OFFICE OF INSPECTOR GENERAL

Summary Report – Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities (January 1999 – March 2001)

Report No. 01-00504-9
Date: October 10, 2001

Office of Inspector General
Washington DC 20420

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report–Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities (January 1999-March 2001)

1. This summary report describes findings identified during Combined Assessment Program (CAP) reviews at Veterans Health Administration (VHA) medical facilities. In our opinion, these findings have occurred with sufficient frequency as to require management oversight.

2. During the period January 1999 through March 2001, the Office of Inspector General (OIG) issued 31 reports of CAP reviews of Department of Veterans Affairs (VA) healthcare facilities. The purposes of these reviews were to evaluate selected facilities' operations, focusing on patient care administration, quality management, and financial and administrative management controls. We also provided fraud and integrity awareness training for facility employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. CAP reviews are an important part of the OIG's program to help VHA and the Congress ensure that our Nation's veterans receive high quality services from VA. CAP review teams combine the knowledge and skills of staff from the OIG Offices of Healthcare Inspections, Audit, and Investigations to evaluate facilities' operations. We intend to conduct 30 CAP reviews at VHA medical facilities during Fiscal Year (FY) 2001 and we will periodically issue summary reports on recurring findings identified during these reviews.

4. To date, CAP reviews of VHA medical facilities have identified the following 15 areas requiring improvement.

- Clinical Staffing
- Clinic Waiting Times
- Documentation and Coding of Insurance Claims
- Employee Concerns
- Credentialing, Privileging, and Background Checks
- Community Nursing Home Program
- Veterans' Eligibility Means Testing

- Treatment Environment in Healthcare Facilities
- Controlled Substances Prescribed to Patients in Mental Health and Behavioral Science Programs
- Pain Management in Acute Care
- Patient Concerns
- Supply Inventory Management
- Clinical Services Contract Management
- Controlled Substances Accountability
- Government Purchase Card Program

5. VHA management should encourage Veterans Integrated Service Network Directors and healthcare facility Directors to promptly address the issues identified. We will continue to follow up on the issues reported here in future CAP reviews and include new areas of inquiry that are initiated by the OIG or requested by the Department. If you wish to provide comments or have questions, please contact Mr. Michael Slachta, Assistant Inspector General for Auditing, at (202) 565-4625, or Mr. Alanson Schweitzer, Assistant Inspector General for Healthcare Inspections, at (202) 565-8305.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Background

The purposes of CAP reviews are to:

- Conduct recurring reviews of selected healthcare system and medical center operations, focusing on patient care and quality management (QM) to determine how well the facilities are accomplishing the mission of providing veterans convenient access to high quality medical services.

- Review selected financial and administrative activities to determine if management controls ensure compliance with statutes and agency policy, to assist management in accomplishing program goals, and to minimize vulnerability to fraud, waste, and program abuse.

- Provide fraud and integrity awareness training to raise employee awareness of the potential for program fraud involving procurement, workers' compensation, and other schemes perpetrated against the VA, and to provide employees instructions on the procedures to follow when referring suspected fraud to the OIG.

- Examine issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

Scope of Review

During the period January 1999 through March 2001, CAP teams reported on operations at 31 VA healthcare system facilities. (See Appendix I, pages 42-43, for a listing of the reports issued.) Generally, the CAP reviews were conducted during 1-week site visits. We interviewed senior management officials, clinical and administrative employees, and patients. Questionnaires were used to survey patients' and employees' satisfaction with the timeliness of service and quality of care, and to solicit opinions and perceptions about the treatment process.

We reviewed selected financial and administrative activities to evaluate 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 ensure that organizational goals and objectives are met.

Administrative activities reviewed included selected contract solicitations, contract documentation, and sample purchases made using Government purchase cards. In addition, we examined management controls over these activities. We also examined supply inventory controls at selected facilities, inspected administrative work areas, interviewed managers and employees, and reviewed pertinent financial and administrative records.

We conducted fraud and integrity awareness briefings during each CAP review. The presentations included a brief film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and question and answer sessions.

We also accepted complaints during the course of CAP reviews. Complaints received onsite were screened and were either addressed during the CAP reviews or referred to our Hotline Division for further follow up.

CAP reviews were performed in accordance with the OIG's Combined Assessment Program Standard Operating Procedures.

Results of CAP Reviews

VHA Managers Should Continually Assess Clinical Staffing Levels to Ensure Sufficient Staff is Available to Meet Patient Needs.

1. Clinical Staffing

Background

Staffing issues were reviewed at 21 facilities. VHA facility employees complained about staffing problems in most patient treatment areas as well as pharmacy, housekeeping, and support services. One of the most frequent complaints was that there was insufficient staff, particularly nurse staffing.

Requirements

Healthcare facilities need an appropriate number and mix of qualified employees to fulfill VA's mission and meet the needs of the veterans they serve. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires management to identify and provide the appropriate number of competent employees to meet the needs of patients served by the facility. Management must provide an adequate number of employees whose qualifications are consistent with job responsibilities.

VHA does not have published guidelines that mandate staffing levels for all clinical services. However, VHA has set workload limitations for some clinicians. For example, primary care providers have patient panel size limitations, and nursing units have locally established minimum nurse staffing levels for safe practice, using a variety of staffing formulas.

Results of CAP Reviews

We surveyed 2,756 randomly selected full-time employees from 21 VA healthcare facilities and asked them whether they had enough employees to treat all of the patients who needed treatment. Fifty-five percent of the employees (1,512/2,756) said no. We also interviewed employees and analyzed nurse staffing on selected inpatient units at the facilities where we addressed this issue.

The following are examples where VHA acted to realign staffing and resources to correct identified staffing deficiencies:

- One facility had a serious shortage of nursing staff. Staffing procedures in place for patient care services including patient classification reports to estimate patient care needs, expert staffing methodology statistics, and the overall assignment of staff in accordance with the organizational plan indicated that Nursing staffing was too low to meet patient care demands. Supporting this view was the fact that more than 32 full-time equivalent employee nursing vacancies existed and

several nursing employees were on limited duty due to on-the-job injuries. Management was not able to fill the nursing vacancies because of a budgetary shortfall. After the CAP review, the facility received supplemental Veterans Integrated Service Network (VISN) funds to acquire additional staff.

- During another CAP review we found that the facility's outpatient workload increased by more than 36,000 visits in 1-year. This rapid outpatient workload growth posed a significant challenge to facility management. Several outpatient specialty clinics had waiting times for the next available appointments significantly in excess of VHA's goal of 45 days. Also, waiting times for prescriptions, scheduled radiology procedures, surgical biopsies, and laboratory test results were excessive. While increasing staffing levels would help alleviate these problems, managers told us that recruitment of doctors and nurses was difficult because of the many competing opportunities in the area. After the CAP review, the facility received additional VISN funds to acquire additional staff.

