Department of Veterans Affairs

Office of Inspector General

COMBINED ASSESSMENT PROGRAM REVIEW

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
OMAHA, NEBRASKA

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EXECUTIVE SUMMARY

Combined Assessment Program Review

Department of Veterans Affairs Medical Center
Omaha, Nebraska

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs VA Medical Center (VAMC) located in Omaha, Nebraska. The purpose of the review was to evaluate selected operations, focusing on the quality of care delivered and the effectiveness of management controls.

2. The Omaha VAMC is a 100-bed tertiary care facility, providing a full range of medical, surgical, and psychiatric services. The facility operates outpatient clinics in its main building and also operates community based outpatient clinics (CBOCs) in North Platte and Norfolk, Nebraska. The facility has no nursing home care or domiciliary beds.

3. For Fiscal Year (FY) 1999, the medical center's budget was about $70 million. In FY99, the medical center employed 776.4 full-time equivalent employees (FTEE), treated 3,510 medical care inpatients, and provided a total of 160,772 outpatient visits. By way of comparison, in FY98, the Omaha VAMC had a budget of about $69.7 million, had 782.3 FTEE, treated 3,231 medical care inpatients, and provided 147,361 outpatient visits. The medical center is part of the Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) 14.

4. The OIG CAP team visited the Omaha VAMC from October 25 to 29, 1999. The Appendices to this report contain the results of the CAP review. The following are highlights of our observations and the results of our limited testing of operations, including areas that appear vulnerable and in need of greater management attention.

- Quality Program Assistance (QPA) - This clinical program review identified several issues that require management attention. These include the need to improve:

  - Communication about quality and performance improvement activities between the Quality Council and the Executive Committee of the Medical Staff.
  - Waiting times for ambulatory care; specifically primary care, Cardiology Clinic, Pain Clinic, prescription filling and radiology studies.
  - Coordination of care for patient transfers and referrals from other facilities in the Greater Nebraska Healthcare System.
  - The primary care processes to insure that all patients have an assigned primary care provider.
  - The transition from inpatient specialty care to primary care.

- The operating room environment.
- The effectiveness of the home glucose-monitoring program, including documentation, education and quality control.

- Management Control - A number of areas were identified in which management controls could be strengthened. Specific areas needing improvement include:

  - The fee basis program.
  - Medical transportation services.
  - The purchase card program.
  - Security of controlled substances.
  - Security of information systems.
  - The storage of the Agent Cashier's safe combination.

- Fraud and Integrity Awareness Briefings - These briefings discussed issues concerning the recognition of fraudulent situations, referral to the Office of Investigations, and the type of information needed to make a complaint referral.

5. Several complaints voiced by veterans relating to a specific program were assessed, and inspection findings pertaining to these issues will be published in a separate report.

6. The Appendices include recommendations that we believe warrant management attention. We consider the issues resolved. The OIG will follow-up at a later date to evaluate the corrective actions taken.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

COMBINED ASSESSMENT PROGRAM DESCRIPTION

The Combined Assessment Program (CAP) combines the skills and abilities of the Office of Inspector General's (OIG) major components to provide collaborative assessments of Department of Veterans Affairs (VA) medical facilities. The OIG team consists of representatives from the Offices of Investigation, Audit, and Healthcare Inspections. They will provide an independent and objective assessment of key operations and programs at VA medical centers on a cyclical basis.

Representatives from the Office of Healthcare Inspections (OHI) conduct a Quality Program Assistance (QPA) review. QPAs are proactive reviews that incorporate standardized surveys, interviews, systematic reviews of the facility quality management program and selected medical record reviews. QPAs evaluate the effectiveness of quality management (QM) processes that local managers use to evaluate treatment quality and safety. OHI staff members evaluate these facilities to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality healthcare, improved patient access to care, and high patient satisfaction.

Representatives from the Office of Audit conduct a limited review to ensure that management controls are in place and are working effectively. Auditors assess key areas of concern which are derived from a concentrated and continuing analysis of Veterans Health Administration (VHA), Veterans Integrated Service Network (VISN), and VHA medical center databases and management information. These areas may include patient management, credentialing and privileging, agent cashier activities, data integrity, and the Medical Care Collections Fund.

During the CAP review process, a special agent from the Office of Investigations conducts a Fraud and Integrity Awareness Briefing. The purpose of this briefing is to provide key staff of the medical center with insight into the types of fraudulent activities that can occur in VA programs. The briefing includes overview and case specific examples of fraud affecting healthcare procurements, false claims, conflict of interest, bribery, and illegal gratuities. Office of Investigations personnel will also investigate certain matters that have been referred to the OIG by VA employees, members of Congress, veterans, and others.

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QUALITY PROGRAM ASSISTANCE

Objectives and Scope

The Quality Program Assistance (QPA) process attempts to provide a balanced perspective of a VA medical center's ability to provide safe, effective patient care to the greatest possible number of eligible veterans. The QPA uses structured survey instruments and interviews to assess the adequacy and efficiency of key operating elements and their ability to provide or support health care delivery.

Office of Healthcare Inspections (OHI) inspectors reviewed numerous quality management (QM) documents and medical records. They also inspected all inpatient and outpatient treatment facilities at the medical center. Inspectors interviewed executive managers, clinical managers, clinicians, and patients. We distributed questionnaires to full-time employees whom we randomly selected from the medical center's staffing roster. The questionnaire return rate was 54.3 percent. OHI inspectors also evaluated a broad range of complex and detailed allegations pertaining to health care and associated administrative deficiencies. The findings and conclusions related to these allegations are being reported under separate cover. We also responded to three issues raised by constituents of United States Senator J. Robert Kerrey, which are described in Appendix III of this report.

The QPA review was done in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

A. Highlights of Positive Initiatives

- Registered nurse (RN) case managers assist with transitions from one level-of-care to another, and with coordination of patient care, especially in subspecialty care.

- The Nurse Manager in acute care utilizes evaluation forms that patients complete after discharge to reward employees and also to address patient care issues.

- The facility utilizes a private company to monitor the weights of home-bound patients who have congestive heart failure, resulting in better treatment compliance and reduction in the frequency of inpatient admissions.

- The facility implemented an Evaluation Unit, resulting in decreased admissions, improved treatment timeliness, and better patient satisfaction.

- The Operating Room and Post-Anesthesia Care Unit Nurse Manager has developed a mentoring program for staff nurses to develop their leadership skills.

- The facility utilizes telemedicine technology, resulting in improved communication of diagnoses and treatments at remote sites.

- Nursing employees are cross-trained for better staff utilization.

- Patients are referred directly from the medical center and the community to the Day Hospital Program, resulting in decreased need for repeat hospitalizations of patients who experience acute mental health conditions.

- Mental health employees escort inpatients to the Mental Hygiene Clinic (MHC) just prior to discharge, in order to familiarize them with the Clinic, meet the care providers, and schedule the first outpatient appointment. This procedure has resulted in reduced MHC "no-shows."

- Medical center clinicians implemented the national VHA clinical pathway for major depression, resulting in increased recognition of the signs of depression, and in making appropriate MHC referrals.

- A pharmacist who has extensive knowledge of psychiatric medications consults with the mental health staff and patients.

- Medical center leadership and Union leadership have developed a strong partnership.

- Local Veteran Service Organizations support the medical center.

B. Executive Management Planning and Oversight

The medical center's Executive Council consists of the Director; the Chief of Staff; the Associate Director; the Chief and Assistant Chief of Medicine; the Chiefs of Surgery, Psychiatry, Laboratory and Radiology; the Assistant Director for Patient Care Services; the Chief Information Officer; the Assistant Director for Ancillary Services; the Assistant Director for Facilities Management; the Chief, Human Resources; and the Chief Quality Officer.

Executive managers are well represented in the Veterans Integrated Service Network's (VISN) major activities. The Omaha Veterans Affairs Medical Center (VAMC) is the only VA tertiary care facility in Nebraska, and many of the managers are involved in efforts to address coordination and eventual integration with the Greater Nebraska Health Care System (GNHCS). The GNHCS comprises VHA's Lincoln and Grand Island facilities. A formal proposal to include the Omaha VAMC in the GNHCS is awaiting approval in VHA Headquarters.

Executive managers have wide-ranging views of VISN involvement in, and support of the facility. With the closing of inpatient beds at the Lincoln and the Grand Island VAMCs, the Omaha facility has become a referral center. This has resulted in the Omaha VAMC having busy inpatient units. The facility has also witnessed a significant increase in the number of unique veterans treated, but has not had a parallel funding increase to compensate for the increased workload. Key positions at the VISN have

turned-over, resulting in the perception by some members of the Executive Council that VISN leadership has been weak, and has had inconsistent policies. Managers applauded the Central Plains Network University, a VISN-wide education program, as a positive effort to provide leadership training.

Executive managers employ numerous mechanisms to communicate with employees, including staff forums, supervisor forums, and newsletters.

C. Major Construction Projects

The Omaha VAMC is anticipating the start of several approved major construction projects. The projects include:

- A $2.8 million renovation project for the ambulatory care area, including primary care and specialty care. The renovation project is expected to improve patient privacy, and additional treatment rooms are expected to improve clinician efficiency.

- A $7.7 million renovation of inpatient units. This project is expected to significantly improve the ambiance and efficiency of the units, and improve patient privacy.

D. Quality Management

1. Quality Management Program

The Omaha VAMC has a comprehensive QM program that includes national and local performance measures, risk management, utilization management, occurrence screening, and peer review. A Quality Council meets regularly to review relevant materials and data. Each department makes a periodic presentation of its important quality of care issues. The Quality Council considers issues of high significance and prioritizes them, selecting four to six issues to work on at a time. At the time of this assessment, the major Quality Council initiatives were:

- Evaluation Unit

- Telephone Care

- Nurse-Pharmacy Communication

- Customer Service

- Laboratory Order Entry

- Discharge Planning

The facility is very proud of the efforts of its Customer Service Team. This team has produced a comprehensive program of employee awareness and education that has resulted in improved customer satisfaction scores.

Ongoing quality of care monitors include infection control, restraint use, medication use, medication errors, operative procedures, blood transfusions, patient and employee safety, staff competence, and medical record documentation. Employees who are assigned to monitor each performance measure are encouraged to find ways to continually improve the quality of care and operational performance.

