Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of VA Medical Center Hampton, Virginia

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VA Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort to ensure that high quality health care is provided to our nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

Combined Assessment Program Review of VA Medical Center Hampton, Virginia

Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Hampton, Virginia. The OIG CAP team visited VAMC Hampton from May 8 to May 12, 2000. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care and quality management; and, on financial and administrative management controls. During the review, we also provided fraud and integrity awareness training for 207 VAMC employees.

VAMC Hampton is a 171-bed primary and secondary acute care facility with a 120-bed nursing home unit and 200-bed domiciliary. The VAMC's fiscal year (FY) 2000 budget was $94.3 million and the staffing level was about 1,046 full-time equivalent employees. During FY 1999, VAMC clinicians treated 5,198 unique inpatients and had 205,000 outpatient visits.

Patient Care and Quality Management. The VAMC had a comprehensive, well organized Quality Management Program that effectively coordinated patient care activities and properly monitored the quality of care. However, some issues related to patient care oversight and environment needed management attention. We suggested that the VAMC Director address patient care oversight issues as follows: (a) ensure that clinicians properly and accurately record the services that they provide; (b) decrease waiting times in the Gastroenterology (GI) and Neurology Clinics; (c) increase gynecology attendant services in the Women Veterans' Treatment Program; (d) secure medications and supplies in the Emergency Room; (e) install additional panic buttons in Mental Health Service; (f) provide the Compensated Work Therapy van driver with emergency communications equipment; (g) fill pharmacist vacancies and provide medication bar coding training prior to implementing 24-hour coverage; and (h) revise competency assessment checklists for addiction specialists. We also suggested that the VAMC Director address patient environment issues as follows: (a) resolve Ward 2N solarium environmental deficiencies and (b) provide a consistent smoking policy throughout the facility.

Financial and Administrative Management. The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve operations, we suggested that the VAMC Director: (a) turn in excess research equipment; (b) assess monitoring of approvals for information technology equipment; (c) address internal control issues in the purchase card program; (d) follow guidelines for approving and reporting commercial printing costs; (e) improve community nursing home inspections; and (f) conduct random audits of the agent cashier. We also recommended that the VAMC Director: (a) pursue reducing community nursing home rates; (b) improve controls over controlled substances; (c) improve administration over research consent forms; and (d) reduce the agent cashier's advance.

Medical Center Director Comments

The VAMC Director concurred with the recommendations and provided implementation plans. (See Appendix III for the full text of the Director's comments.) We consider all CAP review issues to be resolved, but may follow up on implementation of planned corrective actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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Introduction

Hampton VA Medical Center

VA Medical Center (VAMC) Hampton provides primary and secondary care in medicine, surgery, and psychiatry. The facility offered extended care in intermediate medicine, palliative care, spinal cord injury, nursing home care, and domiciliary services. The facility did not operate any satellite or community-based outpatient clinics. The VAMC is one of eight medical centers in Veterans Integrated Service Network (VISN) 6. The VAMC's primary service area includes cities in the Hampton Roads area of Virginia and several counties in northeastern North Carolina. The veteran population in the service area is about 143,000.

Programs. The VAMC had 171 authorized medical, surgical, and spinal cord injury beds at the end of second quarter fiscal year (FY) 2000. The VAMC also had 120 authorized nursing home beds and 200 domiciliary beds. The VAMC was participating in national research studies in dental implants, heart attack trials, and prostate cancer. The facility is host for the National Chaplains and National Chaplains Training Program, the Chief Information Officer Field Office, and the National Compensated Work Therapy/Therapeutic Residency Program.

Affiliations. The VAMC had medical and allied health training affiliations with the Eastern Virginia Medical School and supported 46 medical resident students and 100 medical student positions in 15 training programs. The VAMC was also affiliated with a number of other universities in masters and doctoral programs.

Resources. The FY 2000 budget was $94.3 million, 3.2 percent more than the FY 1999 expenditures of $91.3 million. FY 1999 staffing totaled 1,046 full-time equivalent employees and included 59 physicians.

Workload. In FY 1999 inpatient days of care totaled 57,429. The inpatient average daily census was 157. The outpatient care workload was about 205,000 visits.

Objectives and Scope of Combined Assessment Program

The purposes of the Combined Assessment Program (CAP) review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to VAMC employees.

Patient Care and Quality Management Review. We reviewed selected clinical activities with the objective of evaluating the effectiveness and appropriateness of patient care and quality management (QM). The QM program is comprised of a set of integrated processes that are designed to monitor and improve the quality and safety of

patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient care. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and ensuring staff competence. To evaluate the QM program and patient care management, we inspected patient care areas, reviewed pertinent QM and clinical records, and interviewed managers, employees, and patients. We used questionnaires and interviews to evaluate employee and patient satisfaction and solicited their opinions and perceptions about the quality and delivery of care. In addition, we reviewed the following programs and patient care areas:

- Acute Care Medicine and Surgery
- Domiciliary
- Substance Abuse Treatment Program
- Ambulatory Care Services
- Clinician Staffing
- Informed Consent
- Imaging Service
- Mental Health
- Spinal Cord Injury & Disorder
- Post Traumatic Stress Disorder (PTSD) Program
- Geriatrics and Extended Care
- Physical Medicine & Rehabilitation
- Homeless Veterans Program
- Quality Management Program
- Palliative Care
- Women's Health
- Pharmacy
- Dialysis

Financial and Administrative Management Review. We also reviewed selected administrative activities, with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed managers and employees, and reviewed pertinent administrative, financial, and clinical records. The review covered the following financial and administrative activities and controls:

- Agent Cashier Operations
- Pharmacy Service Security
- Purchase Card Program
- Community Nursing Home Contracts
- Printing Practices
- Information Technology Acquisitions
- Means Test Certification
- Research Service Equipment
- Employee Accounts Receivable
- Research Informed Consent

Fraud and Integrity Awareness Training. During the review we conducted four fraud and integrity awareness briefings for VAMC employees. About 200 employees attended these briefings. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review generally covered VAMC operations for FY 1999 and the first half of FY 2000. The review was done in accordance with the draft Inspector General's Combined Assessment Program Procedures.

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Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management Were Generally Effective

We concluded that VAMC Hampton's patient care and QM programs were comprehensive and generally well managed, and that clinical activities were operating effectively, as illustrated by the following examples.