- Another facility's management reported 101 vacancies. Lack of sufficient direct care clinical staff, clinical support service staff, and clerical staff in patient care areas adversely affected the facility's ability to deliver timely, high quality services in the primary care setting, and contributed to long waiting times and delayed patient treatment. For example, seven critical vacancies in Pharmacy Service had not been filled and this shortage adversely affected prescription waiting times and patient medication education. The Director concurred with our findings and hired an additional Personnel Management Specialist to improve timeliness for hiring staff; consolidated 2 inpatient units freeing an additional 15 staff members to fill vacancies in primary care; reallocated nursing staff to ensure balanced coverage and workload; and increased the intermittent staff by 6 nurses.

- At another facility, sufficient resources were not provided to maintain the domiciliary physical plant and help domiciliary residents achieve therapeutic goals. There was a need to conduct a thorough cleaning of all domiciliary units. Routine maintenance had not been done in months, and much of the furniture and bedding was in poor condition and needed repair or replacement. Several domiciliary residents had only cursory treatment plans without measurable goals, and had excessive amounts of unstructured time. Also, about 40 percent of domiciliary patients were discharged before completing their treatment programs and recidivism rates were high. Based on our findings, management increased the number of housekeeping staff assigned to the domiciliary and created a Domiciliary Coordinator position.

We conclude from our CAP reviews that VHA needs to more aggressively assess changing healthcare system staffing needs and direct VISN resources to those facilities experiencing serious shortages.

Continued Improvement Is Needed to Ensure Compliance with VHA's Clinic Waiting Times Goals.

2. Clinic Waiting Times

Background

Clinic waiting times were assessed at 24 facilities. One of the most frequent complaints the OIG receives from veterans is the length of time they have to wait to obtain appointments with caregivers and to see their caregivers once they have arrived for their appointments.

Requirements

Since 1996, clinic waiting times have been one of the performance measures monitored in the Network Directors' Performance Plan. The six clinics included in this measure are eye care, audiology, orthopedics, cardiology, urology, and primary care. The two target goals of the clinic waiting times performance measure for FY 2001 are to decrease the average waiting time for next available appointments to 45 days (fully successful) or 30 days (exceptional).

VHA also has a long-established goal that patients will not be kept waiting more than 30 minutes to see healthcare providers for scheduled appointments or to receive their prescriptions. The FY 2001 Network Directors' Performance Plan states that patients should not wait more than 20 minutes to see providers.

Results of CAP Reviews

We assessed patient perceptions on 24 CAP reviews through the use of interviews and questionnaires. Overall, 69 percent of patients (524/763) stated that they were able to obtain appointments with specialists within 30-45 days, 68 percent (648/951) stated that they saw their providers within 30 minutes of their scheduled appointments, and 55 percent (462/840) received their prescriptions within 30 minutes.

- In many of the facilities reviewed, most clinics averaged more than 30 days to the next available appointment, including the 6 clinics included in the Network Directors' Performance Plan. Examples from various facilities include:

    - 300 days for the next available primary care appointment,
    - 202 days for the next available orthopedics appointment,
    - 173 days for the next available neurosurgery appointment, and
    - 52 days for the next available urology appointment.

- Managers often cited the lack of available specialists as the reason for long waits to obtain specialty appointments, and the lack of space as the reason for long waits to obtain primary care appointments. Equipment failure or lack of equipment was often blamed for long waits for radiology tests and other specialty procedures.

- Veterans reported that prescription waiting times routinely exceeded 30 minutes, and complaints of 1 to 2 hour waits were not uncommon. Pharmacy staffing shortages, space limitations, and inadequate equipment were often cited as reasons for long waits.

VHA contracted with the Institute for Healthcare Improvement (IHI) to address the clinic waiting time issues at each facility. All the facilities we visited were participating in this initiative and were enthusiastic about the activities. Key individuals in several facilities were able to demonstrate reductions in waiting times at the clinics targeted for improvement through the IHI effort. However, excessive waiting times continue to be a serious problem.

Continued Improvement Is Needed to ensure that All Clinic Visits Are Documented in the Medical Records and assigned Accurate Codes.

3. Documentation and Coding of Insurance Claims

Background

Outpatient coding accuracy, data reliability, training initiatives, and implementation of compliance programs were reviewed at 15 VA medical facilities. In 1997, VHA established a strategic goal that challenged VA medical facility managers to generate 10 percent of their budgets from alternative revenue sources such as medical care cost recovery and sharing agreements. During FY 2000, VHA recovered $381 million from third-party billings.

In 1998 and 1999, an insurance carrier identified inaccurate VHA facility billings. The insurance carrier auditors found that 88 percent of VA and non-VA facilities audited had billing inaccuracies exceeding 5 percent. The inaccuracies included the lack of supporting documentation and coding either higher or lower than the documentation justified.

It is essential that VHA assure that appropriate and accurate claims are filed and that all claims are supported by medical record documentation. With the continuing goal of generating alternative revenue funding, medical care that has the potential to generate revenue must be reviewed for complete documentation of the care provided.

Requirements

All clinic visits should be documented in the medical records and assigned Current Procedural Terminology (CPT) codes. The documentation should be complete and accurate because it is the basis for assigning CPT codes. The codes are maintained in a national VA database of clinical and workload information used for system-wide analysis, reimbursement, and research.

In 1986, Public Law (PL) 99-272 authorized VHA to seek reimbursement from third-party payers for the cost of medical care furnished to nonservice-connected veterans who are treated at VHA medical facilities. The Omnibus Budget Reconciliation Act of 1990 allowed VHA to bill third-party payers for the cost of medical care provided to insured service connected veterans for nonservice-connected conditions.

In 1999, VHA issued Directive 99-052, which provided guidance for the implementation of a Compliance Program at every level of the organization. The Under Secretary for Health directed all VA medical facilities to comply with Medicare regulations.

Results of CAP Reviews

We reviewed outpatient coding accuracy, data reliability, training initiatives, and implementation of compliance programs at 15 VA medical facilities.

- We found that about 50 percent of the 570 outpatient visits reviewed contained coding errors, which was significantly higher than the 30-percent error rate the Health Care Finance Administration (HCFA) reported from its review of private sector billings in 1996.

- We found that employees had made numerous coding and billing amount corrections, but these changes were not reflected in VA's database. Consequently, VHA is expending considerable resources to maintain a national database that is not accurate or reliable in monitoring its goal accomplishments. Managers needed to focus their efforts on identifying and resolving the causes of these inaccuracies.

- We found that managers needed to better educate clinicians on the necessary documentation requirements to accurately bill for services rendered. Managers needed to evaluate training efforts, and include the results of their findings in subsequent training sessions.

- We found that while managers had made progress in implementing the compliance program established in 1999, several improvements needed to be made, including the establishment of a national help-line for complaint reporting.