2. Patient Incident Reporting Program

The facility uses the national VHA patient incident reporting program, however employees submit reports on paper rather than by electronic media. Employees utilize several different forms that are overprinted with additional questions, presumably to gain useful information. The OHI inspector concluded that the information requested from an employee who reports a medication error is excessively detailed and does not appear to be used to improve the process. The inspector referred the Chief Quality Officer to an effective medication error management program at the Lexington, Kentucky VAMC.

3. Utilization Management (UM) Program

The UM Program includes reviews of all scheduled admissions and all continued stays against established criteria. Cases that do not meet criteria are reviewed first by a member of the QM staff, and then, if appropriate, by a physician. The Executive Committee of the Medical Staff (ECMS) reviews a monthly report of UM issues. Inspectors reviewed a sample of 37 inpatient charts and found that all of the admissions were appropriate.

4. External Review

The facility underwent its triennial survey by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in August 1998. JCAHO surveyors did not award any serious recommendations in any of the acute care or ambulatory care areas. However, surveyors made significant (Type I) recommendations in the Day Treatment Program and the Home Care Program. Facility managers corrected the deficiencies that led to these recommendations, and the JCAHO subsequently removed them.

5. Medical Staff Monitoring

Involvement by the medical staff leadership in quality management activities is essential, and it could be strengthened at the Omaha VAMC. The ECMS does review relevant information and data such as radiology film turnaround time, ambulatory care issues, and autopsies, but medical staff leadership needs to be more rigorous in other essential quality management areas. After our review of the meeting minutes from both

the Quality Council and the ECMS, OHI suggests that both groups could benefit from cross-communication. The Chief Quality Officer or a physician member of the Quality Council should periodically brief the ECMS on significant Quality Council activities.

6. Credentialing and Privileging (C&P)

The minutes of the ECMS (the group charged with reviewing and recommending individuals for initial privileges and renewal of privileges) meetings contain the identical statement about clinical quality for each individual undergoing reprivileging. Based on interviews with the Chief of Staff and the C&P Coordinator, data from quality management measures are discussed at the department level. If there are circumstances requiring action or changes in privileges, the situation is discussed at the ECMS but the discussion and recommendations (if any) are recorded in a separate file to preserve confidentiality. They are not included in the ECMS minutes. Since the Medical Center Director attends each meeting, he is aware of the discussion when he signs his approval.

7. Medical Record Review

OHI inspectors reviewed a sample of 37 medical records of patients who had 1, 2, or 3-day lengths-of-stay in FY99. We found that, in this sample of records, clinicians consistently recorded patient care and the patients' conditions appropriately. The medical record documentation supported the need for admission, and treating clinicians appropriately prescribed medications and scheduled patients' follow-up appointments before discharge. The records showed that clinicians provided needed patient education. Inspectors found that documentation of discharge planning could be improved, particularly in those instances in which patients were transferred from other facilities. The inspector suggested that the Medical Record Committee review the forms used for documentation of discharge planning and compare them with applicable standards. Medical center managers should consider establishing a team to assess the coordination of care and treatment planning across the continuum of services offered, including adequate documentation of the process.

8. Patient Representative Program

The Patient Representative is available to veterans and family members who have concerns and complaints. The most common complaints that she receives include: delays in scheduling appointments, waiting times for patients to be seen during scheduled appointments, and lack of notification when appointments are cancelled. The Patient Representative told us that she reviews all of the concerns she receives and refers the issues to the appropriate manager for resolution. She stated that she follows all actions until they are resolved.

The Patient Representative initiated several improvement efforts during the last year, including an improved patient transfer process for cardiac angiography and surgery, and

an admission inventory sheet to prevent lost personal articles. Also, a new patient education handout is being created to assist with understanding the telephone system.

Inspectors found, during their rounds, that there are very few posted signs notifying veterans of the Patient Representative's location and role. Many patients told inspectors that they were not aware of the Patient Representative's existence. Some patients told us that they had gone to her for assistance and found her to be unhelpful. We suggest that managers work to increase patient awareness of the Patient Representative and her role, through the posting of signs and photographs. Also, managers should determine if she has adequate support to manage her patient load and/or if she could benefit from additional training to improve her skills in dealing with patients' problems. We also suggest that medical center managers cross train key employees in each department to handle complaints in their areas.

9. Home Glucose-Monitoring Program

We could not find any documented evidence of quality control activities in the home glucose-monitoring program. VHA guidance for ancillary testing states that glucose meters should be checked on a quarterly basis for calibration and proper use. Although this directive does not apply to home medical equipment, the facility had several policies that were confusing in regards to ongoing monitoring of such equipment. Managers must assure that activities related to the ancillary testing program are clearly specified in policy, properly implemented and documented, including the results of education and quality control. Stronger collaboration and cooperation between the Ancillary Testing Coordinator and clinic coordinators should be reinforced.

E. Access and Timeliness

The medical center's overall patient care workload indicates both a rapid transition from inpatient to outpatient care, and a significant and increasing outpatient workload. The number of veterans who are enrolled in the healthcare plan increased by 15 percent in 1 year. The number of outpatient visits increased nine percent in 1 year. Managers are concerned that resources will not be adequate to continue to accommodate this significant workload increase. They are particularly concerned about the impact on staffing and pharmaceutical costs.

Our interviews with patients found that 82 percent of the patients (107/131) are able to schedule a non-emergent appointment with their primary care providers within 7 days, all or most of the time. Seventy-four percent of the patients (98/133) are able to obtain appointments with specialists within 30 days of referral, all or most of the time. These data suggest that clinicians are working to meet VHA standards. However, the increasing outpatient workload could ultimately have a negative effect on clinicians' ability to maintain these standards.

1. Radiology and Pathology Report Transcription Turn-around Time

Managers acknowledged a problem with prompt transcription of radiology and pathology findings due to a recent change that resulted in the vendor providing off-site transcription service, and delays in recruiting for vacant transcriptionist positions. They are pursuing a new transcription contract and considering the acquisition of voice recognition software that will expedite the turn-around time. They mentioned that the implementation of new software is stalled as a result of a system-wide moratorium on new software until March 2000. They are in the process of submitting a waiver to this moratorium. Managers need to take action to meet the timeliness standards that will expedite clinical decision-making.

2. Outpatient Appointment Waiting Times

We asked patients who presented to the clinics for scheduled appointments whether they were seen within 30 minutes of their scheduled appointment times. Of the 144 patients who responded to the question, 115 (80 percent) said that they were seen within 30 minutes, all or most of the time. In the case of "walk-ins," only 55 of 88 patients (63 percent) told us that they are seen by a clinician within 15 minutes of their arrival in Walk-in Clinics, most or all of the time.

The quality of outpatient care in terms of timeliness is an issue that continuously needs management's attention. Managers need to assure that clinicians see patients within 15 minutes of their arrival in the Walk-in Clinics.

3. Appointment Scheduling

Patients identified delays in getting Primary Care, Cardiology and Pain Clinic, appointments, prescription filling, and scheduled radiology studies. A construction project is due to begin in FY00, that managers hope will improve efficiency. Managers told inspectors about a plan with the University of Nebraska Medical Center to contract for additional providers to staff the Pain Clinic, which currently has waiting times of more than 6 months.

The facility is participating in the VHA/Institute for Healthcare Improvement project that is expected to address system problems and reduce waiting times in select clinic areas.

4. Prescription Filling

Patients told us that the time that they spend in waiting for prescriptions to be filled often exceeds 1 hour. Managers should consider requiring that refills be processed through the Centralized Mailout Pharmacy Program and/or automating their prescription filling processes. Inspectors noted that key pharmacy supervisory positions are vacant. We understand that managers have had difficulty finding qualified candidates for these key positions. We suggest that managers consider creative options for attracting qualified candidates.

F. Coordination and Continuity

The changes in the way that the VISN provides for patient care needs have had significant impact on this facility. Management needs to address the challenges in coordination of care and treatment planning over the entire continuum of care in order to improve patient satisfaction.

1. Referral and Transfer Process

Several patients whom we interviewed told us that they were unhappy with the coordination of care that they received when they were transferred or referred to the Omaha facility. Patients cited problems with scheduling and transportation, as well as confusion as to whether or not surgical procedures would be performed. Inspectors reviewed a flow chart of the referral process that is confusing and difficult to follow. Communication between referral facility clinicians and Omaha clinicians needs to be strengthened to ensure a seamless continuum of care.

2. Transportation

The facility provides shuttle buses that transfer patients to and from the Lincoln, Grand Island, and North Platte facilities. These buses operate at scheduled times, which presents problems for patients whose appointments run late. Management needs to address these transportation needs. The medical center is fortunate to have van drivers who seem to genuinely care about the patients and look after their best interests to the extent possible.

3. Consistency of Care Providers

Patients complained that different care providers see them at each visit. OHI suggests that managers continue to work on the primary care provider assignment process so that patients have consistent care providers. Patients complained that their clinicians often fail to follow-up on the specialty care that they receive such as surgery. We suggest that managers provide for improved transition between inpatient/specialty care and the primary care provider, perhaps through the use of electronic mail notification of primary care providers when one of their patients is admitted.

4. Coordination of Care

Management has responded to concerns about treatment and transition coordination by designating RN case managers to assist with the coordination of care for both inpatients and outpatients.

The facility has created an Evaluation Unit (EU) for patients who need diagnostic evaluations. EU employees coordinate all diagnostic tests and procedures performed in 1 day, on an outpatient basis. The facility has plans to extend and enhance this unit in the coming years.

The VISN chartered a task force to analyze acute mental health care practices and needs. The recommendations of this group included new comprehensive programs for the mentally ill patient population. Some of these recommendations appear to have merit, and we encourage VISN managers to consider them.

G. Facility Environment

OHI inspectors were generally impressed with the cleanliness and accessibility of the facility. But, there are several areas that need to be improved.