Top Managers' Attitudes and Actions Support Quality Management. The VAMC's top management team demonstrated a strong commitment to QM and performance improvement. Many of the employees and patients whom we interviewed made positive comments about top managers' advocacy of quality improvement and their personal efforts in support of patients and employees. For example, the Director had an open door policy that extended to patients, families, employees, union representatives, and veteran service organizations to resolve problems internally. The Director used patient satisfaction survey findings to improve processes and systems aimed at enhancing customer satisfaction. Top managers toured various VAMC areas daily to observe operations and to meet with patients and employees.

The QM Program Was Comprehensive and Well Organized. The VAMC's QM Program included utilization review, performance improvement, risk management, administrative investigations, and the patient advocacy program. Areas that we reviewed included: incident reports, administrative investigations, root cause analyses/focused reviews, external review recommendations tracking, clinical guidelines and pathways, and tort claims. Our review found that QM employees effectively identified opportunities for improvement, tracked results, and ensured appropriate follow up.

Most Patients and Employees Were Satisfied With Quality of Care. We interviewed VAMC top managers, clinical managers, and 96 patients. We also sent survey questionnaires to 300 randomly selected full-time employees; 174 (58 percent) of whom responded. The results of our survey and interviews showed that 81 percent of the VAMC employees whom we interviewed and surveyed, and 89.5 percent of the patients whom we interviewed rated the quality of care provided to patients as good, very good, or excellent.

Domiciliary Care Provided Strong Psychoeducational Treatment Programs. Overall, Domiciliary programs were well organized and appeared to be adequately staffed. The programs offered an appropriate continuum of care for high-risk patients. The 200-bed domiciliary offered multiple treatment programs including Vocational Rehabilitation Services, Compensated Work Therapy/Transitional Residence, ReHabitat (for homeless veterans), Drug Abuse Program, and Domiciliary Case Management. The Vocational Rehabilitation Services Program was accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), and the general domiciliary program

achieved a grid score of 99 out of 100 points during the last Joint Commission on Accreditation of Healthcare Organizations (JCAHO) review. Policies and procedures were current and practices were generally consistent with written policies. Domiciliary clinicians recorded treatment and discharge planning appropriately. Outcome measures indicated that patients achieved program and treatment goals. The domiciliary had a well organized, well staffed, and outcome oriented program for high-risk patients prone to drug relapse, unemployment, homelessness, and mental illness.

Mental Health Clinicians Developed a Commendable Detoxification Program. Mental health clinicians developed a protocol to improve the treatment of Detoxification Program patients who were exhibiting withdrawal symptoms. The protocol outlined a withdrawal scale for registered nurses (RNs) to use to identify problematic withdrawal symptoms. The clinicians developed a standardized physician order protocol that correlated with the withdrawal scale. Results of the initial study indicated a 60 percent decrease in the number of days that patients had to remain in detoxification (from 6 to 3.6 days) and a reduction in the number of adverse incidents and serious complications (delirium tremors, withdrawal seizures, incidents of aggression, and falls) related to detoxification. Patient satisfaction increased as a result of the reduction in discomfort and the time that they had to spend away from loved ones. We recognized that the development and implementation of this protocol enhanced patient care and program efficiency.

The Pressure Ulcer Prevention Program Decreased the Incidence of Decubitus. Implementation of the pressure ulcer prevention program included the purchase of specialty beds, use of low-pressure mattresses, increased staff education, data validation, increased unit resource staff, and implementation of Skin Care/Pressure Ulcer Prevention/Treatment clinical pathways. These efforts yielded a greater than 50 percent decrease in pressure ulcers in the Intensive Care and Spinal Cord Injury Units.

The Dialysis Unit Was Recognized for High Quality of Care. State and regional offices of the Mid-Atlantic Renal Coalition recognized the VAMC's Renal Dialysis Unit for meeting and exceeding quality of care standards in calendar year 1999. Employees were active in promoting patient care excellence, as evidenced by their acceptance of publications in national magazines and presentations at symposiums.

The Psychosocial Awareness Program Made a Difference in the Spinal Cord Injury and Disorders Long-Term Care Center. The VAMC had an active Spinal Cord Injury and Disorders Psychosocial Awareness Program. The program included the Family/Visitor Council, Coping Group, Pet Therapy, Resident Council, and Therapeutic Community activities that helped patients to achieve the highest level of functioning and well being possible. These program components convened regularly and assisted the patients, family members, and significant others to cope with the changes and demands of dealing with permanent disabilities.

Managers Were Taking Corrective Action to Improve Patient Access to Several Program Areas

We identified several areas that needed improvement for which management had initiated or planned corrective action.

Managers Were Addressing Ways to Decrease Unscheduled or Urgent Care Clinic Waiting Times in the Urgent Care Clinic. Over the past 2 years, the number of unique primary care outpatients treated at the VAMC increased from 5,900 to 9,913. Outpatient visits increased from 21,000 to 30,759. The increasing utilization of unscheduled and episodic care resources resulted in nearly half of the patients in the Urgent Care Clinic waiting more than 4 hours from check in to check out (cycle time) as of July 1999. Managers formed a Performance Action Team to analyze and initiate methods to reduce these cycle times.

As an active participant in the Institute for Healthcare Improvement (IHI), the facility aimed to reduce the frequency of patients' Urgent Care Clinic cycle time of 4 hours or longer from 36 percent to 1 percent and to reduce utilization of the Urgent Care Clinic by 50 percent through improved Primary Care Program enrollment. Managers assigned a physician to the Urgent Care Clinic to examine and treat patients who were not yet assigned to a Primary Care team. The February 2000 patient satisfaction surveys showed an overall satisfaction rate of 97 percent, up from 85 percent in March 1999. These improved scores reflected improvements in the program. Based on a 10-day sample in the second quarter of FY 2000, the Urgent Care Clinic's average cycle time was 3 hours and 3 minutes. As of April 30, 2000, the cycle time greater than 4 hours decreased from 36 percent to 25 percent, and managers predicted further improvements.

Employees Were Reducing the Primary Care Program Appointment Waiting Time. On October 26, 1999, the Primary Care Program had an enrollment backlog of 4,000 patients. The facility was enrolling more than 200 new primary care patients through the Urgent Care Clinic each month. In FY 2000 the enrollment rate increased further. Managers initiated action to improve primary care enrollment by: (a) adding health care providers to the service, (b) increasing physician provider panels to 1,200 (number of patients assigned to each provider), and (c) setting Nurse Practitioner/Physician Assistant panel sizes at 800 patients.