We concluded that VHA managers needed to focus their attention on improving coding accuracy, database accuracy, training for clinicians and coders, and implementation of compliance programs at all VA facilities. Currently, VA risks litigation on over-billings and lost revenues on under-billings for services rendered.

Employees Expressed High Job Satisfaction But Continued Emphasis Is Needed to Ensure Positive Employee Morale.

4. Employee Concerns

Background

Employee feedback was obtained through the use of interviews and questionnaires at 21 facilities. Since we began performing CAP reviews, we have systematically elicited employees' perceptions on a wide range of issues. We believe that the resulting data can provide an independent, objective indicator of employee satisfaction for facility management to use in decision-making.

Requirements

VHA aspires to be the employer of choice. In 1997, VA administered the "One VA" survey, but did not follow-up with annual surveys. In the absence of this source of employee feedback, we provided facility management with survey results obtained during CAP reviews.

Results of CAP Reviews

Most employees expressed high job satisfaction. Eighty-seven percent of the respondents (2,691/3,079) asserted that they gained personal satisfaction from their jobs.[1] Eighty-two percent (1,718/2,093) believed that their supervisors were qualified, and 78 percent (2,362/3,031) believed that the performance evaluation process was generally consistent and fair. Eighty-seven percent of the respondents (2,313/2,666) believed that the quality of care at their respective facilities was either good, very good, or excellent. Seventy-eight percent (2,308/2,950) indicated that they would recommend treatment at their respective facilities to family members or friends.

We noted several deficiencies that were common to most facilities.

- Only 41 percent of the responding employees (840/2,038) believed that recognition and awards programs adequately reflected performance.

- Fifty-five percent of the responding employees (1,512/2,756) indicated that staffing was not sufficient in their respective work areas to provide adequate care to all patients. Feedback included concerns for the safety of patients and staff, as well as the assertion that it was not possible to deliver comprehensive care without sufficient nursing and clerical resources.

[1] Employees did not always answer all survey questions resulting in the differences in the numbers of respondents.

- Although 83 percent of the responding employees (1,306/1,581) reported that they were generally comfortable in self-reporting errors that involve patient care, only 66 percent (1,063/1,610) indicated that they were comfortable reporting errors that involved colleagues. Furthermore, only 64 percent (976/1,530) believed that constructive actions were taken when errors were reported.

Continued Improvement Is Needed to Ensure High Quality Maintenance of All VHA Healthcare System Facilities.

5. Treatment Environment in Healthcare Facilities

Background

We assessed facility conditions and the overall environment of care at 27 healthcare facilities. The treatment environment in healthcare facilities influences patients' well-being and safety. Accordingly, healthcare facility management must ensure that all patient care facilities are maintained in such a manner as to promote health, reduce illness and disease, contribute to infection control, and ensure a safe environment. Ultimately, patients are entitled to receive their health care services in facilities that are well-maintained, safe, clean, and sanitary. Because of the importance of these factors in health care, we focused on the environment of care in which patients receive services.

Requirements

Both JCAHO standards and VHA policies require continued, high quality maintenance of VHA healthcare facilities. Management must ensure optimal environmental conditions. Environmental program managers at each facility serve as healthcare sanitation and infection control experts with responsibility for physical plant conditions, sanitation, and safety.

Results of CAP Reviews

The conditions in which patients receive care in VHA healthcare facilities are a continued focus of our oversight review process. CAP reviews include extensive inspections of the facilities in which patients receive care. We routinely inspect cleanliness, safety, and compliance with safety and construction standards. Adequacy of building maintenance, e.g., correction of environmental deficiencies, is also evaluated.

Our physical plant surveys found that:

- Exits were properly marked in all areas surveyed. Fire alarms were visible in 94 percent of the areas (224/238) inspected.

- Cardiac crash cart locations were properly marked in 94 percent of the clinical areas (77/82) inspected.

- Emergency call systems were available in 93 percent of the tunnels/connecting hallways (71/76) inspected.

- Patient rooms were clean in 92 percent of the patient rooms (162/177) inspected.

- Wall handrails were secure in 94 percent of the corridors (176/188) inspected.

- Signs were properly placed identifying wet floors in 95 percent of the instances (105/111) in which employees were mopping floors.

- Patient treatment areas were in good repair in 87 percent of the patient treatment areas (81/93) inspected.

We also identified unacceptable physical deficiencies in some patient care areas. Some examples include: damaged floor tiles in operating rooms and patient rooms; wall cracks in patient rooms and corridors; dirty and broken furniture in patient rooms and lounge areas; dirty floors, bedrails, over-bed tables, medication poles, and treatment carts; and water stains on ceiling tiles. Management generally attributed the deficiencies to shortages and high turnover rates of housekeeping staff.

The following are additional deficiencies identified:

- Wheel-chair accessible bathrooms were available in 94 percent of the patient care treatment areas (307/328) inspected. Other restrooms, while accessible, were difficult for handicapped patients to maneuver in because of the door position, location of waste receptacles, or placement of urinals and sinks.

- Corridors were cluttered with equipment in 46 percent of the corridors (93/201) inspected. Hallway clutter was frequently a problem because of insufficient storage spaces on inpatient care units.

- Only 34 percent of the patient treatment areas (69/205) inspected had signage identifying the location of patient representatives. The dissemination and display of patient representative information is needed to ensure that all patients know where they can go to obtain assistance.

- Only 66 percent of the patient registration areas (83/125) provided adequate privacy for discussions with patients.

- Medical records and other patient identifying documents were secure from public view or theft in 87 percent of the areas (67/77) where records were found.

Continued Improvement Is Needed to Ensure Patients' Needs for Controlled Substances Are Documented in the Medical Records.

6. Controlled Substances Prescribed to Patients in Mental Health and Behavioral Science Programs

Background

We reviewed long-term maintenance prescribing practices of VHA practitioners in Mental Health and Behavioral Science (MH&BS) programs at nine facilities. During FY 2000, nearly 688,000 patients, representing about 19 percent of all patients treated by VHA, received specialized mental health services. The annual cost of mental health care per treated veteran (including both inpatient and outpatient services) was $2,737 in FY 2000, about 77 percent of the cost of an average non-mental health patient in VHA. In FY 2000, inpatient and outpatient mental health treatment expenditures in VHA totaled over $1.5 billion, of which $279 million was devoted to substance abuse treatment. The volume of mental health treatment in VHA raises mental illness and substance abuse treatment to among VHA's top priorities in healthcare delivery.

Pain control poses a significant challenge to providers who treat patients with mental illnesses. Patients may become dependent on or may abuse pain control substances after extended use. Mental health providers must determine when these patients need referral to pain management specialists for alternative treatments.