1. Operating Room Area

The physical environment of the operating rooms (OR) is unacceptable. Several employees told us that the OR was not clean. Inspectors confirmed these conditions. They found that water leaks had damaged the ceilings and walls. The walls have peeling paint that is easily dislodged by touch. The floors are badly rutted and stained, and therefore difficult to keep clean. Nursing employees told us that they had raised these issues, but that they did not believe that managers had made repairs a high priority. Medical center managers should increase environmental rounds to the OR and should more closely monitor the OR environment. We understand that the medical center has a project scheduled, in FY00, that will improve the unacceptable OR conditions. Nevertheless, the ceiling and walls need to be repaired immediately, and the floor should be addressed through a local project proposal.

2. Hallways

Inspectors noticed that carts of all sizes were parked in the hallways throughout the medical center. We also received complaints that carts frequently obstruct wheelchair access to the Prosthetics Section. Cart clutter was especially evident on the inpatient units. Managers need to assess storage needs, and explore innovations in wall storage units as they implement the inpatient ward renovation. The goal should be that the hallways are clear except for carts that are in active use, and that could be easily moved in case of emergency.

3. Laboratory

The Laboratory Manager characterized the location of the Microbiology Unit in the Research building as inefficient. Although relocation of the Microbiology Unit into the Laboratory area has been proposed, it has not been a high priority for the facility. With the projected increase in workload from other VISN facilities, having all Laboratory sections in a single location will improve efficiency and should facilitate better staff utilization. Managers should consider relocating the Microbiology Unit in future construction/space planning.

H. Staffing Issues Raised by Employees

During our review, several managers and employees indicated a need for more employees or a need to achieve more with existing employees. OHI made a number of observations regarding staffing that could affect the quality of patient care, and we offer them for consideration in developing staffing priorities or requesting additional funds.

1. Nurse Staffing

The nurse staffing level is an issue of concern to nursing employees. Many nursing employees feel overwhelmed by their workloads; or more significantly, that their ability to attend to patients' needs is, at times, inadequate. Nurses frequently commented that patient acuity is a concern along with reduced nursing staffing. In our questionnaire, we asked clinicians if they have adequate time to spend with patients when patients are anxious or in need of emotional support. Thirty-five out of 49 respondents (71 percent) told us that they have the time to meet their patients' needs, all or most of the time.

Nursing managers attributed the less-than-optimum staffing levels to factors such as staff shortages, light-duty assignments, and increased sick-leave usage that are often triggered by fatigue that is associated with mandatory overtime. Nurse managers told inspectors that the Director has approved recruitment of more licensed practical nurses, but they are having difficulty recruiting.

2. General Staffing Concerns

Employees at all levels told inspectors that they are required to care for a larger number of patients with fewer resources. Lack of adequate clerical support staff was cited as a significant deficiency, because inadequate clerical staffing has required clinical employees to perform increased clerical duties.

Mental Hygiene Clinic employees raised concerns about inadequate physician support due to the recent departure of three full-time psychiatrists. Managers are actively seeking to fill these positions, but are having difficulty recruiting. Employees also cited the need for a registered nurse in the MHC. The Clinic manager submitted a proposal to re-establish this position, but we were told that no recruitment action had been taken, as of the time of this review.

Employees expressed concerns about the proposed elimination of the Radiology Service midnight shift. Presently, one full-time Radiology employee is assigned to cover the midnight shift. Employees fear that this measure will lead to potential delays in patient diagnosis and treatment. Radiology managers told us that this proposal is still under review, and subsequently decided not to implement this change.

Employees expressed concern with Cardiology Clinic staffing. Patients encounter long waits for Cardiology Clinic appointments.

I. Clinical Manager, Clinician, and Patient Survey Results

Clinical employees and patients generally told us that:

- Employees are courteous.
- Necessary medical technology and specialized care are available.
- Patient and family education is provided and is understandable.
- Call lights are answered within 5 minutes.
- The food is good and of the right temperature.
- Patients are involved in treatment decisions.
- Outpatient appointments and prescriptions are arranged for inpatients before discharge.
- The facility is usually clean.
- System signage is easy to read and understand.

1. Patient Satisfaction

The patients are very pleased with the care that they receive at the medical center. Of the 135 patients who responded to the question, 112 rated the overall quality of care that they receive as good to excellent (83 percent). Eighty-five percent of the patients interviewed told us that if they could go to any hospital, all or most of the time they would prefer to return to this facility (129/152). Eighty-eight percent of respondents told us that they would recommend medical care at this facility to an eligible family member or friend (135/153).

2. Clinical Employees

Clinical employees (includes both clinical managers and clinicians) whom we interviewed generally rated the Omaha VAMC's quality of health care as good to excellent. However, relatively low percentages of clinicians (25/46 or 54 percent) and clinical managers (12/17 or 71 percent) responded positively to a question about whether they would recommend medical care at this facility to an eligible family member or friend, all or most of the time. These data seem to present a contradiction that management may wish to explore in more detail.

3. Employee Questionnaires

Eighty-two employees responded to OHI's confidential questionnaire. However, not all respondents answered every question. Therefore the denominator will not always be the same.

All employees indicated that they believe they are qualified to do their jobs; and 94 percent of employees agree or strongly agree (77/82) that their jobs contribute to improving patient satisfaction. Eighty-two percent (67/82) of the employees reported that they gain personal satisfaction from their jobs. Ninety-four percent (74/79) told us they feel safe coming to and leaving work, and in their work areas.

More than 90 percent of the surveyed employees, who are involved in direct patient care, told us that they are offered annual preventive health measures such as TB testing, Hepatitis B immunizations, and flu shots. Seventy-eight percent (39/50) have received violence prevention and management training.

Sixty-eight percent (56/82) of employees told us that they feel their performance is evaluated fairly, although 47 percent (38/81) told us that recognition and awards do not reflect performance. In general, employees seem satisfied with their supervisors in terms of accessibility, qualifications, and frequency of contact.

Only 60 percent (49/82) of the employees told us that the quality of care at this facility is a source of job satisfaction. Sixty-eight percent (56/82) told us that most of the time their work is manageable, although 44 percent told us that they cannot be totally efficient because of inadequate resources. Forty percent (31/78) told us that their particular areas are not sufficiently staffed to provide care to all patients who need it. We asked employees if they would recommend the facility to an eligible friend or family member and only 46 percent (38/82) told us that they would recommend care at this facility.

Inspectors accepted telephone calls from veterans and employees, and met with 16 individuals who expressed issues that were within the scope of this review. OHI inspectors reviewed and closed all of the issues that complainants raised during the week.

Summary of Recommendations

The Medical Center Director should:

1. Improve communication about quality and performance improvement activities between the Quality Council and the Executive Committee of the Medical Staff.

2. Assess waiting times for clinics and, as appropriate, take corrective actions to reduce waiting times to acceptable limits. Priority should be given to the Primary Care, Cardiology, and Pain Clinics, prescription filling, and radiology studies.

3. Improve patient transfers and referrals from other facilities to Omaha to ensure effective coordination and continuity of care.

4. Improve the primary care process to insure that all patients have an assigned primary care provider. The assigned provider should be a consistent staff member rather than a medical resident who works in the facility for a short time as part of a training program.

5. Improve patient transition from inpatient specialty care, such as surgery, to primary care.

6. Take immediate action to correct the physical environmental concerns in the operating rooms.

7. Review the effectiveness of the home glucose-monitoring program, including documentation, education, and quality control. Collaboration and cooperation between the Ancillary Testing Coordinator and the clinic coordinators should be reinforced.

Medical Center Director Response:

The full text of the Medical Center Director's response is available for review in Appendix IV. The response indicates full concurrence with all recommendations. OHI considers the plans detailed in the response to be adequate, and no further follow-up is necessary.

MANAGEMENT CONTROL

Objectives and Scope

The Office of Audit reviewed selected medical center administrative activities and management controls. The objectives of the review were to determine if the selected activities and controls operated effectively.

We reviewed the following 12 activities and management controls:

Construction Planning	Ambulance Contract Administration
Equipment Accountability	Government Purchase Card Controls
Credentialing and Privileging	Controlled Substances Security
Leased Space Management	Warehouse Security
Telephone System Use	Information Technology Security
Fee Basis Medical Services	Agent Cashier Operations

The review covered the Omaha VAMC's operations for FY99. In performing the review, we inspected work areas, interviewed VAMC management and staff, and reviewed pertinent administrative, financial, and clinical records.

The administrative activities reviewed were generally operating satisfactorily and management controls were generally effective.

A. Construction Projects Were Justified.

We reviewed justifications for three approved construction projects.

1. Boiler Plant, Building 2 Structural Repairs (non-recurring maintenance approved project cost is $226,000).
2. Replace A, B, and D Wing Roofs (non-recurring maintenance approved project cost is $540,000).
3. Outpatient Clinic Expansion Phase 2 (minor construction approved project cost is $2,878,000).

The justifications for all three projects were adequately developed and supported,[1] and the project applications complied with the instructions contained in the FY00 call letters.

B. Equipment Accountability Was Satisfactory in Clinical Services.

We reviewed the 18 Consolidated Memorandums of Receipt (CMR)[2] for the clinical services. The designated official for each clinical service certified that the CMR was complete and accurate. We selected 10 pieces of equipment listed in the CMRs and verified that the equipment was at the medical center. We also selected five pieces of

[1] For the outpatient clinic expansion project, our review did not attempt to validate the need for any particular component of the project, nor the amount of space planned.
[2] Listings of nonexpendable equipment that must be accounted for by responsible officials.

equipment in two services and verified that the equipment was listed on appropriate CMRs.

C. Procedures for Credentialing and Privileging of Physicians and Dentists Met Handbook 1100.19 Requirements.

We obtained a list of the names of the 423 physicians and dentists who provide care for the Omaha VAMC's patients. A credentialing and privileging folder had been established for each physician and dentist. We reviewed the credentialing and privileging folders for six physicians and one dentist. In every case, the folders had complete documentation for steps required by VHA credentialing policy.

D. Leased Property Was Essential to Medical Center Operations.

We reviewed the only space leased by the medical center. The lease was for a 2,444 square foot building used by the Veterans' Center in Omaha. The lease was appropriate because Veterans' Centers are normally located off the medical center campus.