Managers also directed other changes. For example, each Primary Care Team began managing its own "walk-in patients", and the triage nurse started referring patients who were already enrolled in a Primary Care Team immediately to the patient's clinic. The status of patients not seen in 18 or more months and of those who did not have future appointments was changed to inactive. Administrative employees also deleted deceased patients from the database. Elimination of these patients from panels allowed providers to fill their panels with patients from the backlog list. As a result, the backlog list decreased from 4,000 to 3,100 names by April 30, 2000.

Managers Were Acting to Reduce Waiting Times for Barium Enema Studies. Waiting times for routine barium enema studies exceeded the 2-week standard and were approaching 90 days in FY 2000. One reason for this backlog was that the Imaging Service had only one fluoroscopy suite. The Chief, Imaging Service, asserted that one suite was inadequate to manage the workload, and that this resulted in a slowly but steadily increasing backlog of patients who required these studies.

Within the past several months, VAMC managers allotted additional space for another fluoroscopy suite. A resource request was pending for two additional technologists and conversion of two temporary technologists to permanent status. These additional employees would support the new fluoroscopy suite and allow for 24-hour computerized tomography (CT) on-call coverage. The Chief, Imaging Service, collaborated with the Union to achieve 24-hour on-call coverage and expected implementation within 60 days of our visit. The service chief anticipated that these additional resources would immediately reduce waiting times for barium enema studies.

Medical Center Managers Were Taking Action to Reduce Waiting Times for Magnetic Resonance Imaging (MRI) Studies. Waiting times for routine MRI studies exceeded the 2-week standard and were approaching 90 days in FY 2000. The medical center did not have MRI equipment, and referred patients to VAMC Richmond for these studies as appointment availability permitted. According to the Chief, Imaging Service, improved MRI technology has expanded the range of testing that can be done, and that this factor has resulted in an increase of MRI studies from 20 to 80 per month. The volume increase created a backlog, which increased waiting times. Medical center managers were aware of the problem and were reviewing alternative solutions, including the purchase of a portable MRI. In the interim, employees were sending patients who needed emergent MRIs on a fee basis to a local hospital and were sending patients who needed routine MRIs to VAMC Richmond.

Pharmacy Service Has Initiated Action to Fill Vacancies and Reduce the Mail Out Prescription Backlog. Pharmacy Service lost three full-time pharmacists in the past year and was unable to recruit qualified candidates, apparently due to a reportedly low salary scale. The pharmacist vacancies resulted in waiting times for mail out medications that increased beyond the service's internal standard of 5 days on several occasions. In March 2000, Pharmacy Service managers employed mandatory overtime to clear a 10-day mail out backlog. On at least 1 day during our visit, the mail out waiting time was 8 days.

After completion of an April 2000 salary survey that resulted in improving pharmacists' compensation, Pharmacy Service successfully recruited candidates to fill the three vacancies. According to the Chief, Pharmacy Service, the addition of these employees some time after May should improve mail out waiting times and support the service's move toward 24-hour pharmacist coverage and medication bar coding.

Top Managers Should Address Various Patient Care Oversight and Environment Issues

During the review, we noted patient care oversight and environment issues that warranted medical center managers' attention.

Clinicians Need to Properly and Accurately Record Patient Treatment in the Medical Records. Our review of 54 randomly selected inpatient medical records found that clinicians needed to improve recording patient assessments and treatments. We reviewed 45 medical records (medical, surgical, mental health, spinal cord injury, and domiciliary) and 9 nursing home patients' medical records during our visit. Our review of the 45 medical records showed that improvement was needed in the documentation of wandering/elopement risk assessments, spiritual assessment, evidence that clinicians advised patients about advance directives, interdisciplinary patient/family education, and interdisciplinary treatment plans. The review of these 45 medical records found that:

- 96.9 percent did not have a wandering/elopement risk assessment.
- 34.0 percent did not have spiritual assessments.
- 28.5 percent did not have evidence that clinicians had discussed advance directives with the patients.
- 26.8 percent did not have any evidence of interdisciplinary patient/family education.
- 22.7 percent did not have interdisciplinary treatment plans.

Nursing home care medical records lacked documentation of quarterly care plans, recreation therapy, oral care screens/assessments, Resident Assessment Protocol (RAP) summaries, and spiritual assessment. The review of nursing home care medical records revealed that of the 9 medical records:

- 44.4 percent did not have quarterly care plans.
- 33.3 percent did not have recreation therapy or oral care screens/assessment within 14 days of admission, as required.
- 28.5 percent did not have a RAP summary completed within 14 days of admission, as required.
- 22.2 percent did not have spiritual assessments.

Medical center managers should ensure that these services are provided and that responsible clinicians properly and accurately record this information in medical records.

Managers Need to Improve Patient Access to the GI and Neurology Clinics. The GI Clinic and the Neurology Clinic had the most excessive waiting times of all specialty clinics with 71.3 days and 183.6 days, respectively. The GI Clinic had 1 provider who completed 378 endoscopy procedures and 571 colonoscopies in FY 1999. The magnitude of this workload, and the 71-day backlog suggests the need for additional

staffing. Similarly, the Neurology clinic had less than 1.0 full-time equivalent employees. Managers were actively recruiting for additional GI Clinic staffing, and were considering reassigning a Spinal Cord Injury Program physician to the Neurology Clinic. However, managers had not established a target date, nor had they developed a specific proposal for Neurology Clinic staffing changes at the time of our review. Managers should develop specific proposals for reducing the waiting times in these clinics.

The Women Veterans' Treatment Program Needs Adequate Trained Gynecological Attendant Services. Local policy required the presence of a gynecology attendant to chaperone all pelvic examinations in the Women Veterans' Treatment Program. In addition to chaperoning pelvic examinations, the attendant's duties included preparing pap smears and culture slides. We found that managers had not ensured that a trained gynecology attendant would be consistently available to assist physicians during pelvic examinations. There was only a 0.3 full-time equivalent trained attendant assigned to this function. We also found that when untrained attendants were used to provide these services, the laboratory tests were often invalid because of improper specimen preparation. Invalid test results require that patients return to the clinic to repeat the procedure, and often causes unnecessary anguish and inconvenience for the patients. Enhancing trained gynecological attendant services would improve program efficiency and patient care.