Requirements

The JCAHO requires that healthcare organizations have procedures designed to govern prescribing and administering drugs for maintenance use when they have abuse potential, are known to involve a substantial risk, or are associated with significant, undesirable side effects. In addition, the JCAHO requires that physicians who prescribe controlled substances for maintenance purposes document in the patients' medical records the reasons for prescribing the drugs.

Prescribing clinicians are to ensure that alternatives to the long-term use of controlled substances are explored. The patients must be counseled and confirm their understanding of the treatment plans. Prescribing clinicians must document that other treatment modalities have failed, before instituting the administration of long-term controlled substances.

When care is not planned to meet all identified needs, medical practitioners must document that fact in patients' medical records. If the need for long-term administration of a controlled substance is not addressed in the interdisciplinary treatment plan, practitioners should document in the medical record why this need is not being

addressed. This documentation may be found in the physician's history and physical examination, admission notes, or progress notes.

Results of CAP Reviews

The long-term maintenance prescribing practices of VHA practitioners in MH&BS programs were reviewed during nine CAP reviews. The reviews were conducted to evaluate prescribers' management of long-term use of controlled substances issued to MH&BS patients for non-psychiatric purposes (e.g., chronic pain control).

We interviewed 72 psychiatrists and reviewed 66 medical records of patients who were receiving mental health treatment and had been prescribed controlled substances for non-psychiatric purposes. These patients received one or more of the following medications: Percocet®, Percodan®, Tylenol-III®, and Darvocet®.

Positive aspects, as well as opportunities for better management of the patients' care, were identified from these reviews.

- Nineteen psychiatrists (26 percent) told us that they documented the need for maintaining patients on controlled substances for non-psychiatric purposes in their medical records.

- Twenty-three (32 percent) told us they routinely reassessed and documented in the medical records patients' long-term treatments involving the use of controlled substances.

- Twenty-seven (38 percent) told us they refused to prescribe controlled substances to patients for long-term (maintenance) use.

- Forty-six (64 percent) indicated that senior managers supported their decisions regarding prescribing controlled substances to mental health patients.

- Thirteen medical records (20 percent) contained clinical documentation of the patients' care needs and treatment goals related to the long-term use of controlled substances.

- Twenty-four medical records (36 percent) contained evidence that psychiatrists had justified the continued use of controlled substances for non-psychiatric purposes.

- Twenty-nine medical records (44 percent) contained evidence that prescribing psychiatrists had considered and/or referred patients for alternative treatments, e.g., biofeedback, acupuncture, Pain Management Clinic services, nerve stimulation, or chiropractic care.

Continued Improvement Is Needed to Ensure Compliance with VHA's National Pain Management Strategy.

7. Pain Management in Acute Care

Background

We reviewed pain management programs at 13 facilities. Pain management has been identified as a significant problem in American health care. Dr. C. Everett Koop, former Surgeon General, pointed to the absence of effective pain management as the chief impetus behind the physician assisted suicide (PAS) movement. Medical literature suggests that patients seeking PAS cease their pursuit of that objective when their pain is managed effectively. The literature also suggests knowledge and techniques to control most pain are known, but are not always applied effectively. Proactive, aggressive management of both acute and chronic pain is universally recognized as an essential component of health care. However, there is substantial evidence that pain is not managed adequately in most healthcare systems.

Requirements

In 1998, the Under Secretary for Health issued the charge to implement a National Pain Management Strategy.[2] He directed each VISN to identify an individual as the point of contact for this national initiative. The purpose of the strategy was to develop a system-wide approach to pain management that would reduce acute and chronic pain and suffering associated with a wide range of illnesses, including terminal illnesses.

Pain assessment and treatment is the hallmark of this initiative. The National Pain Management Strategy states, "Procedures for early recognition of pain and prompt effective treatment shall be implemented by all VA medical treatment facilities. VHA will implement 'pain as the 5th vital sign' in all clinical settings to assure consistent assessment of pain."[3]

Results of CAP Reviews

We reviewed the pain management programs at 13 VHA facilities; reviewed 116 medical records; interviewed 128 nurses, 28 physicians, and 281 employees during CAP reviews and found that:

- Thirteen facilities (100 percent) had implemented the "pain as the 5th vital sign" initiative.

[2] Under Secretary for Health Memorandum, Pain Management Strategy, November 12, 1998.
[3] Pain Assessment, the 5th Vital Sign, published by VHA, Acute Care Strategic Health Care Group and Geriatric/Extended Care Strategic Health Care Group, 1998.

- Three facilities (23 percent) had current policies regarding pain management. Two facilities (15 percent) had out-dated policies. Six facilities (46 percent) had policies that were in draft and two facilities (15 percent) did not have any policies regarding pain management.

- One facility (8 percent) met the policy for JCAHO standards/VHA Toolkit requirements. Six facilities (46 percent) met the policy for JCAHO education requirements.

- Fifty medical records (43 percent) reviewed had documentation to support patient/family education. Twenty-six medical records (22 percent) reviewed had documentation showing that the facilities' clinicians assessed patients' knowledge about pain management and related expectations on admissions.

- Eighty-five nursing employees (66 percent) and 12 physicians (43 percent) interviewed had received pain management training.

- Seventy employees (25 percent) told us that the potential for patient addiction influenced their decisions regarding pain relief. Two hundred sixteen employees (77 percent) indicated a need for more national training in pain management.

Patient Satisfaction Was High, But Continued Emphasis is Needed to Ensure that Clinic and Pharmacy Waiting Times Are Reduced.

8. Patient Concerns

Background

Surveys measuring patient satisfaction were conducted at 24 facilities. Since we began doing CAP reviews, we have systematically elicited patients' perceptions of several key treatment indicators. We believe that we can provide an independent, objective source of patient satisfaction data for facility management to use in decision-making.

Requirements

One of VHA's goals is to be the health care provider of choice. VA administers annual surveys of inpatients and outpatients. However, since VHA facilities do not receive the results of VA-administered surveys for several months, we survey patients at each facility and provide the Directors summaries of the results.

Results of CAP Reviews

We surveyed 609 inpatients and 1,013 outpatients at 24 facilities. Common responses include the following:

- Inpatients were generally satisfied with all aspects of their care. Some highlights of the survey were: 94 percent of inpatients (445/471) felt that the reasons for their hospital admissions were being adequately addressed; 83 percent (288/346) felt that clinicians answered their call lights within 5 minutes; and 94 percent (563/598) would recommend their respective facilities to eligible family members or friends.[4]

- Ninety-five percent of inpatients (574/607) rated the quality of their care as good, very good, or excellent.

- Outpatients generally expressed satisfaction with their care. Eighty-nine percent of outpatients (984/1107) rated the quality of their care as good, very good, or excellent. Ninety-two percent (932/1,013) would recommend their respective facilities to eligible family members or friends.