E. Long Distance Telephone Charges Were Reasonable.

We reviewed the long distance telephone costs for commercial calls made during the prior 24 months and procedures for approving the calls. We concluded that the costs for commercial phone charges were kept to a minimum and that approval procedures were satisfactory. The average monthly cost was $150. Medical center staff needing to make a long distance telephone call on a commercial line must obtain pre-approval from the Manager, Information Resources Management (IRM), who then authorizes the telephone operator to make the call.

F. Areas That Could Be Improved.

1. Fee Basis Claim Payments — Improved Controls and Procedures Could Eliminate Overpayments.

Omaha VAMC managers implemented several good controls and procedures for care provided on a fee basis, as shown below:

a) Fee basis care was usually pre-authorized.
b) Fee basis staff usually sent an authorization to the care provider explaining what care was being authorized.
c) Care providers seeking payment were required to submit documentation that described the care provided, which facilitated the processing of payments.
d) Fee basis staff maintained all records and documentation related to each payment and filed the information by each quarter in the fiscal year.

e) Managers identified high cost and high use outpatient and inpatient procedures, and established contracts with providers that minimize the expenses related to these procedures.

We identified some fee basis controls that needed to be strengthened to ensure that payments are proper. Several procedural weaknesses left VA vulnerable to overpayments and fraud.

f) Authorization and Payment Duties Should Be Separated. Both of the fee basis clerks had the ability to authorize and make payments. Sound fiscal controls require that the same employee should not perform both of these duties, because an employee could potentially input a fraudulent authorization and process the payment undetected.

g) Access to Automated Programs Needed Better Monitoring. Employees had access to the fee basis program within VISTA[3] but no longer required it. An employee access list identified 11 employees who had access to the fee basis program, including 1 who no longer required access and 2 who could have been limited to "read only" access. The fee basis program manager was not aware that these employees still had access.

h) Authorization Periods Should Be More Specific. Fee basis staff routinely authorized a health care provider a period of 1 year to provide care and receive fee basis payments, although a year was usually more time than necessary to complete the authorized treatment. According to the fee basis staff, authorizing a 1-year period reduced workload by limiting the number of authorizations for veterans who had multiple visits throughout the year. However, in many instances, the multiple visits were for different medical procedures. The authorizations were not specific and did not inform the payment processor which medical procedures were authorized and payable. This allows the potential for payments to be made for unauthorized care. In addition, it was inferred that inputting a separate authorization into the VISTA system for each episode of fee-based care would require too much electronic data storage space. However, our reviews of much larger fee basis programs at other medical centers have not identified this as an issue.

i) Better Management of Treatment Plans Could Reduce Costs. Although the care for specific patients is usually vigorously managed, we identified a patient whose care, and the costs entailed, should have been better managed. The patient, who had an eating disorder, suggested that she be treated at a $700-per-day clinic in another state, where she had previously been treated. The VA physician agreed that it would be medically appropriate to continue treatment at that facility. The fee basis program manager was then instructed to process the payments for the bills. Although other clinics were available at less cost - notably, one at the University of Nebraska Medical Center - an analysis of available alternatives and

[3] Veterans Health Information System and Technology Architecture (VISTA) is the medical center's information system.

their costs was not conducted. Ultimately, when budget shortfalls were pending for the Omaha VAMC, it was decided that a less costly alternative in Omaha would be appropriate.

j) The Lincoln VAMC Should Manage Home Health Care Payments. The Lincoln VAMC manages the home health care treatments for the Omaha VAMC. However, we identified two instances in which the Omaha VAMC's staff circumvented the Lincoln VAMC's management and may have paid $12,395 inappropriately. The Omaha VAMC's fee basis program manager stated that the Lincoln VAMC had denied payment in both cases since they were not pre-authorized. In addition, a representative of a service organization had become involved on the behalf of both veterans to get their home health care paid by VA. The Omaha VAMC's fee basis program manager approved the payments because he believed that VA would have paid the claims if appealed by the service organization.

   The fee basis clerk who processed the payments believed that the Lincoln VAMC had denied one veteran's claim because the veteran was receiving aid and attendance benefits, which should have been used to pay the home health care claims. This particular veteran was reimbursed $1,804 for past home health care that had been paid on the veteran's behalf.

   The second veteran was reimbursed $9,233 for past home health care that had been paid on the veteran's behalf. In addition, the fee basis clerk made two payments totaling $1,358 for this veteran's home health care that remained unpaid and incorrectly input a combined total into the fee basis system. These multiple treatments should have been input individually for each date of treatment. The clerk stated that he was unaware of the exact procedures since the Lincoln VAMC usually processed home health care payments.

k) Fee Schedule Reporting Needed Improvement. There was an appearance of overpayment to fee providers. We identified at least 45 CPT-coded[4] payments that were as much as $1,892 higher than the amounts specified on the fee schedules. Eleven of the payments were overpaid by more than $100. The total amount overpaid was $7,252.

   VAMC managers stated that limitations in the VISTA software caused them to combine the supply charges with the CPT charge to correctly pay the obligation to the provider. The combined amount was entered into the software instead of the fee schedule default amount, which created the appearance of overpayments. We have determined that VACO fee basis program officials have been considering alternative software systems to replace the current software, which would allow separate entries for the supply charges and the CPT charges.

[4] Common Procedure Terminology.

Conclusion. To strengthen fee basis controls and improve procedural weaknesses to ensure that payments are proper, the fee basis program manager should:

- Separate the fee basis care authorization and payment duties.

- Evaluate and limit employees' access to fee basis system data as necessary.

- Limit fee basis authorizations to the period of time that is medically necessary to accomplish the planned treatment. Ensure that authorizations specify authorized care.

- Determine the most effective alternative of care and prepare cost analyses and justifications as appropriate.

- Refer the management of all home health care payments to the Lincoln VAMC.

2. Medical Transportation Contracts — Better Coordination with Other VA Facilities and Revised Contract Provisions Could Improve Transportation Management.

We reviewed the management of the medical transportation (ambulance) contracts and programs at the Omaha VAMC. The Omaha VAMC's medical transportation program costs, for FY99, were as follows:

Contract Description	FY99 Payments
Ambulance Service	$235,184
Contract Van Service	147,436
Courtesy Car Service	81,954
Total Medical Transport Costs	$464,574

We reviewed a sample of six invoices and interviewed the Travel Office Coordinator and determined that policies and procedures were generally appropriate and effectively implemented in accordance with the contract terms.

We determined that the medical transportation program could be improved. Better coordination of shuttle service between VA facilities in Nebraska would eliminate unnecessary travel expenses. In addition, revised contract provisions would provide additional cost efficiencies.

a) Coordination Between VA Facilities Needed Improvement. The Omaha VAMC provides daily scheduled transportation shuttles to and from the Grand Island VAMC. Although the shuttles can accommodate wheelchair patients at a low cost, the Omaha VAMC was transporting patients to the Grand Island VAMC's nursing home via contract van services that cost $287 each way. According to the travel office coordinator, these patients are presently unable to utilize the

scheduled VA shuttle because the Grand Island VAMC requires that admissions occur before noon. Morning arrivals allow the nursing home physicians to evaluate and admit the patients the same day. The Travel Office Coordinator stated that the Omaha VAMC's shuttles do not depart in time to get patients to the nursing home before noon. If the shuttle was rescheduled or other arrangements were made, contract van costs could be avoided. We were unable to determine the impact on the travel budget because the trip information is not automated and the number of trips to the Grand Island nursing home was not readily available.

The above noted procedural deficiency was brought to our attention through discussions with the Travel Office Coordinator, who believed that the Assistant Director, Facilities Management Department, who supervises the travel office, was aware of this situation. However, we determined that the Assistant Director was unaware of the potential cost savings that could be achieved through better coordination and procedural changes. We informed the Travel Office Coordinator that possible program improvements and cost efficiencies should be brought to management's attention. Also, managers should remind employees that significant suggestions for improvements are potentially eligible for VA's award program.

b) Contract Provisions Needed to Be Revised. The provisions of the ambulance contract need to be revised to provide additional cost efficiencies. The contract provides for a round trip charge when the patient is transported from the Omaha VAMC to a radiation treatment facility and returned, which includes a minimal wait by the ambulance staff. However, we determined that the contract does not provide for a round trip charge when the patient is transported from a residence to the radiation treatment facilities and returned. In such cases, the Omaha VAMC is charged for two separate trips at twice the price.

Our review showed that the contract allowed for one charge if a veteran was delivered to the Omaha VAMC from within the city limits, but an additional charge was applied if a veteran was delivered from suburban areas. We identified instances in which veterans who lived in suburban areas lived closer to the Omaha VAMC than some veterans who lived in Omaha. In some instances, the mileage was identical, but the Omaha VAMC was billed for an additional charge from the suburban area. For example, one veteran's residence was located in Papillion, a suburb of Omaha. The Omaha VAMC is actually closer to Papillion than the northern boundary of Omaha. Therefore, an additional mileage charge should not be appropriate. The Assistant Director, Facilities Management Department, agreed that revising the contracts to define the "city limits" or distance from the Omaha VAMC before applying mileage charges would be beneficial to the medical transportation program.

c) Ambulance Trip Data Needed to Be Automated. Although the travel office coordinator kept adequate records of ambulance trips and approvals, the records

were kept manually. Our review showed that the records needed to be automated to improve contract administration. Since they were not automated, VA was unable to estimate its needs accurately for the contractor, because the number and frequency of actual trips was not readily available. The contract's estimates for services to be provided by the contractor were based on the prior contract's estimates. As a result, the contractor was also unable to identify the number of vehicles and staff that needed to be available. Our review of the ambulance contract records identified instances where this caused ambulance services to be delayed. In one example, the contractor underestimated the number of vehicles needed in service at one time. In another example, the contractor underestimated the number of trips, which caused the contractor to place vehicles in service for more extended trips than originally planned. The Assistant Director, Facilities Management Department, agreed that automating the medical transportation information would enable better estimates for planning and contract preparation purposes, and should help reduce the number of delays. In addition, accurate estimates will enable potential contract bidders to estimate costs more precisely.

Conclusion. To maximize cost efficiencies and improve ambulance contract administration, the Assistant Director, Facilities Management Department, should:

- Coordinate transportation scheduling with other VA facilities and revise procedures to utilize VA shuttle services, when appropriate.

- Notify employees that they should bring known program improvements and cost efficiencies to management's attention, and emphasize the possibility of awards for significant suggestions.