Emergency Room (ER) Medications and Supplies Must Be Secured. During our inspection of the ER, we found medications on an unlocked cart in an open, unsecured room. We also found needles, syringes, and scalpels in unsecured locations throughout the ER. The immediate proximity of patients to these areas requires improved security awareness on the part of ER employees.

The Installation of Additional Panic Buttons Will Enhance Mental Health Service Safety and Security. Managers had installed panic buttons in nursing stations on Wards 2N and 2S of the Mental Health Service and in an inpatient room that was reserved for female patients. Common areas such as day rooms and hallways that are vulnerable to the occurrence of violent incidents, and that require additional staffing or security assistance did not have any panic buttons or other warning devices. Medical center managers agreed that installing additional panic buttons in common areas would enhance safety and security. Managers should give priority to installing these additional panic buttons.

The Compensated Work Therapy Van Driver Should Have Communications Equipment to Report En-Route Emergencies. The Compensated Work Therapy Program had a van and a driver assigned to transport patients to work assignments. Local policy assigns responsibility to the van driver for the safety of patients and requires that the driver contact the proper authorities in the event of an emergency. However, managers had not equipped the van with a 2-way radio or other form of communication with which to report en-route emergencies. Equipping the van or the driver with emergency communications equipment would enhance patient safety.

Competency Assessment Checklists for Drug Abuse Program (DAP) Addiction Specialists Should Include Urinalysis Screening and Breathalyzer Testing. Addiction specialists routinely conducted urinalysis screening and breathalyzer testing to detect the presence of illicit drugs or alcohol in DAP patients. However, the competency assessment checklist for addiction specialists did not include urinalysis screening or Breathalyzer testing as competency areas. Including these clinical performance responsibilities in the checklist would ensure that employees meet prescribed proficiency standards for such duties; thus, enhancing the assurance of appropriate care. The Chief, Domiciliary Care, assured us that the addiction specialist competency assessment would be revised to reflect this change. Top managers should ensure this action is taken.

Engineering Service Should Resolve Ward 2N Solarium Environmental Deficiencies. The solarium on Ward 2N is a common area used by Mental Health Service for a variety of patient activities. However, its use has been limited to the 6 cooler months of the year because the space has not been environmentally controlled for hot weather. Measures taken thus far to improve this condition, such as the use of fans and the installation of air conditioning units have not been effective. Mental Health Service managers have discussed this condition with top managers, but the problem has not been resolved. Wards 2N and 2S had limited common areas for patient use and closing down the solarium for 6 months each year adversely affects the quality and quantity of patient activities. We suggest that managers explore further modifications such as installing sun shades or glass tinting to permit year around use.

Smoking Policy Should Consistently Apply to All Patients. Based on complaints from both employees and patients, we found that the medical center smoking policy permitted smoking in designated areas throughout the facility except for acute inpatient psychiatry. Mental Health Service Line Managers cited the restriction on acute psychiatry patients as a health incentive. Paradoxically, patients who are restricted from smoking during an episode of acute psychiatric hospitalization would have smoking privileges when they made an outpatient visit or if they were to be admitted to a medical ward. This appeared to be an inequitable and potentially confusing application of facility policy. We recognize that encouraging smoking cessation is a desirable goal, but we encourage management to reconcile inconsistencies in the facility's smoking policy between agency, facility, and Mental Health Service guidelines.

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Financial and Administrative Management

Management Controls Were Generally Effective

VAMC management had established a positive internal control environment, the administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. We found no significant deficiencies in two of the activities reviewed.

The Administration of Means Tests Has Improved. Effective January 2000 the facility implemented a monitor to ensure that applications for health care were complete, accurate, and means tests were signed no later than the day after patient data was entered into the computerized patient database. Samples of cases requiring means tests for the period October 1, 1999 to March 31, 2000, showed improvement in administration of the means test program starting in January 2000. A review of 20 means test cases for 1999 found 6 administrative folders did not contain a signed means test (30 percent). Our review of 10 administrative files for means tests conducted in FY 2000, found only one administrative file that did not contain a signed means test.

Employee Accounts Receivable Were Generally Current and Follow up by the Accounting Section Was Timely. As of May 10, 2000, the medical center had 34 accounts receivable for 19 current or former employees totaling $12,535. The accounts receivable generally related to workers' compensation or leave without pay payroll and leave adjustments. We found that significant debts had current repayment plans and that the Accounting Section followed up on employee accounts receivable timely.

Suggestions for Management Attention

During our review, we noted several administrative issues that did not warrant individual recommendations, but needed management attention. We made suggestions for improvements in the following areas.

The Facility Should Turn in Excess Research Equipment. VAMC Hampton discontinued animal research in about 1995 and placed 152 pieces of equipment associated with the programs that could not be used for other purposes, in storage. The original purchase value of the equipment totaled about $85,000. Subsequently, the facility decided that animal research would not be continued and offered the equipment to the Regional Research Equipment Program (RREP). In November 1999, RREP declined the VAMC's offer because the equipment was either beyond reasonable repair or too old to function within required scientific standards. RREP recommended excessing the equipment. Management should implement RREP's recommendation in order to make the storage space available for other purposes and to recover any salvage costs that might accrue.

Designated Officials Should Approve the Purchase of Information Technology Equipment. VA policy outlines a variety of management controls over procurement of information technology hardware depending upon the type and costs involved. We reviewed the approvals for 2 of 73 purchase orders placed since October 1998. The Medical Center Director did not approve the purchase of a notebook computer costing $1,264 as required for the category of purchases of $10,000 or less. Similarly, the purchase of a $17,000 ceiling-mounted projector was not a specific part of an approved ADP plan and was not supported by its own individual plan approved by the Under Secretary for Health as required for a purchase in the range of over $10,000 to $50,000. Management should review recent purchases to determine the frequency and causes of why required approvals may not be obtained and to take necessary corrective action.

The Purchase Card Coordinator Should Not Be a Cardholder or Approving Official, and Should Follow up on Internal Review Findings. Controls over the purchase card program were generally effective; however, the facility could eliminate a separation of duties condition and improve the timeliness of cardholder reconciliations and supervisory approvals. From October 1998 through March 2000 cardholders processed more than 12,000 purchase transactions totaling about $8.8 million.

