target Completion Date:** 8/30/04

The deadline for implementing Engineering into GIP was August 31, 2004. Logistics had begun working to meet that deadline at the time of the IG CAP review. A GIP primary inventory point consisting of 390 Engineering items was completed on August 30th and the first auto-generation was conducted at that time. The inventory is still running and more items are being added as they are identified. Since Engineering is setup to run as a mirrored primary inventory point, all items are now inventoried monthly. Logistics has met all mandatory GIP inventory areas by the VISN and by VACO.

and (c) reduce excess inventory levels to a 30-day supply.

Concur **Target Completion Date:** 4/30/05

The VISN Logistics department goal is the reduction of the medical center's long-supply by 45% and the department continues to reduce the inventory. We are still spending the EOY funds that we received and it is projected that the majority of items purchased with the EOY funds will be distributed by the end of the 2nd quarter. Logistics had been in the process to identify and remove inactive items and those items with excess supplies. Currently, the over 30-day stock items is $97,027 (unadjusted for new/emergency and EOY items) and $79,131 adjusted for those items. (Compare to IG reported amount in August of $172,570.) Logistics was given $108,000 in FCP 1755 (medical supplies) in end of year funds. Some of these supplies are still in our inventory and thereby raise stock-on-hand levels. The inactive item percentage (2%) is below the VACO guideline of 5%. The medical center's Long Supply (17%) is still greater than the VACO guideline of 10% but this is affected by the EOY funds and we are working on bringing that down and have improved that number from an average of 20.33% for FY 04.

In April 2004 an order for cardiology related implants (defibrillators and leads) totaling over $247,000 was processed, with an expectation based on past usage that the items would move quickly (30 days). By placing the bulk order the facility received an additional discount of 5% or approximately $12,350. Due to patient's conditions requiring the use of a different model than routinely used, four of the items totaling approximately $54,150 did not move as quickly as anticipated. There were no provisions made in the purchase agreement to allow exchange of the purchased units for a different model once this need was identified. Therefore, these units remained on the shelf over 30 days. The last unit was implanted in January 2005.

Logistic staff have been instructed that in the future when an opportunity to receive discounts occurs, they are to consider the usage and ensure that a provision is included allowing for the exchange of an unused unit, when the need for another different model unit is identified and/or agreement to refund any units that are not implanted within 30 days.

The other items that exceeded 30 days stock on hand are items that continually fluctuate in demand and/or the need to have at least one on the shelf at all times exists, but are necessary to have readily available when required by the patient. Prosthetics will always have some items that will exceed 30 days stock on hand.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director: (a) implements local scheduling procedures that comply with VHA policy.

Concur **Target Completion Date:** 2/18/05

A Medical Center Memorandum-Scheduling of Patients (PCSL-111-03-552) was written to set local policy and procedures to comply with the VHA directive for scheduling outpatient clinic appointments.

and (b) develops a training program for schedulers.

Concur **Target Completion Date:** 2/18/05

A training program utilizing the Internet and videotapes has been set up for staff members (both clerical and clinical) who schedule appointments. After each staff member has completed this training, they must take a web-based test and are then given a VISTA Scheduling Software Certificate of Completion. Any staff member who fails to complete the required training will no longer be able to schedule appointments until they have successfully completed the training. Refresher training programs will be provided as needed to maintain staff proficiency.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) obtain appropriate background investigations for all personnel in high-risk positions.

Concur **Target Completion Date:** 5/31/05

Background investigations have been initiated for the identified programmer, Chief of Staff, and the Chief, Police & Security

(b) include the information security clause in all IRM position descriptions.

Concur **Target Completion Date:** 2/8/05

The Security Clause has been added to the position descriptions of all IRM employees. The clause had been included in the individual performance plans for IRM employees.

(c) update contingency plans annually to include a designated alternate processing site and a complete listing of home and work telephone numbers for key personnel.

Concur **Target Completion Date:** 1/31/05

The contingency plans have been updated to address alternate processing sites and listings of home and work telephone numbers for key personnel.

(d) establish a process to review and immediately remove former employee and contractor access and privileges.

Concur **Target Completion Date:** 8/23/04

A procedure has been established to review and remove former employee and contractor access privileges. Employee privileges are addressed on "clearing" and change of position. Contractor privileges are addressed at the end of a project and reviewed on a monthly basis

(e) Enforce employee compliance with the requirement to complete annual security awareness training.

Concur **Target Completion Date:** 10/18/04

Users in each category will be reviewed on a monthly basis to assure completion by the end of each fiscal year. If employee is over 90 days overdue for this training their access is "disusered". To have access reinstated employees must show completion of security awareness training. The new Information Security Officer was assigned in August 2004 and is closely monitoring compliance with the VA policy.

and (f) install physical safeguards to protect communication closets.

Concur **Target Completion Date:** 1/31/05

Physical safeguards have been installed to address the visibility and security of communication closets

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) improve the timeliness of follow-up collection efforts for third-party receivables.