- Amend the medical transportation contract to:
  - ✓ Better define the distance from which additional mileage charges would apply.
  - ✓ Specify round trip charges from the veterans' residences, when the trip includes a short waiting time to accomplish the treatment.

- Automate records of ambulance trips and approvals.

3. Purchase Card Program — Purchase Card Management Needs Better Oversight.

VA medical centers are required to use government issued purchase cards for small purchases of goods and services (usually $2,500 or less per order). Our review of management controls over purchase cards showed that better oversight is needed to ensure that:

- Facility policy is kept current and enforced.

- Cardholders cannot approve their own transactions.

- The cards of departing employees are retrieved and deactivated.

- Account setups for cardholders and approving officials are kept current in the Purchase Card Program Contractor[5] proprietary system and IFCAP.[6]

- Cardholders' accounts are reconciled timely.

  a) Facility Policy Needed to Be Updated and Enforced. The station level policy, dated August 1997, was due for review, in August 1999, but had not been updated. The policy designated the Assistant Director, Resource Management, to serve as the facility's Purchase Card Program Coordinator. However, since the policy was first issued, the coordinator duties had been reassigned to an employee at the Lincoln VAMC. Our review showed that the policy could be better enforced, as described below.

  b) Controls Over Cardholders and Approving Officials Needed Improvement. VHA policy[7] requires the coordinator to set up on-line accounts for cardholders and approving officials in the Program Contractor's proprietary system as well as in IFCAP. The coordinator is also responsible for daily maintenance on-line; to include changes in cardholders or approving officials.

  Our review showed that, as of October 28, 1999, 53 persons had active purchase cards. We identified one cardholder who was also inappropriately designated as the approving official for two fund control points. The cardholder—the Chief, IRM—was able to make individual purchases of up to $10,000 without oversight, with monthly limits of up to $20,000. According to the VA Training Guide for Government Purchase Cards, revised April 1999, cardholders cannot approve their own transactions.

  Our review also showed that 2 of the 53 active cardholders were former employees. VHA policy[8] requires the Purchase Card Program Coordinator to retrieve and cancel cards of any employee who either terminates employment with VA or violates purchase card procedures. However, action was not taken to eliminate the possibility that these departed employees could use the cards.

  The names of both former employees were still shown as cardholders in the Program Contractor's proprietary system; one was also shown as an approving official. In one instance, the former employee left VA employment in June 1999. However, there was no documentation to show that the coordinator contacted the Program Contractor to cancel his card. The other former employee left VA employment in September 1999. The coordinator retrieved and destroyed the employee's purchase card and promptly contacted the Program Contractor to cancel the card.

[5] Commercial credit card provided under contract to government activities for purchase of goods and services.
[6] VA's Integrated Funds Distribution, Control Point Activity, Accounting Procurement System.
[7] VHA Handbook 1730.1, paragraph 2e(4) and (6)(b).
[8] VHA Handbook 1730.1, paragraph 2e(3).

Nine other persons who had terminated VA employment were still shown as approving officials in the Program Contractor's proprietary system. These persons terminated VA employment between February 1997 and October 1999.

c) Purchase Card Transactions Should Be Promptly Reconciled. VHA has established controls to ensure that items purchased were actually received, charges were for official purposes, and bills were correctly paid. Cardholders must reconcile payment charges reported by the Program Contractor with the purchase amounts recorded in IFCAP within 5 days of the IFCAP message confirming VA payment. The approving official must then certify reconciled charges in IFCAP within 14 days. The Fiscal Officer is responsible for monitoring reconciliations of cardholders.

Our review showed that on October 26, 1999, 329 of 415 unreconciled transactions (79 percent) totaling $321,355.44 had not been reconciled by cardholders within the required 5 days. Reconciliations were delinquent by as much as 117 days. As a result, it may be difficult to ascertain whether frequently procured items were received and billed correctly, or if they should be disputed.

In one instance, a cardholder had 48 of 65 transactions that were not reconciled within the required 5 days. The reconciliations were delinquent by as much as 26 days. The cardholder is the Requirements Analyst at the Lincoln VAMC, who is responsible for ordering medical supplies for both the Lincoln VAMC and the Omaha VAMC. The cardholder's supervisor–the Manager, Acquisition and Materiel Management Section (A&MMS)–explained that the cardholder's primary responsibility, ordering medical supplies, preclude her from being timely with reconciliations.

In another instance, a cardholder had 156 of 166 transactions that were not reconciled within the required 5 days. The cardholder is one of two purchasing agents in A&MMS. The transactions were not reconciled because purchasing responsibility had not been decentralized to other medical center departments. The 2 purchasing agents had responsibility for 58 purchasing cards. When one of the agents was on sick leave, the other agent's workload precluded her from reconciling her transactions timely. The purchasing agents have been given extra time to reconcile transactions. VHA policy[9] requires that purchase card usage not be centralized in A&MM. Managers are in the process of transferring the purchasing responsibility for some of the 58 cards to the Pathology and Laboratory Medicine Department and to the Associate Chief of Staff, Research. However, a concerted effort is needed to decentralize the purchase cards.

[9] VHA Handbook 1730.1, paragraph 2b.

Conclusion. To eliminate the vulnerability of unauthorized purchases, the coordinator should ensure that employees are not cardholders (procurement agents) and also approving officials, purchase cards are retrieved and cancelled for departing employees, and that the Program Contractor has been notified to terminate the status of departing employees as approving officials. This may require a procedure in which Human Resources and/or the department manager notifies the coordinator when an employee has terminated employment or is no longer an approving official.

To eliminate the vulnerability of items purchased that are not actually received, charges being made for items that are not for official purposes, and bills not correctly paid, the coordinator should work with supervisors to improve timeliness of reconciliations, and report reasons for continued delinquency. If these measures do not markedly improve overall reconciliation timeliness, purchase card responsibilities should be reassigned where necessary. Additionally, management should make a concerted effort to decentralize purchase cards.

4. Controlled Substance Security — Inspection Procedures Were Effective But Could Be Enhanced.

Our review of controlled substance security showed that controls were generally adequate. The facility's policy for controlled substance inspections was in accord with VACO procedures. Our review of inspection records and procedures showed that facility policy was usually followed. As required, inspections were conducted monthly and unannounced. The Controlled Substances Inspection Coordinator had selected inspectors who did not handle drugs. An adequate number of staff had been selected to assure that staff was available to conduct the inspections. The coordinator evaluated inspectors' findings on an on-going basis for trends.

We also identified pharmacy procedures that could be enhanced and instances where compliance with VA policy could have been better.

a) Fewer Persons Should Have Access to the Controlled Substances Vault. We determined that all 13 pharmacists and 2 pharmacy technicians had access to the vault where controlled substances are stored and dispensed. VA policy requires that access should be limited to 10 or fewer persons. The Chief Pharmacist agreed that access needed to be limited.

b) To enhance controlled substance inspections, the Controlled Substances Inspection Coordinator should ensure the following:

    1) Inspectors Should Account for Doses Prepackaged and Kept In The Vault. Our review of vault dispensing and inspection procedures showed that vault technicians prepackage vials of Tylenol with Codeine (12 tablets per vial) and keep them in the vault. The vials are issued to the Emergency Room as needed. When inspecting the vault, inspectors did not account for those prepackaged doses. Since the vials are made of clear plastic, they can be

counted without opening the vials. The Chief Pharmacist agreed that inspectors should account for the prepackaged tablets and that the inspection procedure would be revised to include them.

2) Inspection Results Were Not Always Recorded For Each Area. Our evaluation included a review of the July 1999 inspection records, which show that results were not recorded for inspections of the Surgical Intensive Care Unit, Preop, Recovery, and one of three Research areas. The Inspection Coordinator stated that he had inspected those areas and had not documented them, but he agreed that results should be recorded.

3) Inspectors Did Not Identify Instances of Expired Controlled Substances. Our review showed that expired drugs were usually identified. However, we identified one ward in which drugs had expired, in April 1999, but were not identified until July.

4) Inspectors Did Not Identify an Area Where Controlled Substances Should Not Have Been Dispensed. Our review showed that several controlled substances were issued to one ward but that some of the controlled substances were infrequently administered to patients. Ward staff and inspectors had consistently accounted for the controlled substances since 1996. The Chief Pharmacist and the Inspection Coordinator agreed that unneeded controlled substances should be returned to the pharmacy.

5) Inspectors Did Not Confirm That Instances of Physician Orders Had Been Written For Dispensed Doses. Our review showed that inspectors generally sampled one or two patients' charts in ward areas to confirm that physicians had prescribed the controlled substances and the dosages that were dispensed. However, they did not sample charts for clinics. The coordinator explained that the charts were usually no longer available at the clinics because they had been returned to the file room when the patient visit was completed. In our view, the inspectors should periodically sample physician orders for each of the areas inspected.

Conclusion. To enhance controlled substance security in the vault, the chief pharmacist should limit access to fewer than 10 staff, and the Controlled Substances Inspection Coordinator should ensure that inspectors:

- Account for prepackaged doses in the vault.
- Document results for each area inspected.
- Are alert to expiration dates of controlled substances.
- Identify opportunities to reduce or discontinue issuances of controlled substances where they are infrequently dispensed.

- Sample charts periodically for physician orders for patients who have received controlled substances in clinics.

5. Information Technology Security — System Security Could Be Enhanced.

We performed a limited review of the medical center's automated information system controls. Overall, the medical center staff had implemented policies to protect the integrity and confidentiality of data in automated systems. Procedures were in place to control and monitor access to automated systems and local area network applications. Physical security for the computer room was adequate. Our review did find that system security could be enhanced.

The Manager, IRM relies on medical center managers and supervisors to inform IRM of personnel changes that affect levels of access to information. Our review showed that this procedure was not effective when employees moved to another service. For example, our review of fee basis payments showed that three employees no longer required access to fee basis information, but IRM was not informed. We believe Human Resources Management has the best knowledge of changes in personnel and should notify IRM when employees have transferred within the hospital or have left VA employment. The change would provide IRM with sufficient and timely information to allow quick follow-up with managers to determine whether an employee's needs for computer access have changed.