The Purchase Card Coordinator was both a cardholder and approving official. This was against program policy and created an internal control weakness regarding separation of duties. The Director noted that corrective action would immediately be taken to resolve this condition.

The facility conducted regular quality reviews and audits of the program as required to ensure that items purchased under this decentralized procurement method were actually received, charges were for official purposes only, and bills were correctly paid. The results of such reviews consistently identified the need for improvement by cardholders to reconcile vendor charges with purchase amounts more timely and for approving officials to be more timely in their certifications of reconciled purchase transactions. Instances of approvals exceeding timeliness standards often exceeded 35 percent in FY's 1999 and 2000 through April 2000. The recurring conditions suggest that follow up on problem employees was not sufficient to resolve the deficiencies identified in internal reviews. We suggest management take more aggressive follow up on analyzing the review results to identify problem employees. Action is needed to correct conditions of untimely reconciliations and certifications through training, closer supervision, and/or reassignment of duties.

Employees Should Follow Guidelines for Approving and Reporting Commercial Printing Costs. Generally, any printing done off-station by other than the Government Printing Office (GPO) must be reported to the VA Office of Administration semi-annually. Single line items exceeding printing costs off-station of $1,000 must also be pre-approved by GPO. From February 1999 through April 2000 the facility spent $11,518 on GPO printing services. Off-site printing by other than GPO totaled $2,780 during the same period for 7 jobs ranging from $30 to $1,551. Employees did not obtain approval for the job costing $1,551 as required, and did not report the use of non-GPO

sources to the Office of Administration as required. Management should remind the service chiefs of requirements for obtaining approval for commercial printing jobs and to ensure that employees report non-GPO print jobs as required.

Recommendations for Improving Management Controls

The VAMC Should Pursue Lower Contract Rates and Improve Controls Over Inspections for Community Nursing Homes

Community nursing home (CNH) rates exceeded Medicaid rates by more than 15 percent, and inspections of CNHs were not effectively coordinated with the award of contracts. The VAMC had 18 patients in 11 CNHs for contracts negotiated locally. Occupancy ranged from one patient in six of the CNHs to three patients at two of the CNHs.

Contract Rates. Generally, contracting officers should not award contract rates in excess of Medicaid rates plus specified percentages to cover ancillary costs without sufficient justification. VAMC negotiated rates for basic care in excess of the benchmark rate of Medicaid plus 15 percent in 17 of 18 contracts. The per diem difference ranged from 61 cents a day to $35.23 a day. Even though some facilities provided detailed cost and pricing data of less than 15 percent, the facility used the 15 percent benchmark and added it to the ancillary costs already outlined in the cost data.

Contracting and CNH program employees generally explained their acceptance of such rates based on reasons often cited for exceeding the rates, but which have proven to be unsupported on previous nationwide audits – low Medicaid rates for their state, exceptional costs incurred by CNHs, etc. In our opinion, the facility did not aggressively negotiate with facilities to obtain lower rates, and did not understand how to effectively use cost and pricing data provided to them. Reviews of contract files and discussions with contract and program employees did not provide any support for accepting the rates recommended by the CNHs. For example, 73 percent of the patients at one nursing home were placed at Medicaid rates, yet VA employees accepted the claim that Medicaid rates plus 15 percent were not sufficient to cover the cost of a VA patient. The additional costs to the VAMC may average about $79,000 annually.

Inspections. Annual inspections of CNHs prior to renewing or awarding contracts are required to ensure the continuing quality of care and safety of patients. Employees should also review discrepancies reported by the State-licensing agency in conjunction with annual VA inspections. A nurse or social worker must also visit each CNH patient no less frequently than every 30 days, and nurses must make visits at least once every 60 days.

Inspection records did not clearly support that all members of VA inspection teams either received or reviewed the discrepancies on file by the state Medicaid offices.

Employees reported that this took place but agreed that it was not documented. Regardless, the employees' inspection reports did not document that the deficiencies were specifically reviewed for VA patients. We suggest that the checklist used on annual inspections include a review of the specific issues outlined in state licensing agency reports.

Annual inspections and reviews of Health and Human Services (HHS) reports were also often completed after the contract with the CNH had been awarded; thus, negating some of the benefit of doing the reviews in conjunction with the award action. Employees should coordinate their reviews and inspections to ensure that they take place shortly before and as a condition of awarding or renewing contracts.

While recurring social worker visits were evidenced in patient records, nurses did not perform visits at least every 60 days as required. Employees attributed this condition to lack of nurse staffing dedicated to this program activity. Alternative staffing options should be pursued to resolve this condition.

Recommendation 1 - The Medical Center Director should pursue opportunities to negotiate community nursing home care rates in line with benchmark rates suggested by policy.

Medical Center Director Comments –

The Director concurred with the finding and recommendation.

We agree that justification for exceeding Medicaid rates can be improved and have started requesting Medicaid Cost Reports from the Virginia Department of Medical Services office. Based on the recommendation, contracts are being renewed for no more than a month, until the Medicaid Cost Report is received and incorporated into the contracting office negotiations. In the future, all contracts due for renewal will be negotiated utilizing the Medicaid Cost Report.

While we do not disagree that we may save $79,000 in contracting, we also do not necessarily recognize that it will directly reduce overall medical center costs. We are concerned that the lower reimbursement rate may result in slowing of transfers of our veterans from acute programs to contract nursing homes; thereby potentially resulting in higher costs in acute medicine, surgery and psychiatry as a result of the increased bed days of care and lengths of stay. With our current reimbursements, we believe that contract nursing homes are acting quickly to accept our referred patients and that our referrals compare favorably to other referrals from the community. Additionally, Hampton VAMC's contract rates, while modestly higher than the State Medicaid rate, are comparable with our VISN 6 counterparts. We cannot reliably predict and estimate what impact the result of successfully reducing the per diem will have on the current process of transfer and the potential for increased costs in other areas.

Office of Inspector General Comments –

The Director's actions were responsive to the intent of the report recommendation.

The VAMC Should Improve Internal Controls Over Security of Controlled Substances

Physical security of the pharmacy areas was generally adequate; however, the VAMC needed to comply with requirements for security of controlled substances regarding monthly inspections and disposal of unusable drugs.