Concur **Target Completion Date:** 4/30/05

Staff will continue running their individual insurance payment trend reports and follow up on claims within 45 days to prevent bills from exceeding 90 days. Bills nearing or exceeding 90 days are given high priority for collecting and closing.. Monitors are in place to ensure that follow-up action has been completed in a timely manner.

and (b) reduce the backlog of unbilled third-party receivables.

Concur **Target Completion Date:** 4/30/05

Staffing has being adjusted to address the backlog. Billing delays have been reduced from 107 days at the time of the OIG/CAP survey to 75 days.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) clinical employees receive CPR certification and medical center policy addresses this requirement.

Concur **Target Completion Date:** 3/30/05

The medical center will expand the requirement for CPR education to include all members of the medical and dental staff, i.e. physicians, dentists, optometrists, podiatrists, as well as mid-levels such as physician assistants, nurse anesthetists, and nurse practitioners. The Code K committee will develop the criteria to establish initial compliance and monitor continued currency with this requirement. CPR education classes are currently offered monthly by VA Nursing Education staff who area certified CPR instructors and will be expanded as necessary. Staff identified as requiring CPR education may also meet this requirement by providing documentation that the training was obtained through non-VA sources, e.g. American Red Cross, American Heart Association, that are authorized to provide comparable training.

and (b) medical center policy is revised to specify the clinical locations where moderate sedation is authorized to be administered.

Concur **Target Completion Date:** 9/26/04

Chief of Staff SOP 11-087, Sedation and Anesthesia Care, was revised to include locations where moderate sedation is authorized.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) pull cords for emergency call systems with audible alarms are installed.

Concur **Target Completion Date:** 2/15/05

Environmental Management Service staff replaced the missing pull cords in the medical unit and Prime (Primary Care) Clinic. An audible alarm has also been installed in the primary care clinic restroom.

(b) sharp instruments are secured in patient care areas.

Concur **Target Completion Date:** 10/31/04

New supply cabinets which can be locked have been purchased and installed in the clinic area.

(c) biohazardous materials and contaminated items are held in locked designated areas.

Concur **Target Completion Date:** 11/21/04

Locks have been placed on designated dirty utility rooms where bio-hazardous and contaminated items are stored.

(d) patient care equipment is regularly inspected and repaired or removed from service if damaged.

Concur **Target Completion Date:** 9/24/04

The torn vinyl toilet covers, damaged wall behind the toilet, and torn gurney mattresses in the MICU were repaired

(e) refrigerator temperatures are monitored and the correct temperature is maintained for the storage of patient nourishment.

Concur **Target Completion Date:** 11/21/04

Staff were reinstructed on appropriate checks and actions to be taken when the refrigerator temperature is found out of range.

(f) patient health information is secured.

Concur **Target Completion Date:** 8/30/04

HIPAA rounds are conducted on a monthly basis with reporting bi-monthly to the Compliance Committee. Any instance of unsecured patient health information is reported to the immediate supervisor of the unit where the security breach was found so that appropriate corrective action can be taken.

and (g) medication storage areas are secured and access limited to authorized employees.

Concur **Target Completion Date:** 8/30/04

All staff members within the medication distribution chain have been educated on appropriate measures to maintain the security of medications. Upon the nurse manager's return, the punch lock code was changed and staff members were counseled regarding the security of the medications areas.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the VAMC Director takes action to: (a) charge the two physicians identified in our sample with annual leave for the hours not on duty.

Concur **Target Completion Date:** 8/30/04

For August 10, 2004, one physician was charged annual leave and the second physician was charged Leave Without Pay (LWOP) for not being on duty as assigned.

and (b) ensure that part-time physicians are physically present at the medical center during their scheduled tours of duty.

Concur **Target Completion Date:** 8/30/04

Part-time physician attendance (core hours) monitor was implemented in June 2003 with weekly reporting to the facility director. The monitor was expanded to include all part-time physician attendance (non-core hours) in March 2004. This is reported monthly to the VISN. Any physician identified as not present is reported to the appropriate service line director for administrative action/follow-up. Other actions implemented include: a) Ensuring that part-time physicians request and receive prior written approval prior to taking leave and that such requests are promptly documented in the time and attendance system. b)Ensuring that part-time physicians obtain prior approval in writing to change their tour of duty (except in emergencies) and that such changes are promptly documented in the time and attendance system.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) procedures for ordering bulk oxygen, monitoring the oxygen levels, and maintaining the systems are documented in a medical center policy.

Concur **Target Completion Date:** 2/15/05

Multiple policies have been consolidated into a single bulk oxygen policy.

(b) all oxygen deliveries are monitored by a qualified employee.

Concur **Target Completion Date:** 9/30/04

Logistics/Contracting staff and the vendor revised the delivery schedule. The vendor now delivers oxygen only when a qualified VAMC employee is present to supervise the delivery.

and (c) alarm panels are fully operational.

Concur **Target Completion Date:** 9/30/04

The alarm panels at the John Cochran(JC) and Jefferson Barracks (JB) divisions were deactivated as they were in the process of repair, which was completed prior to the OIG team leaving on August 13, 2004. Interim Life Safety Measures were put in place prior to the deactivation of the panels. This included daily oxygen level checks being performed to ensure patient care was not compromised during the repair activity.