Conclusion. The security of the facility's computer system would be enhanced if Human Resources Management informed IRM of personnel changes and IRM followed up with managers to identify necessary changes in access to system information.

6. Agent Cashier - The Current Combination to the Agent Cashier's Safe Should Be Maintained ***(b)(2)***.

We caused an unannounced audit of the Agent Cashier's advance to be conducted. During the cash count we were not able to count the funds of one of the alternate cashiers. The alternate cashier was on emergency leave, and the Agent Cashier could not find a key to open the alternate cashier's cash box. The Agent Cashier position had recently been filled, and the new Agent Cashier informed us that the safe combination had not yet been placed ***(b)(2)***. The Agent Cashier had a sealed envelope with her name and the alternate's name. A statement on the envelope indicated that there was a key inside. The envelope did not contain a key. The Agent Cashier stated that she had written on the envelope that a key had been given to the alternate cashier. These envelopes were in the Agent Cashier's safe awaiting the signature of the Chief of Fiscal Operations.

The cash count was not completed. We accounted for all of the $12,000 advance except for ***(b)(2)*** in the alternate cashier's cash box. We identified an overage of $1, which was subsequently deposited into the medical care appropriation account.

The physical security of the Agent Cashier's Cage was adequate. ***(b)(2)*** .....

Conclusion. ***(b)(2)*** ..... should contain the current combination to the Agent Cashier's safe.

Summary of Recommendations

The Medical Center Director should:

1. Enhance the fee basis program by ensuring that the program manager:

    a) Separates the authorization and payment duties.
    b) Evaluates and limits employees' access to fee basis system data as necessary.
    c) Limits fee basis authorizations to the period of time that is medically necessary to accomplish the planned treatment, and ensures that authorizations specify care.
    d) Determines the most effective care for each patient and prepares cost analyses and justifications as appropriate.
    e) Refers the management of all home health care payments to the Lincoln VAMC.

2. Enhance medical transportation services by ensuring that the Assistant Director, Facilities Management Department:

    a) Coordinates transportation scheduling with other VA facilities and revises procedures to utilize VA shuttle services, when appropriate.
    b) Notifies employees that they should bring known program improvements and cost efficiencies to management's attention, and emphasizes the possibility of employee awards for significant suggestions.
    c) Amends the medical transportation contract to:

        1) Better define the distance from which additional mileage charges would apply.
        2) Specify round trip charges from the veterans' residences, when the trip includes a short waiting time to accomplish the treatment.

    d) Automates records of ambulance trips and approvals.

3. Improve purchase card management by:

    a) Updating the facility policy for purchase card management.
    b) Making a concerted effort to decentralize purchase cards to user activities.
    c) Ensuring that cardholders' accounts are reconciled timely.
    d) Ensuring that the Purchase Card Program Coordinator:

        1) Retrieves and cancels purchase cards for departed employees.
        2) Establishes account setups in which cardholders cannot approve their own transactions.
        3) Maintains current account setups for cardholders and approving officials in the Purchase Card Program Contractor proprietary system and IFCAP.

4. Enhance controlled substance security by:

    a) Ensuring that the Chief Pharmacist limits access to the controlled substances vault to fewer than 10 staff.
    b) Requiring the Controlled Substances Inspection Coordinator to ensure that inspectors:

        1) Account for prepackaged doses in the vault.
        2) Document results for each area inspected.
        3) Are alert to expiration dates of controlled substances.
        4) Identify opportunities to reduce or discontinue issuance of controlled substances where they are infrequently dispensed.
        5) Sample charts for physician orders for patients who have received controlled substances in clinics.

5. Improve security of information systems by establishing a procedure in which:

    a) Human Resources Management staff notifies IRM of changes in employees' job status.
    b) IRM staff follows up with managers to determine whether changes in employees' job status necessitate changes in access to system information.

6. ***(b)(2)*** has the current combination to the Agent Cashier's safe.

Medical Center Director Response:
The full text of the Medical Center Director's response is available for review in Appendix IV. The Director indicated concurrence with all recommendations.

FRAUD AND INTEGRITY AWARENESS

Objectives and Scope

On October 26, 1999 Special Agents assigned to the Central Field Office of Investigations conducted two fraud and integrity awareness briefings at the Omaha VAMC. The presentations were well received by approximately 97 individuals from all services of the facility. The briefings included a lecture, a short film presentation, and a question and answer period. Each training session lasted approximately 75 minutes.

The presentations included a history of the Office of the Inspector General, discussions of how fraud can occur, examples of criminal cases, and information regarding how to prevent, detect, and report fraud and other crimes. Specific case examples were cited to demonstrate how administrative safeguards have been circumvented and to illustrate what the Office of Investigations does.

Other entities within the Office of the Inspector General, which are devoted to different disciplines, were also briefly discussed. For example, the Office of Audit conducts audits to ensure that VA is utilizing its budget and other vital resources in the most efficient manner. Some audits are scheduled reviews of programs and critical operational areas while other audits are conducted in response to specific allegations of mismanagement. Additionally, the Office of Healthcare Inspections conducts inspections of VA's medical facilities to ensure that the highest possible quality of care is provided to veterans. The Office of Healthcare Inspections also addresses specific allegations involving patient care issues.

Additional topics were addressed as follows:

A. Reporting Requirements

Attendees of the fraud and integrity awareness briefings were strongly encouraged to immediately report all types of illegal activity to their direct supervisors or to the Inspector General Hotline Center in Washington, DC. The relevant VA policy and procedures manual, MP-1, Part 1, Chapter 15, delineates the responsibility of VA employees to report suspected fraud and other crimes. Since the OIG is heavily dependent upon employees to report such matters, the attendees were notified that contact with the OIG to report suspected crimes would be handled in a confidential manner. The telephone number and address of the Inspector General Hotline were provided to all attendees.

B. Importance of Timeliness

Promptly reporting allegations of fraud or other crimes to the OIG is important for several reasons. First, criminal activity must be stopped as soon as possible. Secondly, the testimony of witnesses is often critical; a significant amount of time between the occurrence in question and the interview of a witness can result in the

witness' failure to accurately recall details. Additionally, relevant documentation or other evidence is more likely to be misplaced or destroyed (whether intentionally or not) over longer periods of time. Lastly, most federal crimes have a 5-year statute of limitations.

C. Referrals to the Office of Investigations - Administrative Investigations Division

The Administrative Investigations Division investigates allegations of serious misconduct on the part of VA officials that are not criminal in nature. Such an example is misuse of a government-owned vehicle by a VA official. An allegation of misconduct, which is substantiated by the Administrative Investigations Division, is referred to the appropriate VA management authority, usually a medical center or regional office director, for whatever disciplinary action, if any, is deemed necessary.

D. Referrals to the Office of Investigations - Criminal Investigations Division

Upon receiving an allegation of criminal activity, the Office of Investigations assesses the allegation and makes a determination as to whether or not an official investigation will be initiated. Not all referrals are accepted. If an investigation is warranted, the matter is assigned to a case agent who conducts the investigation. Records are gathered (with and without subpoenas) and interviews are conducted; many other investigative techniques may be utilized as well such as surveillance, consensual monitoring, search warrants, handwriting analyses, etc. When an investigation substantiates criminal activity, the matter is referred to the Department of Justice, i.e. usually to the local United States Attorney's Office. An Assistant U.S. Attorney then decides whether or not the matter will be accepted for criminal prosecution. Not all cases referred to the U.S. Attorney's Office are accepted for prosecution. Cases that are accepted for prosecution usually result in an indictment or an information - two vehicles that are used to formally charge an individual with a crime. Following the issuance of an indictment or information, the defendant must either plead guilty or go to trial. If a guilty plea is entered or the defendant is found guilty at trial, a sentencing will follow during which restitution, imprisonment, community service, a fine, probation, and/or home confinement may be ordered.

E. Areas of Interest for the Office of Investigations - Criminal Investigations Division

The Office of Investigations, Criminal Investigations Division, is responsible for conducting investigations of suspected criminal activity effecting any VA programs or operations. The range and types of investigations conducted by the office are very broad because VA is the second largest Federal Government department. As such it employs a great number of people, administers many different programs for veterans and their dependents, and purchases a large volume of goods and services. Different types of procurement-related fraud include bid rigging, defective pricing, product substitution, over billing, false claims, and bribery of VA purchasing officials. Bribery of VA officials can also occur within the arena of benefits programs. Other benefits-related

crimes include misappropriation by fiduciaries, compensation and pension entitlement fraud, loan origination fraud, and equity skimming. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, improper fee basis billings, and illegal receipt of medical services. Other areas of interest include theft and workers' compensation fraud.

F. Specific Issues Addressed

During the period October 25, 1999 through October 28, 1999, Office of Investigations personnel addressed the following three issues that had been raised by constituents of United States Senator J. Robert Kerrey (Nebraska) who referred them to the Inspector General. While the first two issues pertained to separate allegations of potentially criminal matters, the third issue, while not criminal in nature, was inter-related to the second issue and was therefore addressed as well.

1. Alleged Theft of Property from VA Medical Center Patients (Not Substantiated).

An allegation of recurring thefts of personal property from patients originated from one complainant. Approximately 2 years ago, the complainant accompanied a veteran to the VA Medical Center for an urgent care admission. Upon being admitted the veteran turned over his personal belongings, i.e., clothing, shoes, keys, and a wallet, to the medical center staff. The veteran subsequently passed away after which the complainant attempted to retrieve the veteran’s personal effects, but was told by medical center officials that the items could not be located. All attempts to locate the veteran's belongings were unsuccessful. Therefore, the complainant discussed the matter with the Medical Center Director and was apparently told that this type of loss “had been happening and was worse lately.”

Largely as a result of this incident, medical center officials including members of the Police Service examined the means by which patients’ personal effects were maintained. It was concluded that missing items resulted from a lack of accountability rather than a widespread theft problem; a policy to secure, maintain, and retrieve the personal belongings of admitted patients was not in place. In order to remedy the situation, management created and instituted such a policy (Memorandum No. 95-04), which set forth a standard operating procedure for accepting and maintaining the personal possessions of patients. Patients' belongings are now logged on a standardized inventory sheet upon admittance. Each patient’s signature is required to certify the accuracy of the inventory upon both admittance to and release from the medical center. According to management and police officials, since implementation of this policy in April 1998 the problem of missing personal items has been alleviated.