[4] The wide variance in the denominators for both inpatients and outpatients is because frequently patients did not answer all of the survey questions.

The following responses require management attention:

- Only 55 percent of outpatients (462/840) responded that they received their new prescriptions within 30 minutes (see the Clinic Waiting Times topic, pages 8 and 9). Seventy-five percent (582/777) stated that they received counseling by pharmacists about new medications. Since most patients use the Consolidated Mail Outpatient Pharmacy for established prescriptions, we asked if they received their refills before they ran out of medicine, and 78 percent (612/787) responded that they did.

- Only 64 percent of outpatients (519/813) responded that they were generally able to schedule appointments with their primary care providers within 7 days. However, 89 percent (451/506) felt that their primary care providers properly managed their overall care.

In commenting on these survey results, several facility Directors stated that they would increase efforts to keep patients informed about changes and improvements they make or contemplate that may cause temporary inconveniences, particularly as they pertain to pharmacy or clinic waiting times.

Continued Improvement Is Needed to Ensure Physicians Are Credentialed and Privileged and that Background Checks Are Completed Before Service Start Dates.

9. Credentialing, Privileging, and Background Checks

Background

Over the past 15 years, the level of interest in physician competence and integrity has increased significantly throughout the healthcare community and the public at large. Cases in which physicians have been found to be practicing without valid licenses, or with histories of felonious behavior, appear in press reports sporadically and cause a furor among the public and Congress. In one high-profile case a physician obtained a residency position and performed a clinical rotation at a VHA facility whereupon, subsequent to arrest and indictment, he admitted to murdering several patients. This case provided the impetus to reviewing this topic during CAP reviews.

Requirements

All VHA practitioners must be credentialed and privileged according to VHA policy.[5] VHA's credentialing and privileging (C&P) policy applies to licensed independent practitioners who provide patient care. These individuals may be utilized in any of the following capacities: full-time or part-time, intermittent, consultant, attending, without compensation, fee-basis, contract, or sharing agreement. The JCAHO requires that all accredited facilities meet stringent medical staff standards for new appointments and biennial renewals of privileges of all licensed independent practitioners.

Results of CAP Reviews

We reviewed C&P files at seven VHA facilities and identified vulnerabilities at all seven facilities involving human resources management (HRM) processing and contract physician security clearances.

- The required HRM procedure is to fingerprint physicians on the day they report for service. HRM employees told us that it generally takes from 3 to 6 months to get the results of criminal background checks. One facility required fingerprinting in advance of the start date. However, the results generally were not received prior to the practitioners' start dates. Therefore, all independent practitioners were working for several months prior to the facility completing background checks.

[5]VHA Handbook 1100.19, Credentialing and Privileging, March 4, 1999.

- We reviewed the C&P files of 18 physicians hired on contracts to provide services to veterans. We found that 50 percent of the contract physicians (9/18) did not have the required fingerprints and background checks completed when they began working at VA facilities.

- We found that C&P files were maintained in accordance with VHA requirements, but six did not include explanations of breaks in employment of more than 30 days.

Oversight of the CNH Program Should Be Improved to Ensure that Veterans Receive High Quality Care.

10. Community Nursing Home Program

Background

We reviewed oversight of the Community Nursing Home (CNH) program at 17 facilities. VHA has projected that the number of veterans age 85 and older will increase from 327,000 to 645,000 between 1998 and 2003, and peak at 1.3 million in 2013. To meet workload requirements, VHA provides nursing home care through VA nursing home care units and through contracts with privately owned CNH facilities.

During the early 1990s, we issued three audit reports on VHA's CNH program addressing contracting procedures, quality of care, and program management.[6] These audits reported that: CNH contract rates frequently exceeded the Medicaid plus 15 percent rate, patients were not visited by VA nursing or social work employees every 30 days, and annual CNH inspections were not performed.

Requirements

VHA policy requires that CNH contract rates not exceed the State Medicaid plus 15 percent rate for intermediate skilled care, unless prior approval is obtained from VHA headquarters. Additionally, VA policy requires that a multidisciplinary VA healthcare facility committee monitor the quality of care provided VA patients at CNH facilities.

A social worker or nurse must visit each CNH patient at least every 30 days or as often as necessary to assist the patient and ensure good care. A nurse must visit each patient at least every 60 days.

Multidisciplinary healthcare facility committees must conduct annual inspections of all CNHs to ensure that they meet VA safety and quality standards. Additionally, the committees should evaluate the results of inspections conducted by external agencies to determine whether deficiencies identified by these agencies have been corrected and whether the findings are relevant to the committees' oversight responsibilities.

[6] Audit of Department of Veterans Affairs Contracting Procedures for Community Nursing Home Care (Report No. 2R3-E02-023, January 27, 1992).
Audit of Veterans Health Administration Activities for Assuring Quality Care for Veterans in Community Nursing Homes (Report No. 4R3-A28-016, January 11, 1994).
Assessment of the Veterans Health Administration's Nursing Home Care Program (Report No. 5R3-A07-046, March 31, 1995).

Results of CAP Reviews

We reviewed CNH programs during CAP reviews at 17 facilities and identified opportunities for improvement at 14 facilities (82 percent). Overall, program managers needed to improve inspections and patient follow-up visits, and reduce excessive contract rates.

- Seven facilities (41 percent) did not conduct annual CNH inspections to ensure compliance with VA safety and quality standards; some CNHs had not been inspected since 1992.

- Three facilities (18 percent) did not review inspections conducted by Federal and State agencies to ensure previously identified problems were corrected.

- Four facilities (24 percent) did not follow up on deficiencies identified during prior CNH inspections conducted by VA multidisciplinary committees to ensure deficiencies were corrected.

- Two facilities (12 percent) did not ensure a nurse visited CNH patients every 60 days to assess their health status.

- One facility (6 percent) did not ensure patients received annual physical examinations.

- Two facilities (12 percent) needed to establish multidisciplinary committees to oversee the quality of care provided by the CNH program.

- Five facilities (29 percent) needed medical staff to provide input or participate in the approval of CNH contracts prior to initiation and renewal.

- Five facilities (29 percent) needed to establish policies for collection and analysis of CNH performance improvement information.

- Two facilities (12 percent) awarded CNH contracts that exceeded the State Medicaid plus 15 percent rate. The costs were not justified or approved by VHA.

- One facility (6 percent) did not have enough contracts for CNH care, resulting in long waits to place patients.

Facility employees did not conduct annual inspections as required because they misunderstood VHA policy. For example, some facilities did not conduct inspections because managers felt that their inspections duplicated inspections performed by State agencies. In some cases, the CNH committees relied on State inspection reports to make contract decisions.

VHA Means Testing Procedures Need to Be Improved to Assure Compliance with Requirements for Income Verification Matching.