The alarm panel for building 51/JB was deactivated; however, there was no oxygen being used anywhere within the building. It has since been taken completely out of service (on September 24, 2004), when the oxygen system was deactivated for the entire building. The alarm panel for building 52/JB that was cited is a remote alarm and does not affect the alarm on the ward. The non-functional remote alarm was replaced as part of a project awarded on September 30, 2004. In the interim, daily oxygen level checks were being conducted to make sure patient care was not compromised.

The order for additional oxygen had already been placed (on Friday, August 6, 2004) when the OIG team observed the gauge was below the reorder level. The delivery occurred on Thursday, August 12, 2004, prior to the OIG team completing the survey. Daily oxygen level checks were occurring to make sure patient care was not compromised during the order/deliver time period.

Recommended Improvement Action 10. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) finalize and implement the proposed policy changes for the QM program to include annual review and approval of the facility-wide QM plan and quarterly review of program performance.

Concur **Target Completion Date:** 3/31/05

Leadership responsibility for the Quality and Performance Management Council has been assigned to the Assistant Director. The committee has been restructured to include service line directors and individuals with responsibility for key program areas. The Council has the responsibility for monitoring the facility-wide QM program. MCM 00-28 "Quality & Performance Management Council" is being revised to reflect the changes to committee structure and processes.

(b) ensure that all service lines contribute to the facility-wide QM plan.

Concur **Target Completion Date:** 1/31/05

All service line directors were notified of the FY 2005 VISN and medical center goals. As appropriate, goals were incorporated into service line performance improvement plans.

and (c) ensure that peer reviews are properly documented.

Concur **Target Completion Date:** 3/5/05

Since the completion of the OIG survey and prior to the receipt of this report, VHA directive 2004-054 "Peer Review for Quality Management" was issued on September 29, 2004. The medical center is redesigning the peer review process to comply with this directive. This will include proper documentation of the peer review process.

Recommended Improvement Action 11. We recommend that the VISN Director ensure that the Medical Center Director requires SPD management to strengthen infection and environment controls and all personnel to wear protective clothing in the SPD decontamination area.

Concur **Target Completion Date:** 8/31/04

It has been reinforced to all staff that no food or beverages are ever to be brought into the instrument tray preparation area. The housekeeping aid assigned to this area has been instructed to clean the preparation area immediately after collecting trash each morning.

All staff, including contract maintenance personnel, also have been re-educated on the infection control requirement to don protective clothing when working in this area.

Recommended Improvement Action 12. We recommend that the VISN Director ensure that the Medical Center Director requires contracting staff to: (a) prepare PNMs and request pre-award audits by the OIG for sole source contracts in excess of $500,000

Concur **Target Completion Date:** 8/31/04

In March 2004, just prior to the OIG review, the Network Contracting Office instituted a new peer review procedure, described in VISN 15 SOP #37, CONTRACT PEER REVIEW PROCEDURES, to ensure that each contract file contains all required documents. After a contract is completed, a second Contracting Officer reviews the file, using the checklist contained in the SOP, to ensure that all required documents are present. This new procedure should eliminate the possibility of missing documents, such as those found during the audit. The files that were discovered during the audit to have missing documents were completed prior to the implementation of the new peer review procedure. The peer review policy put into place by the NBO Contracting Office will provide the opportunity for another contracting officer to review all contracting actions before award. The Network Contract Manager has met with the Medical Services Team to insure there is no confusion or misunderstanding about the pre-award audit requirements for Scarce Medical Contracts.

and (b) include Certificates of Insurance in the contracting files as required.

Concur **Target Completion Date:** 8/30/04

Certificates of Insurance were located for the identified records and placed in the contract files. In March 2004, just prior to the CAP review, the Network Contracting Office instituted a new peer review procedure, described in VISN 15 SOP #37 CONTRACT PEER REVIEW PROCEDURES to ensure that each contract file contains all required documents. After a contract is completed, a second Contracting Officer reviews the file, using the checklist contained in the SOP, to ensure that all required documents are present. This new procedure should eliminate the possibility of missing documents, such as those found during the audit. The files that were discovered during the audit to have missing documents were completed prior to the implementation of the new peer review procedure.

Recommended Improvement Action 13. We recommend that the VISN Director ensure that the Medical Center Director takes action to collect duplicate payments identified in this review.

Concur **Target Completion Date:** 5/31/05

Bills of collection were generated for all of the identified duplicate payments. All but one of the established bills has been collected and closed. Collection activity continues on the remaining bill (amount $714.02).

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Reducing inventory to 30 day levels would provide funds that could be used for other purposes.	$58,373
5	Reducing the backlog of unbilled episodes of medical care would provide additional resources sooner.	364,518
13	Collect duplicate fee basis payments.	12,395
	Total	$435,286

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr. (708) 202-2670
Acknowledgments	Verena Briley-Hudson Paula Chapman Mark Collins Sheila Cooley Joe Duffey Kevin Gibbons Tamara Jones Dana Martin Cherie Palmer John Pawlik Jennifer Roberts Leslie Rogers Raymond Tuenge Jaclyn Yamada Ora Young

Appendix E

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