Inspections. We examined records of the monthly-unannounced inspections of all Schedule II, III, IV, and V controlled substances for November 1999 through April 2000. Employees did not conduct 9 of the 30 inspections required during this period, including all of the inspections in January. Also, a review of the reports of the completed inspections identified ways of improving other aspects of the inspection program:

- Inspection reports should include more supporting documentation showing the scope of review performed.
- Follow up on discrepancies should be more effectively monitored to resolution, contributing to more timely or complete correction of discrepancies. Resolution of 12 missing inventory “green sheets” from an inspection in March 2000 had not been corrected at the time of our audit in May.

In discussions with inspectors and Pharmacy employees, we were told that discrepancies were frequently resolved by word of mouth and that resolution actions were not documented. We believe that this informal procedure contributed to the failure of the inspection process to resolve identified discrepancies and to inspections not being completed as required. In our opinion, responsibility for resolving discrepancies should be formally assigned and the resolution documented in writing.

Unusable Drugs. Employees had not disposed of outdated or otherwise unusable controlled substances on a quarterly basis as required. The last two disposals of drugs were March 1999 and February 2000 . Employees did not believe that the quantity of drugs (valued at about $21,000) since March 1999 warranted quarterly disposal prior to February 2000. A quarterly disposal schedule would enhance security over controlled substances.

Recommendation 2 - The Medical Center Director should strengthen controls and improve monitoring of the scheduling, completion, and resolution of discrepancies of inspections of controlled substances; and ensure that unusable controlled substances are destroyed quarterly.

Medical Center Director Comments –

The Director concurred with the findings and recommendations.

Pharmacy Service will (i) improve training of narcotic inspectors to include a better understanding of their role and proper documentation of the scope and findings of their review; and (ii) introduce a standardized written report format for all narcotic inspection reports by September 30, 2000. Also, effective immediately, unusable controlled substances will be destroyed on a quarterly basis as required.

Office of Inspector General Comments –

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

Researchers Should Obtain Signed Consent for Participation in Research Projects and Document the Consent in Patients' Records

At the time of our review, the VAMC administered 14 active research projects involving 195 patients. We reviewed a sample of 20 patients' records and associated administrative files from 5 of the projects to determine if consent forms were signed and documented as required. Principal investigators appropriately described the issues of consent to research participants in the records we could review, but researchers did not document signed consent forms in some administrative files and patients' medical records. Although 17 of 20 patients in our sample had copies of consent forms filed in administrative records, 10 of the 20 sampled patients did not have a consent form documented in their medical record as required. Three of the 20 patients did not have consent forms documented in either their medical records or in administrative files of the principal investigator, or of the Associate Chief of Staff for Research.

A single investigator was responsible for the three missing informed consent documents in our sample. The Associate Chief of Staff for Research considered the missing consent forms a serious condition and scheduled a discussion of the problem for the June meeting of the Institutional Review Board. The chief indicated that he would initiate disciplinary action against the investigator and conduct more frequent audits of that investigator's records in the future.

Recommendation 3 - The Medical Center Director should improve internal controls for ensuring that signed consent forms are documented in patients' records and should conduct a review of consent forms for all active projects.

Medical Center Director Comments –

The Director concurred with the findings and recommendations.

Audits will be increased from annually to bi-annually; and a Center Memorandum has been published. "Consent Forms" which assigns responsibility for ensuring that signed consents are filed in the Administrative folder for each patient participating in a project is in the draft stage being circulated for concurrence.

Office of Inspector General Comments –

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

Management Should Conduct Random Audits of the Agent Cashier, and Decrease the Agent Cashier's Advance

Each facility is required to perform an unannounced audit of the agent cashier's advance at least every 90 days. The dates and times of unannounced audits should be varied to prevent the establishment of a pattern of regularity, and to ensure the element of surprise. Fiscal Service management should ensure that the level of the agent cashier advance is appropriate by ensuring that it is turned over at least every 3 weeks.

We reviewed the results of audits performed since January 1, 1999. Audits ranged from 59 to 105 days apart with 2 of the audits exceeding 90 days. Audits followed a pattern of regularity in that they were not held sooner than 2 months from the previous audit and were always performed from 8 to 9 a.m. We suggest scheduling six audits a year with at least one audit less than 30 days, and holding at least two audits later than 8 to 9 a.m., to ensure randomness.

The agent cashier's advance has been $100,000 since at least January 1999. In our opinion, this was excessive. For example, from March 1 through May 8, 2000, the total cash on hand and cash on deposit never fell below $36,000 and exceeded $40,000 daily except on 1 date. Typical equations for computing the appropriate level of the cash advance appear to be misleading because of the unique circumstance of making large payments to the compensated work therapy program once every other week. The agent cashier agreed that at least a $15,000 decrease in the cash advance was reasonable; however, the Chief, Accounting Section, believed that as long as financial indicator reports did not report the advance as an out-of-line condition that the facility need not decrease the advance. Excessive cash advances needlessly tie up funds that could be used more effectively for other purposes.

Other guidelines for the performance of audits were met related to separation of duties, training of auditors, and regular transfer of responsibility to the alternate cashier. The physical security of the agent cashier function met standards.

Recommendation 4 - The Medical Center Director should initially decrease the advance by $15,000 and re-evaluate the advance quarterly thereafter to assess the potential for further decreases.

Medical Center Director Comments –

Subsequent to contact from the Team, we took yet another look at our advance quarterly assets and have concluded that in fact there does present an opportunity to improve the management controls in this area. Therefore, immediate steps have been taken to turn in $15,000. We thank you for this opportunity to readdress this issue.

Office of Inspector General Comments –

The Director's actions are responsive to the intent of the report recommendations and we consider the issue resolved.