11. Veterans' Eligibility Means Testing

Background

We reviewed means testing procedures at 15 facilities to determine whether the facilities complied with applicable requirements. In accordance with the provisions of PL 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996," VHA has implemented a patient enrollment system to manage the delivery of health care services to eligible veterans. The enrollment system categorizes veterans into seven groups, with Priority Groups I through VI consisting of veterans with service-connected disabilities, low incomes, or those who fall into special categories (e.g., former prisoners of war). Generally, veterans in Priority Group VII are not treated for service-connected disabilities and have incomes above the limits needed to qualify for free care.

VHA requires Priority Group VII patients to report income information so VHA staff can determine entitlement to free medical care. This procedure is called the means test. VHA verifies the self-reported income information by computer matching VA records with income information maintained by the Internal Revenue Service (IRS) and Social Security Administration (SSA). The computer matching agreement between VA and IRS authorized VA to match only information that was self-reported by the veteran and supported by a current signed means test form in VHA records. VHA's Health Eligibility Center (HEC) in Atlanta, Georgia manages the Income Verification Match (IVM) process for VHA.

In 1997 and again in 1999, we reported that VHA was computer matching veterans' income information that was not self-reported by veterans or was not supported by signed means test forms. Because these findings showed continued violations of the terms of the matching agreement, IRS terminated the agreement in July 1999, and required VA to purge all Federal Taxpayer Information (FTI) from Veterans Health Information Systems and Technology Architecture (VISTA) files.

In January 2000, VHA initiated a 100-percent review of all new means tests to ensure that forms were properly completed and signed by the veterans. Patient records were reviewed to determine whether signed means test forms were on file where IVM data was used to revise patient eligibility during calendar years (CYs) 1993-1997. Although IVM data was not used during CYs 1998 and 1999, medical centers also validated 1998 and 1999 means test information for veterans included in the 1993-1997 review. The purpose of this review was to determine whether medical centers made progress complying with IRS requirements for IVM. VHA found less than 50 percent compliance, with the best performance in 1999 (48.6 percent compliance).

Requirements

PL 101-508 (the Omnibus Budget Reconciliation Act of 1990)	Authorizes VA to verify income reported by nonservice-connected veterans with income reported for income tax purposes.
PL 104-262 (Veterans' Health Care Eligibility Reform Act of 1996)	Expanded the verification program to include zero percent (noncompensable) service-connected veterans seeking care for nonservice-connected conditions.

Results of CAP Reviews

Our CAP reviews found that facilities did not obtain signed means test forms in 23 percent of the cases (92/402) we reviewed in CY 1999, and in 17 percent of the cases (30/177) we reviewed in CY 2000.

Because of the continued deficiencies identified during CAP reviews and to respond to a request for a review by the Under Secretary for Health, we initiated an audit of the HEC in May 2000. During that audit we evaluated means testing at an additional 13 facilities. Results of that audit showed that means tests were not signed or could not be located in 17 percent of the cases (76/446) reviewed in CY 2000.

Results of the HEC audit showed that, although VHA purged FTI from VISTA files maintained at facilities, the HEC did not purge all unauthorized FTI from it's electronic files and paper records. These conditions occurred because:

- VHA had not implemented our 1999 recommendation to centralize means testing to the HEC.
- VHA and the HEC had not developed a process to filter unsigned means tests prior to conducting the IVM with IRS and SSA.
- The HEC relied on inaccurate information and did not purge FTI from its files for all cases where signed means tests were not obtained.

These results show that VHA's means test processes do not provide reasonable assurance that only self-reported income would be included in the cases VHA planned to match during IVM. Pending implementation of our 1999 recommendation to expedite centralized means testing to the HEC, we recommended that VHA:

- Provide positive assurance that signed means test forms support means test information provided to the HEC.

- Direct the HEC to purge all FTI that was not supported by signed means test forms.

Implementation of our audit recommendations would provide reasonable assurance that only self-reported income is matched with IRS and SSA, and provide VHA the ability to bill for nonservice-connected services valued at about $15.3 million. The Under Secretary for Health concurred with the audit findings and recommendations and provided acceptable action plans.

VHA Healthcare Facilities Should Reduce Excess Supply Inventories by More Effectively Using Automated Inventory Controls.

12. Supply Inventory Management

Background

We examined supply inventory management practices during CAP reviews at 22 facilities. The OIG has identified inventory management as one of VHA's most serious management challenges. VHA facilities maintain significant inventories of medical, prosthetic, pharmacy, engineering, and other supplies. With inventories of thousands of items, deliveries every day, and distributions to hundreds of users; automated inventory controls are the only practical way to manage supply inventories effectively. Modern inventory management principles provide that inventories should hold sufficient supplies to meet current operating needs, but inventory levels should not exceed current requirements so funds are not tied up in excess inventories.

Our audits have found that VHA facilities have maintained excessive supply inventories and have not used automated inventory controls effectively. For example, our March 1999 audit of medical supply inventories management found that the value of excess medical supply inventories totaled approximately $64.1 million, 62 percent of the VHA total.

Requirements

In response to our audits of inventory management practices, VHA revised its inventory management policy in October 2000. The new policy requires that VHA facilities eliminate excess inventories and use automated inventory management systems to manage all supply inventories except subsistence items. The policy also establishes goals for reducing inventory levels. The initial inventory goal for pharmacy supplies is a 10-day supply, and the initial goal for all other types of supplies is a 30-day supply.

Results of CAP Reviews

We evaluated medical supply inventories at 22 facilities, prosthetic supply inventories at 7 facilities, pharmacy supply inventories at 7 facilities, and engineering supply inventories at 5 facilities. CAP review results show that:

- Nineteen facilities (86 percent) had excess inventories in at least one supply category.

- Ten facilities (45 percent) did not use automated inventory systems to manage one or more supply categories.

- Twelve facilities (55 percent) had inaccurate automated inventory data in one or more supply categories.

- Two facilities (9 percent) did not separate duties relating to ordering, receiving, and recording supply transactions among employees, and one facility (5 percent) did not maintain adequate physical security of medical supplies.

Excess Inventories

As summarized in Table 1 below, 19 of 22 facilities reviewed held excess inventories in at least one supply category.

Table 1. Results of CAP Reviews of Supply Inventory Levels

Supply Categories	Facilities Reviewed	Facilities with Excess Inventories
Medical	22	17 (77%)
Prosthetic	7	5 (71%)
Pharmacy	7	5 (71%)
Engineering	5	5 (100%)
Total Facilities	22	19 (86%)*

*Total reflects excess facility inventories in more than one category.

The following examples illustrate the conditions found.

- One facility maintained a medical supply inventory of 2,025 line items valued at $807,108. Stock on hand for 1,805 line items (89 percent of the total line items stocked) valued at $652,792 (81 percent of the total inventory value) exceeded the 30-day benchmark. Two other facilities held additional medical supply inventories but did not use automated inventory systems so we could not determine the value of the supplies stocked or the amount of excess inventory.