2. Alleged Abuse of a Patient by VA Medical Center Police Officers (Not Substantiated).

This allegation resulted from an incident wherein a veteran outpatient became angry and combative after his request for a narcotic pain suppressant was refused by a physician's assistant. The physician's assistant became fearful when the veteran swung his cane in a threatening manner. While the veteran left the area, VA police officers were summoned and responded. A short while later the veteran was located in another area of the medical center. As the police officers approached him, the veteran was brandishing his cane, still in a highly agitated state. The veteran refused to comply with the officers' repeated instructions to drop the cane and instead raised the cane as if to strike one of the officers. When the veteran stepped toward one of the officers with the raised cane in hand, the officer discharged his oleoresin capsicum (O.C.) projector, a.k.a. pepper spray, at the veteran twice. The veteran's aggression did not cease and a struggle ensued on the floor between the officers and the veteran. A third police officer arrived on the scene and though the veteran resisted their efforts, the police officers successfully handcuffed the veteran and effectuated an arrest at which time the veteran ceased to be combative. Subsequently, the veteran was immediately provided with medical care to treat the effects of O.C. spray and to assess his complaint of a sore ankle.

Statements by several VA employee witnesses corroborated these events. The U.S. Attorney declined this matter for federal criminal prosecution of assault charges citing a lack of evidence and instead suggested that local authorities could pursue a disorderly conduct charge.

Subsequent inquiry disclosed the Omaha City Attorney's Office has accepted this case for criminal prosecution. On November 8, 1999, an arrest warrant was issued for the veteran; on November 11, 1999, the veteran turned himself in to and was arrested by Omaha Police Department officials. The veteran has been charged with three misdemeanors: disorderly conduct, obstruction of justice, and resisting arrest. Prosecutive action is pending.

3. Alleged Inappropriate Dismissal of a VA Employee for Protecting a Patient (Not Substantiated).

During the arrest of a disorderly veteran outpatient by VA police officers (the incident mentioned in item no. 2 above), a VA employee intervened unsolicited while the officers were struggling with the veteran. It was alleged that the employee failed to follow one officer's instructions to back away and demanded that the officers let the veteran go. It also was alleged that the employee grabbed the arm of one officer during the incident.

Approximately 1 week after the incident, VA Medical Center officials conducted an administrative investigation which included a recorded interview of the

employee who was represented by an attorney. The employee denied being told to back away by police officers during the incident and also denied touching either of the police officers during the incident. However, statements by several VA employee witnesses corroborated the aforementioned events. Subsequently, at the request of the employee's attorney, management conducted additional employee interviews. Those interviews were conducted forthwith and no exculpatory testimony was noted.

After medical center management imposed disciplinary action, the employee, through counsel, filed an appeal with the Merit Systems Protection Board (MSPB). The case was dismissed after both parties reached a mutually acceptable settlement agreement that was also accepted by the administrative law judge.

The employee was not the source of this complaint. Based on our review of all of the facts, including that the employee was provided due process and was represented by counsel, and that the appeal was dismissed by MSPB, we concluded that the allegation is unsubstantiated.

Responses from the Medical Center Director
February 22, 2000

QUALITY PROGRAM ASSISTANCE

1. Improve communication about quality and performance improvement activities between the Quality Council and the Executive Committee of the Medical Staff.

Concur

Quality Council minutes are now reviewed by the Executive Committee at each monthly meeting.

2. Assess waiting times for clinics and, as appropriate, take corrective actions to reduce waiting times to acceptable limits. Priority should be given to primary care, Cardiology Clinic, Pain Clinic, prescription filling and radiology studies.

   2.a) Primary Care

Concur

The Omaha VAMC is currently involved in the Waits and Delays Activities through the IHI. Staff has attended the national training sponsored by the VA.

Clinic space is being redesigned in a multi-phased reconstruction project. Phase 1 is almost completed and Phase 2 is soon to begin. This project will increase the number of examination rooms and expedite the flow of patients through the area. Current efforts are in place to establish a written plan of care when a patient is returned to Primary Care from a specialty referral. This plan of care will expedite and better coordinate the follow-up care in the Primary Clinic thus using clinic time more efficiently.

   2.b) Cardiology Clinic

Concur

One of the problems in the Cardiology Clinic is that many patients are referred and there is not an efficient process in place to review the need for continued care in the specialty clinic and return appropriate patients to primary care follow-up. An RN Case Manager has been identified for the Cardiology Clinic. This position was approved at the time of the IG Inspection. This individual will work with the Cardiologists to identify patients who no longer need to be followed in the Cardiology Clinic and then work with the Primary Clinic to coordinate transition of cardiac care. This process will open additional appointments for the new referrals received by the clinic.

2.c) Pain Clinic

Concur

Prior to the IG inspection, this is an area which had been identified as a need. Scott Hofmann, M.D., Chief of the Anesthesiology Section, has been working on this issue for some time. Negotiations are underway with the University Of Nebraska Medical Center to contract for additional providers to staff the Pain Clinic. A Nurse Practitioner position has been filled and is currently being negotiated as part of the contract. This individual should be on staff within the next two weeks. This will increase the number of available appointments in the Pain Clinic.

2.d) Prescription Filling

Concur

The goal of the Omaha VAMC is to meet the VHA national standard for a waiting time not to exceed 30 minutes. Collection and analysis of this data are ongoing efforts. Data collected during 1999 indicate that we are very close to our goal.

Month	Average Waiting Time
September	36 minutes
October	38 minutes
November	38 minutes
December	35 minutes

When the Pharmacy receives complaints of excessive waiting times we review the period in question to determine if there were special causes for the variation in time. Some of those variations include: 1) Time of Day - later in the day as Clinics are completing their work for the day, sometime a larger number of prescriptions are received. Processing time can be increased as we follow the established processes to insure safe dispensing of all medications. 2) Non-formulary Requests - An order for a non-formulary drug requires the clinicians to obtain the proper approval (usually from the Department Chief) for the ordered medications. If this is not done prior to the prescription being received in the Pharmacy, both the prescribing physician and the Chief must be contacted. Since these individuals are involved in patient care there can be a delay in their ability to answer a page immediately. 3) Staffing - There are times of unexpected staffing changes due to sick leave. There is a policy limiting the number of staff that can be gone at one time but that does not account for the unexpected use of sick time. Whenever possible, when a special cause for variation is identified action is taken to prevent a recurrence.

2.e) Radiology

Concur

The IG report indicates that some veterans reported waiting more than one hour for a Radiology procedure. We have not received complaints regarding this waiting time either within the Department or through the Patient Advocate. This has not been a concern expressed during our outpatient call-backs regarding satisfaction with care received.

When patients are seen in the clinics, every effort is made to accommodate the order for radiology studies during that visit with feedback to the clinician. In reviewing data from the 1st Quarter FY00, we determined an average waiting time of 27 minutes for Radiology procedures. However, it is possible for a patient to experience a longer wait when certain procedures take longer than expected, an increased number of tests are ordered at a certain time, or if there are unmet staffing needs due to illness or unplanned leave. We will continue to monitor waiting times and will respond to all specific complaints regarding excessive waiting time.

3. Improve patient transfers and referrals from other facilities to Omaha to ensure effective coordination and continuity of care.

Concur

This is a recurring problem with patients referred from Grand Island and Lincoln. Many of the problems result from inconsistent processes at those two sites. There are multiple issues involved, many of which will be addressed during the process of facility integration (approved by HQ in November).

An RN Case Manager has been identified for the Cardiology Clinic. This position was approved at the time of the IG Inspection. This individual will facilitate the continuity of patient care for cardiac procedures, the transfer of patients and patient data between institutions, develop and apply critical pathways for the management of common cardiovascular diseases, develop a means of monitoring the outcomes of both procedures performed in Cardiology and treatment strategies employed by the staff in an effort to improve the quality of patient care.

A position for a Surgical Case Manager is being posted. This individual will prepare and manage the surgical clinics, coordinate discharges of surgical inpatients with referring facilities, incorporate and maintain protocols which will assist in the management of surgical patients, coordinate follow-up care in the surgical clinics as needed and with the primary care physician, home health, or community services. There is currently a process of weekly videoconferences with the Surgical Case Manager from Omaha, the surgical coordinators from Grand Island and Lincoln and the surgical resident in Omaha. Primary Care physicians are welcome to participate in these conferences to discuss referrals for surgical care.

4. Improve the primary care process to insure that all patients have an assigned primary care provider. The assigned provider should be a consistent staff member rather than a medical resident who works in the facility for a short time as part of a training program.

Concur

We agree with the statement that all patients should be assigned to a primary care provider. All patients at the Omaha VAMC are assigned to a primary care staff physician. There is consistency in primary care provider assignment. Currently many of the primary care physician panel sizes are very large. This decreases the amount of time the staff physician has available for each patient or delays the time interval available until new patients can be initially seen or until returning patients can be seen again. We are currently in the process of evaluating the panel sizes in primary care and planning to increase the number of physicians working in the primary care clinics.

Patients are seen by residents in the primary care clinics. Contrary to the statement in the recommendation, these residents are <u>not</u> assigned to a primary care clinic for a short period of time. Most residents are assigned to a primary care clinic for 3-4 years thus establishing an on-going relationship with the veteran.

5. Improve the transition from inpatient specialty care, such as surgery, to primary care.

Concur

We will take several measures to improve the transition from inpatient specialty care to primary care. We have a PI Team for Discharge Planning that will be instrumental in improving the process. The group will assess coordination of care and treatment across the continuum. The PI Discharge Planning group will analyze the discharge planning form, documentation of discharge planning, and make changes that will facilitate the transition to primary care. A case manager role will be added to the ambulatory care staff and attend weekly inpatient discharge planning meetings. The case manager will be a member of the Discharge Planning PI team. Videoconference meetings with Lincoln and Grand Island will be implemented to facilitate coordination of referrals for patients being seen in specialty care clinics in Omaha. This meeting will also assist with the coordination of the transition back to primary care. Inpatient Discharge Planners and the Ambulatory Case Manager attend the on-going discharge planning meetings in the inpatient areas.