Fraud and Integrity Awareness Briefings

As part of the CAP review, four 90-minute Fraud and Integrity Awareness briefings were conducted, which included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. About 207 VAMC employees attended the briefings. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1, delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Management is required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that is not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, Division employees assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the Division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, over billing, false claims, and violations of the

Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, Compensation and Pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Important Information To Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** -- Names, position titles, connection with VA, and other identifiers.
- **What** -- The specific alleged misconduct or illegal activity.
- **When** -- Dates and times the activity occurred.
- **Where** -- Where the activity occurred.
- **Documents/Witnesses** -- Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

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

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center, Hampton, Virginia

Project Number: 2000-01225-R3-0228

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Reduced contract rates for community nursing home care.	$79,000	
4	Reduction in the agent cashier's advance.	$15,000	
Total		**$94,000**	

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Medical Center Director Comments

DEPARTMENT OF VETERANS AFFAIRS **Memorandum**

Date: August 3, 2000

From: Medical Center Director, VA Medical Center Hampton, VA (590/00)

Subj: Response to Draft Report: Combined Assessment Program Review – VA Medical Center, Hampton, Virginia (Project No. 2000-01225-R3-0228)

To: Assistant Inspector General for Auditing (52)

1. Thank you for the opportunity to respond to recommendations made in the Draft Report of our recent OIG CAP visit.

2. Attached is our response to the suggestions and recommendations made by the team in this Draft Report.

3. If you have any questions, please do not hesitate to contact me.

/s/

B. W. STORY, Ph.D.

Attachment

Medical Center Director Comments

Combined Assessment Program Review Of VA Medical Center Hampton, Virginia

Results and Recommendations

Patient Care and Quality Management

Clinicians Need to Properly and Accurately Record Patient Treatment In the Medical Records. Concur. In addition, a new patient assessment policy is being developed to include all those recommended areas mentioned by the Team. Service/Service Line Chiefs will accomplish follow up with support from the Medical Records department. Suggestions specific to nursing home care medical records have been assigned to the Associate Chief of Staff (ACOS) for Geriatrics and Extended Care who will ensure monitoring to improve performance in this area.

Managers Need to Improve Patient Access to the GI and Neurology Clinics. Concur. Recruitment efforts for a neurologist have yielded an excellent candidate who has completed the credentialing process. Verification of Board certification is expected in the very near future and it is anticipated that the candidate will be on board within one month. In addition, progress is being made to bring a Fee Basis neurologist on board. Recruitment efforts of last year did not prove successful for an appropriate candidate to fill the much-needed GI position. We agree that this also is a critical area. The Chief, Medical Service is continuing his efforts to recruit an appropriate candidate for this position with recurring follow-up with the Chief of Staff. Efforts to see those patients in Clinic continue to be a work in progress with a solution in the near future. It is important to remember that urgent needs for these Clinics are accommodated by over booking clinics. This is effective given the high no-show rates for these Clinics. We are continuously assessing this situation and working diligently to achieve success.

The Women Veterans' Treatment Program Needs Adequate Trained Gynecological Attendant Services. Concur. The current part-time nurse is being advanced to full time support to the Women Veterans' Program. This individual is fully trained and competent to provide this expertise. In addition, the Associate Director for Patient Care Services has determined the need to

Medical Center Director Comments

request an additional position to ensure coverage for a trained gynecology attendant.

Emergency Room (ER) Medications and Supplies Must be Secured. Concur. Actions were taken immediately to correct the deficiency noted on inspection by the Team. The issue of medications being on an unlocked cart was corrected by obtaining a cart, which was working properly. The needles, syringes, and scalpels found in an unsecured area are part of the IV kit for the ER and should not have been unsecured. The kit is now stored in the Medication Room and not in the ER treatment area.

The Installation of Additional Panic Buttons Will Enhance Mental Health Service Safety and Security. Concur- with comment. Panic buttons for staff to obtain assistance in dealing with difficult patients are located in all appropriate areas at this time. While panic buttons do exist for staff use in the dayroom, these are not felt to be appropriate in hallways for patient access. A panic button does exist in the female patient room.

The Compensated Work Therapy Van Driver Should Have Communications Equipment to Report En-Route Emergencies.
Concur. An order for a cellular telephone to be issued to the driver will provide a method to communicate during emergencies.

Competency Assessment Checklists for Drug Abuse Program (DAP) Addiction Specialists Should Include Urinalysis Screening and Breathalyzer Testing. Concur. Accomplished. The competency assessment checklist for addiction specialists now reflects urinalysis screening and Breathalyzer testing.

Engineering Service Should Resolve Ward 2N Solarium Environmental Deficiencies. Concur. We are exploring increasing the size of the air conditioning units to meet summer load. We will also work towards installation of an outdoor awning to replace direct sunlight.

Smoking Policy Should Consistently Apply to All Patients. Do not Concur. While we see the perceived paradox presented by not allowing acute psychiatry patients to smoke while an inpatient and they are allowed to smoke when transferred to the Domiciliary and become outpatients, our commitment is to ensure that inpatient psychiatry patients do not smoke while in acute psychiatric care.

Medical Center Director Comments

Financial and Administrative Management

Results and Recommendations

The Facility Should Turn in Excess Research Equipment: **Concur**. Action was taken to excess 152 pieces of equipment in response to recommendation of the Regional Research Equipment Program (RREP), and IG CAP team suggestion. All pieces of said equipment were picked up on June 28, 2000.

Designated Officials Should Approve the Purchase of Information Technology Equipment. **Concur**. Purchases will be reviewed by the Associate Director for Operations, as Chair of the Resource Management Committee, to assure that required approvals are obtained.

The Purchase Card Coordinator Should Not Be a Cardholder or Approving Official, and Should Follow up on Internal Review Findings. Concur. The Purchase Card Coordinator's Citibank Card was cancelled on May 19, 2000. The following measures are being instituted to ensure compliance with the time constraints for reconciliation and approval of credit card payments:

- Employees who consistently fail to reconcile or approve their payments within the allotted times will be reported to the Associate Director for Operations by the Fiscal Section. The Associate Director for Operations will counsel the offenders.
- Continued failure by the employee to reconcile/approve credit card payments will result in cancellation of the Citibank Card.
- Training is held on an annual basis but will also be administered on a one to one basis as reviews show necessity.

Employees Should Follow Guidelines for Approving and Reporting Commercial Printing Costs. Concur. Tracking this type of misuse of credit cards is difficult since the orders input, approved by the approving official and reconciliation is done through the Salem VA Medical Center. Announcement of

Medical Center Director Comments

the seriousness of this activity will be published in our weekly all employee newsletter and Director's Staff Conference. The amount spent, as you reported is $2,780, which constitutes a minimal impact but we view any impact as serious and the message will be relayed strongly to staff.