- Another facility maintained a prosthetic supply inventory of 396 line items valued at $194,000. Stock on hand for 376 line items (95 percent of the line items stocked) valued at $145,000 (75 percent of the total inventory value) exceeded the 30-day benchmark. Stock on hand for 263 items valued at $63,047, exceeded 1-year's usage.

At 12 facilities, automated inventory data was available and sufficiently accurate to evaluate inventory levels. We determined that the estimated value of excess inventories on hand at these 12 facilities was $5.0 million, or 62 percent of the $8.1 million total inventory.

Automated Inventory Controls Were Not Used Effectively

Ten facilities (45 percent) did not use automated inventory systems, such as VA's Generic Inventory Package (GIP) or Prosthetic Inventory Package (PIP), to manage supplies, and 12 facilities (55 percent) did not have accurate inventory data. Automated systems can help minimize many of the problems that result in accumulation of excess inventories. Table 2 shows the number of facilities that did not use automated inventory systems and the number of facilities with inaccurate inventory data by supply category.

Table 2. Results of CAP Reviews of Facility Use of Automated Inventory Systems

Supply Categories	Facilities Reviewed	Not Using Automated Systems	Inaccurate Inventory Data
Medical	22	3 (14%)	11 (50%)
Prosthetic	7	0 (0%)	2 (29%)
Pharmacy	7	7 (100%)	0 (0%)
Engineering	5	5 (100%)	0 (0%)
Total Facilities	22	10 (45%)	12 (55%)*

*Total reflects inaccurate facility inventory data in more than one category.

The most basic requirement of an effective automated inventory control system is to maintain accurate and complete perpetual inventory records. Accurate perpetual inventory records provide a continual count and dollar value for every item in stock. If inventory data is not maintained or is not accurate, inventory managers cannot track demand which must be known to establish appropriate stock levels.

Inadequate Separation of Duties and Physical Security

To safeguard supplies and reduce the possibility of theft, duties associated with ordering, receiving, and recording supply transactions should be performed by different employees. In addition, access to supply inventories should be restricted. At two facilities (9 percent) reviewed, the same employee could order, receive, and record supply transactions in the inventory system. In addition, at one facility the door of the medical supply storage warehouse was kept open, leaving the supplies unsecured.

Negotiation and Administration of Noncompetitive Clinical Services Contracts Needs to Be Improved.

13. Clinical Services Contract Management

Background

We evaluated clinical services contracts on 14 CAP reviews. VHA facilities use clinical services contracts with affiliated medical schools, community hospitals, and physician practice groups to support patient care. Typically, these contracts are used to purchase scarce medical specialist services. These are services of medical specialists who are difficult to recruit, hire, and retain; such as radiologists and anesthesiologists. Clinical services contracts may be awarded competitively or noncompetitively, and a significant number are noncompetitively awarded to medical schools affiliated with VHA facilities.

VHA facilities should establish adequate controls to meet two important goals. First, the contract negotiation process should ensure that VA's costs are appropriate and reasonable for the services provided. Second, contract administration procedures should ensure that VA receives all contracted services and pays only for services provided in accordance with contract terms.

Requirements

Noncompetitive contracts, regardless of value, must be supported by cost or pricing data and/or other information such as price lists, to show that the proposed contract prices are reasonable. For contracts exceeding $500,000, pre-award audits of the contractors' proposals should be requested.

The contracting officer should prepare a Price Negotiation Memorandum (PNM) to document the most important elements of the contract negotiation process, including the purpose of the negotiations, a description of the services being procured, and an explanation of how contract prices were determined. PNMs should be included in the contract files.

Throughout the contract performance period, VA staff should monitor contractor performance to ensure that services are provided in accordance with the terms of the contract.

Results of CAP Reviews

Results of reviews showed inconsistent compliance with VA contracting policy. Six facilities (43 percent) generally complied with the policy. Clinical services contracts were properly negotiated and reasonably priced, and contract prices were properly supported, contract negotiations were well documented in the contract files, and facility

staff were monitoring contractors' performance. Minor deficiencies were found at two facilities (14 percent). The remaining six facilities (43 percent) evidenced more significant deficiencies in clinical services contract management falling into two broad categories: inadequate support for contract prices and ineffective monitoring of contractor's performance.

Inadequate Support for Contract Prices

Accurate cost data is the most important information a contracting officer needs to effectively negotiate a noncompetitive contract. Without cost data the contracting officer does not have a reliable basis for negotiating contract prices and ensuring that VA obtains the best value available. The following example illustrates the problem of inadequate support for contract prices:

- One facility paid more than necessary for physician consultation services priced on a per-procedure basis. Medicare rates are the benchmark price for VA per-procedure contracts. The contracting officer had negotiated one large general clinical services contract based on Medicare rates less a 21 percent discount. However, a smaller contract for physician consultation services was not based on Medicare rates. Instead, the facility agreed to a flat rate of $150 per consultation, although the Medicare rate was less than $150 for a large proportion of the consultations performed. If the facility renegotiated the contract using discounted Medicare rates, consultation costs could be reduced by about $181,000 annually. VA costs should generally not exceed Medicare rates, and because of the volume of services purchased, VA facilities can often negotiate prices below Medicare rates.

Ineffective Monitoring of Contractor Performance

The Contracting Officer's Technical Representative (COTR) should monitor contractor performance and approve payments to the contractor. To accomplish these responsibilities the COTR should establish controls to ensure that contracted services are provided and contractor bills are correct. The following examples illustrate ineffective contract monitoring:

- One healthcare system did not effectively monitor a contract for radiology services. Under the contract, a private radiology group was retained to provide the services of a full-time radiologist at a VA clinic. The radiologist was required to be on duty 8 hours a day, Monday through Friday, but was actually present only 4 hours a day.

- Another VHA facility awarded a surgical services contract that did not contain a clear and measurable statement of work describing the services that the contractor was expected to provide. Because of this, it was not possible for the COTR to effectively monitor the contract. The hospital awarded the contract

even though a VA Central Office pre-award technical and legal review pointed out the deficiencies in the statement of work.

Facilities Need to Improve Controlled Substances Accountability.

14. Controlled Substances Accountability

Background

We reviewed controlled substances accountability during 23 CAP reviews. Problems were found in the way 20 facilities accounted for and safeguarded controlled substances. VHA policy requires facilities to maintain accountability of all Schedule II-V controlled substances and to fully comply with all Drug Enforcement Administration regulations governing prescribing, storing, dispensing, and disposing of controlled substances. The primary control to ensure compliance with VHA policy is the unannounced monthly controlled substances inspections.