6. Take immediate action to correct the physical environmental concerns in the operating rooms.

Concur

A project to replace the floors was submitted last August. The amount of the project ($103,000) exceeded the station level funding so the request was forwarded to the

VISN for approval. The project (636-176) did not rank high enough for the funding. It will be the Omaha VA Medical Center's top priority this August, which should rank it high enough to be funded. This was discussed with the IG inspector at the time of the CAP inspection although the discussion is not reflected in the report.

The in-house painters and plasterer will begin work in the Operating Rooms in about 3 weeks to repair the ceilings and the walls. The water leaks that caused the paint to blister and peel have already been corrected.

The actions will be communicated to the OR nursing staff.

7. Review the effectiveness of the home glucose monitoring program, including documentation, education, and quality control. Collaboration and cooperation between the Ancillary Testing Coordinator and the clinic coordinators should be reinforced.

Concur

In an effort to work more collaboratively between all services we have met and developed a hospital-wide policy designed to outline and standardize the home glucose monitoring procedure. All other policies have been rescinded. With this procedure the primary care physician can request that the patient's glucose meter be checked. Processes are in place to document all patient education and training and correlation methods used to check the glucose meters. From this data we will be able to monitor the equipment's function.

Glucose meters currently used in the clinics fall under the VHA Ancillary Testing Guidelines. Documentation of the control checks for these monitors is maintained by the Laboratory as part of our CAP (College of American Pathologists) documentation.

MANAGEMENT CONTROL ISSUES

1. Enhance the fee basis program by ensuring that the program manager:

    1.a) Separates the authorization and payment duties.

Concur

A division of duties is being designed into our process in conjunction with the integration of these functions across the three campuses in Nebraska. Employees with the ability to authorize non-VA services will not have the ability to process the payments for the services they have authorized. Employees with the ability to process payments for non-VA services will not have the ability to authorize services for which they are processing payments. Our plan is to have all payments processed at only one of our campuses to provide an even clearer separation of authorization and payment duties.

1.b) Evaluates and limits employees' access to fee basis system data as necessary.

Concur

The employee access list has been reviewed and corrective action taken. Only fee employees with a need for access, now have access. Other employees with a need to view fee basis information have been assigned “read only” access.

1.c) Limits fee basis authorizations to the period of time that is medically necessary to accomplish the planned treatment, and ensures that authorizations specify care.

Concur

New procedures have been put in place and staff have been instructed to specify the date (or dates) of care for which the specific service is authorized.

1.d) Determines the most effective care for each patient and prepares cost analyses and justifications as appropriate.

Concur

This recommendation is accepted with reservations. We agree that, ideally, the most effective care should be provided in the most cost-effective setting and we will continue to strive for this. This is accomplished through a team approach between clinicians and administrative support staff, and it is not possible for the *fee basis “program manager* to determine the most effective care for each patient…” Even in the case cited in the findings, which implied this to be an exception to our “…usually vigorously managed…” program, it is noted that the physician felt that this was a “medically appropriate” plan. Circumstances specific to this patient caused us to believe that the plan we implemented was “the most effective care” even if it was not the least expensive. Once the care plan was determined, the fee basis program manager did negotiate a significantly reduced payment rate from the out of state provider.

1.e) Refers the management of all home health care payments to the Lincoln VAMC.

Concur

We accept and agree with this recommendation, but would comment on the findings. We will refer all home health requests to the Clinic of Jurisdiction for authorization. Although some process and posting errors may have occurred in the two cases cited, it is important to note that both veterans are severely disabled, service-connected veterans who were, and are eligible for the services we processed for payment.

2. Enhance medical transportation services by ensuring that the Assistant Director, Facilities Management Department:

2.a) Coordinates transportation scheduling with other VA facilities and revises procedures to utilize VA shuttle services, when appropriate.

Concur

This process was put in place approximately one year ago through a performance improvement team. A trial period was established and has been completed. The team will be reconvened within the next 30 days to review the results of the trial period and to make recommendations for additional actions or will implement the current actions as permanent changes.

2.b) Notifies employees that they should bring known program improvements and cost efficiencies to management's attention, and emphasizes the possibility of employee awards for significant suggestions.

Concur

This was discussed at the last Engineering meeting. In addition, it will be discussed at the Facilities monthly staff meetings. This has been in practice for at least a year and has been communicated to staff members. As a result, Engineering staff members, through their suggestions, have saved over $50,000 for the Medical Center. These individuals were awarded for their suggestions and efforts in making the changes happen.

2.c) Amends the medical transportation contract to:

1) Better define the distance from which additional mileage charges would apply.

Concur (see below)

2) Specify round trip charges from the veterans' residences, when the trip includes a short waiting time to accomplish the treatment.

Concur

The Manager, Engineering Department will work with the Travel Coordinator and the Contract Specialist to make an amendment to the contract within the next 60 days.

2.d) Automates records of ambulance trips and approvals.

Concur

The Assistant Director of Facilities Management will work with the Travel Coordinator to automate her system as much as possible within the next 60 days. Additional training which might be required for the employee will be provided as soon as possible.

3. Improve purchase card management by:

3.a) Updating the facility policy for purchase card management.

Concur

The Chief, Acquisition and Materiel Management for the state of Nebraska will revise this policy and communicate the changes to all affected employees within the next 30 days. A Network (VISN) policy has also been written and is awaiting signature. Implementation of the VISN policy will ensure standardization across the 6 medical centers in our Network.

3.b) Making a concerted effort to decentralize purchase cards to user activities.

Concur

The Department of Pathology and Laboratory Medicine and the Department of Research are two larger departments which currently do not participate in the purchase card program. The Chief, A&MMS will communicate with the leaders of these departments to explore the opportunities for use of the purchase card program within their departments. When the program is in place in those departments, the Chief will work with the leaders of smaller departments to finalize the decentralization of the purchase cards.

3.c) Ensuring that cardholders' accounts are reconciled timely.

Concur

Around the first part of October, Omaha's purchase card responsibilities were given to the Purchase Card Coordinator for the VA Greater Nebraska Healthcare System. That individual has made great strides in standardizing the policy and procedures for the Nebraska sites as well as working with her counterparts in Iowa at the Network level. She has also excelled in increasing the awareness of responsibilities to all employees by conducting purchase card training for cardholders and supervisors who are approving officials. The training outlines responsibilities for all individuals involved in the purchase card program. Failure to reconcile accounts in a timely manner will be tracked with follow-up with individual employees as needed.

3.d) Ensuring that the Purchase Card Program Coordinator:

1) Retrieves and cancels purchase cards for departed employees.

Concur

The Purchase Card Program Coordinator has been training the staff for the past 3 months on the process of returning their credit cards to their supervisors prior to clearing from the medical center. In addition, the Secretary, A&MM, and the Chief, A&MM have agreed to communicate to the Purchase Card Coordinator when employees clear through their office in Omaha so the Purchase Card Coordinator can clear them from her accounts.

2) Establishes account setups in which cardholders cannot approve their own transactions.

Concur

The Purchase Card Program Coordinator has been working to eliminate this process on all Omaha's accounts for the past 3 months. She believes she is at least half way through ensuring that each account is established appropriately, e.g., each cardholder has a different approving official, and each approving official has a back-up approving official to meet timeframes, etc. She anticipates completing this task within the next 6 months.

3) Maintains current account setups for cardholders and approving officials in the Purchase Card Program Contractor proprietary system and IFCAP.

Concur

The Purchase Card Coordinator has access through the Internet to Citibank's records and updates information in both systems when necessary.

4. Enhance controlled substance security by:

4.a) Ensuring that the Chief Pharmacist limits access to the controlled substances vault to fewer than 10 staff.

Concur

The Omaha VAMC will comply with guidance provided in VHA Handbook 1108.1.

4.b) Requiring the Controlled Substances Inspection Coordinator to ensure that inspectors:

1) Account for prepackaged doses in the vault.

Concur

Narcotic Inspectors will include inspection of the controlled substances in the "mini-pharmacy" and prepackaged controlled substances in the vault during monthly inspections. Inspectors will check for appropriate package integrity, expiration dates, and inventory. Results will be reported to the Controlled Substance Security Officer (CSSO) monthly.

2) Document results for each area inspected.

Concur

The documentation is continually monitored by the CSSO when inspections are completed for each period. Inspectors complete their inspection reports and submit them to the CSSO. When the CSSO periodically needs to complete reports he/she will also document inspections.

3) Are alert to expiration dates of controlled substances.

Concur

Ward, clinic, and unit supervisors insure that all expired narcotics are promptly returned to the pharmacy for appropriate disposition. The Assistant Director for Patient Care will provide training to appropriate staff regarding policy and procedure for daily monitoring of expiration dates. Expiration dates of controlled substances are also monitored during each inspection period. Narcotics noted as expired or approaching expiration during inspection will be noted and returned to pharmacy according to current turn-in procedures. The Chief, Pharmacy Services and the CSSO will monitor this monthly.

4) Identify opportunities to reduce or discontinue issuance of controlled substances where they are infrequently dispensed.

Concur

The Assistant Director of Patient Care assures Head Nurses complete a check of current narcotic inventory usage every 2 weeks. Those narcotics, which are no longer used or are in excess of use requirements, will be immediately returned to pharmacy services for disposition.

5) Sample charts for physician orders for patients who have received controlled substances in clinics.

Concur

Add chart check to the outpatient clinical samples during the narcotic vault inspection process. The CSSO will monitor for completion of sample checks. The Chief, Pharmacy Services and the CSSO will provide inspector training and follow-up monitoring.

5. Improve security of information systems by establishing a procedure in which:

5.a) Human Resources Management staff notifies IRM of changes in employees' job status.

5.b) IRM staff follows up with managers to determine whether changes in employees' job status necessitate changes in access to system information.

Concur

A form has been developed in Human Resources which will be completed whenever an employee changes positions within the Medical Center. The form will be sent to the Manager, IRM for action. The Manager, IRM, will follow-up with the new supervisor to verify what access is required by the employee in the new position and will make all necessary changes in access.

6. Ensure that ***(b)(2)*** has the current combination to the Agent Cashier's safe.

Concur

The Agent Cashier's safe combination is in ***(b)(2)***

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