Recommendations for Improving Management Controls

The VAMC Should Pursue Lower Contract Rates and Improve Controls Over Inspections for Community Nursing Homes

Recommendation 1: **The Medical Center Director should pursue opportunities to negotiate community nursing home care rates in line with benchmark rates suggested by policy**. **Concur.** We agree that justification for exceeding Medicaid rates can be improved subsequent to and in response to the IG visit and their helpful consultation. We have formally requested from the Virginia Department of Medical Services office (see Attachment 1) that a copy of the Medicaid Annual Cost Report submitted by local community nursing homes (CNH) used to determine future Medicaid rates be forwarded to the Contracting Office through the Home and Community Care Manager (COTR). This report contains the Allowable Medicaid Cost for each CNH and will enable the contracting office to negotiate more effectively. Based on the recommendation, contracts are being renewed for no more than a month, until the report is received and incorporated into the contracting office negotiations. In the future, all contracts due for renewal will be negotiated utilizing the Medicaid Cost Report.

While we do not disagree that we may save $79,000 in contracting, we also do not necessarily recognize that it will directly reduce overall medical center costs. We are concerned that the lower reimbursement rate may result in slowing of transfers of our veterans from acute programs to contract nursing homes; thereby potentially resulting in higher costs in acute medicine, surgery and psychiatry as a result of the increased bed days of care and lengths of stay. With our current reimbursements, we believe that contract nursing homes are acting quickly to accept our referred patients and that our referrals compare favorably to other referrals from the community. Additionally, Hampton VAMC's contract rates, while modestly higher than the State Medicaid rate, are comparable with our VISN 6 counterparts.

Medical Center Director Comments

We cannot reliably predict and estimate what impact the result of successfully reducing the per diem will have on the current process of transfer and the potential for increased costs in other areas.

We also agree with the helpful comments regarding the inspection process and have already revised the process. All inspections will occur within 60 days of renewal of the yearly contract. This will allow the contracting office the opportunity to view the inspection report and the cost data prior to award. Additionally, a checklist has been developed to document review of the state inspection as well as future OSCAR data prior to the time of inspection. A nurse has been detailed to assure that all nursing home residents are visited at least every 60 days as required by regulation. This resumption of nurse supervision has already produced positive results. We are receiving referrals by the visiting nurse for podiatry care and other services. These referrals would not have occurred without the resumption of the nurse visits.

The VAMC Should Improve Internal Controls Over Security of Controlled Substances

Recommendation 2 – **The Medical Center Director should strengthen controls and improve monitoring of the scheduling, completion, and resolution of discrepancies of inspections of controlled substances; and ensure that unusable controlled substances are destroyed quarterly**. **Concur**. Pharmacy Service will:

- Improve training of narcotic inspectors to include a better understanding of their role and proper documentation of the scope and findings of their review. NLT 9/30/00
- Introduce a standardized written report format for all narcotic inspection reports. All inspection reports will be routed through the Chief of Pharmacy for immediate follow up and resolution of all discrepancies written seven days after inspection. NLT 9/30/00
- Effective immediately, unusable controlled substances will be destroyed on a quarterly basis as required. 6/30/00

Researchers Should Obtain Signed Consent for Participation in Research Projects and Document the Consent in Patients' Records.

Recommendation 3 – **The Medical Center Director should improve internal controls for ensuring that signed consent forms are documented in patients' records and should conduct a review of consent forms for all active projects**. **Concur**. The following actions have been taken:

Medical Center Director Comments

- Audits will be increased from annually to bi-annually. 6/30/00
- A Center Memorandum has been published (see Attachment 3); "Consent Forms" which assigns responsibility for ensuring that signed consents are filed in the Administrative folder for each patient participating in a project is in the draft stage being circulated for concurrence. Publication is anticipated in the near future. The investigator or his/her designee is additionally responsible for affixing a sticker to the outside jacket of the patient's most recent clinical/medical volume of the chart identifying the patient as being a subject in a research study (see Attachment 4). The decision to file the consent in the administrative record was made after consulting with Dr. John Mather, Office of Research Compliance Assurance (ORCA) and based on the reduced risk that the consent was less likely to be "thinned" from the record, misfiled, or accidentally removed. 7/15/00
- In response to concerns raised by the Institutional Review Board members that placing a label on the medical record and identifying the patient as the subject of a research study might constitute a violation of confidentiality, consultation was made with the Medical Center's attorney who recommended the wording currently appearing on the label. 7/15/00
- If upon audit, it is discovered that an investigator will be directed to discontinue all research at this facility will be initiated:
    - The investigator will be directed to discontinue all research at this facility until the next regularly scheduled IRB Committee meeting.
    - The investigator will have to produce or provide duplicate consents with the original signatures of inclusion in the patient's record.
    - The Research and Development Committee (R&D)/IRB will establish an appropriate period of time during which the investigator's consent forms will be audited monthly until the IRB/R&D Committee is satisfied that the investigator is following established protocols. 7/15/00

Management Should Conduct Random Audits of the Agent Cashier, and Decrease the Agent Cashier's Advance. **Concur**. Six audits a year will be scheduled by the Office of the Associate Director for Operations. At least one audit will be less than 30 days after the previous one. Audits will be conducted at varying times of day.

Medical Center Director Comments

Recommendation 4 – **The Medical Center Director should initially decrease the advance by $15,000 and re-evaluate the advance quarterly thereafter to assess the potential for further decreases**. **Concur**. Subsequent to contact from the Team, we took yet another look at our advance quarterly assets and have concluded that in fact there does present an opportunity to improve the management controls in this area. Therefore, immediate steps have been taken to turn in $15,000. We thank you for this opportunity to readdress this issue.

Medical Center Director Comments

Medical Center Director's Comments

On behalf of the Hampton VAMC employees and patients, I wish to extend our sincere appreciation for your hard work in performing the OIG CAP visit, your helpful consultation, and your suggestions and recommendations.

We seized this opportunity as a learning tool to help us become the very best health care provider to the veterans we serve. I have received many comments by staff regarding the value added gained from the Team members during the visit.

Our goal was to learn as much as we could to improve our organization. We believe that goal was achieved thanks to your efforts and willingness to assist us.

We look forward to learning more as we continue this process.

It is unfortunate that we cannot agree with all of the suggestions and recommendations. We look forward to your response to our rationale for our positions.

Again, we thank you for your fair and beneficial review of our programs.

/s/
B. W. STORY, Ph.D.
Medical Center Director

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