Requirements

VHA Handbook 1108.1 (May 16, 1997) describes criteria for storing, dispensing, and disposing of controlled substances and procedures for accounting for controlled substances and complying with Federal regulations. VHA Handbook 1108.2 (July 23, 1997) sets forth additional criteria governing inspections of controlled substances. VA medical facilities are required to maintain perpetual inventories over controlled substances, and Pharmacy Service is required to verify inventory balances at least every 72 hours.

VHA policy requires monthly unannounced narcotics inspections and reconciliations with inventory records. Records of Pharmacy Service inventories are to be reviewed during the monthly unannounced narcotics inspections. The inspections should be conducted by facility staff appointed by the facility Director and selected from among employees who do not have routine duties associated with prescribing, storing , or dispensing controlled substances. For example, pharmacists, nurses, physicians, or supply officials may not be selected to participate in controlled substances inspections. The facility Director is required to retain records of the findings of the inspections, ensure that deficiencies are resolved, and trend inspection results. The facility is required to provide appropriate training in controlled substances inspections and to maintain documentation of the training.

Results of CAP Reviews

We identified accountability deficiencies in 3 areas at 20 of the 23 facilities reviewed:

- Noncompliance with the requirement for monthly narcotics inspections.
- Inadequate physical security over controlled substances in patient treatment and pharmacy areas.

- Improper disposal of expired controlled substances.

Monthly Narcotics Inspections

Monthly narcotics inspections were not properly conducted at 11 facilities. The following examples illustrate some of the control deficiencies identified:

- At one facility, a monthly inspection was compromised because Pharmacy Service staff did not cooperate when inspectors called an unannounced inspection. Staff in Pharmacy Service stated that they did not have time to perform the inspection and that the inspector should "come back later." In this instance, the inspector made three attempts to initiate the inspection before it was finally performed. On two other occasions, inspections were performed 1 month late. Additionally, inspectors did not receive required training and, as a result, were dependent on the Pharmacy Service staff whose activities they were to inspect. A Pharmacy Service employee provided orientation for the inspectors while the inspection was being conducted, compromising the inspection.

- At one facility division, inspections were conducted up to 90 days late. At another division of the same facility, no monthly inspections were conducted in FY 1999. Pharmacy Service staff were assigned as inspectors, although participation by Pharmacy Service staff is prohibited by VHA policy because of the inherent conflict of interest. Additionally, all ward or patient treatment areas were not inspected.

- At another facility, narcotics inspectors did not locate a critical Controlled Substance Administration Record during 9 of 12 monthly inspections examined during the CAP review. This record is used to document all transactions pertinent to a specific quantity of a specific controlled substance in a particular location. As a result, all accountability was lost over the drug listed on the missing document. Although they did not conduct the inspections, Pharmacy Service staff had been completing reports of monthly inspections, a conflict of interest proscribed by VHA policy.

- At another facility, 12 Controlled Substance Administration Records had been missing for 2 months at the time of our CAP review.

Physical Security Over Controlled Substances

VHA policy requires that facilities provide adequate safeguards in areas where controlled substances are stored or dispensed. VHA has issued a detailed guide for the security of controlled substances, but the guidance was not consistently followed.

- Pharmacy entrance doors were constructed of wood instead of steel.

- Intrusion alarms were not tested on a regular basis.

- Controlled substances were stored in unlocked cabinets.

Disposal of Expired Controlled Substances

VHA policy requires that facilities inventory expired controlled substances as part of the monthly inspections, and destroy them quarterly. We found that six facilities did not destroy expired controlled substances quarterly as required. At one facility, no destructions had occurred over a period of 15 months, and at another, no destructions had been performed in a year. At a third facility, local policy required that expired narcotics be destroyed only every 6 months and expired narcotics were not included in monthly inspections.

Controls Over the Government Purchase Card Program Need Improvement.

15. Government Purchase Card Program

Background

We reviewed Government purchase card program activities at 19 facilities. The General Services Administration instituted a decentralized purchasing program for direct purchases under $2,500 using Government purchase cards.[7] To reduce the opportunity for fraud and abuse, policy and procedures have been established governing the use of purchase cards, setting purchasing limits, and accounting for purchases. Internal controls over purchase card program activities help to provide management with reasonable assurance that the program will operate efficiently and effectively. Cardholders are required to comply with Government procurement regulations and adhere to mandatory procurement sources.

Requirements

Cardholders should identify procurement sources that are advantageous for the Government. Staff entrusted with procurement responsibilities are expected to "comparison shop" on behalf of the Government. In addition, cardholders should spread their purchases among different vendors, favoring minority and woman-owned businesses.

Cardholders are required to reconcile bills from the charge card company within 5 days of notice that payment has been made, and a higher-level approving official must certify that payment was correct within 14 days of receipt of the reconciled credit card bill. These steps have been included in agency policy to ensure that items purchased were actually received, that the correct amounts for the goods or services were remitted by VA, and that the items purchased were appropriate and intended for Government use.

Results of CAP Reviews

Deficiencies were identified at each facility reviewed.

- Cardholders did not reconcile purchases with credit card bills on time at nine facilities. At one facility, 69 of the 117 cardholders were delinquent in reconciling purchases.

- Approving officials did not certify payments on time at 12 facilities. At one facility, approving official certifications were delinquent between 16 and 517 days.

[7] Purchase cardholders must be assigned a purchase "warrant" with a specific dollar limit to make single purchases above the $2,500 micro-purchase limit.

- Warrant limits for purchases were exceeded at three facilities. At one facility, cardholders with warrants limited to $15,000 made 11 purchases ranging from $25,000 to almost $69,000. At another facility, a cardholder with a $1,000 warrant made single purchases of up to $14,000.

- Procurements at three facilities were not made from mandatory sources considered advantageous to the Government. At one facility, a hip prosthesis costing more than $6,000 was purchased from a non-Federal Supply Schedule (FSS) vendor at the direction of a physician. However, the same prosthesis could have been purchased from an FSS vendor for $2,800, saving over $3,200. At another facility, we noted procurement of medical items valued at $445,000 with no assurance that the most cost-effective sources had been utilized or even considered. Instead of soliciting and comparing prices from various procurement sources, cardholders simply purchased from the sources suggested by the staff requesting the items. Failure to use mandatory sources or FSS procurement sources significantly increases when Government purchase cards are used because cardholders often do not have the training or levels of expertise of procurement officials.

- Indications of improper purchase splitting were identified at many of the facilities reviewed.[8] At one facility, landscaping services valued at $20,000 were split into 10 purchases of $2,000 each to remain below the $2,500 micro-purchase limit. At another facility, a cardholder with a $25,000 warrant made two purchases within hours of each other for furniture totaling $34,000.

[8] Purchase splitting involves separating a single purchase into two or more procurements to circumvent the credit card dollar limit or the cardholder's warrant limitation. Purchase splitting is also employed to avoid requirements for competition in the procurement of higher value goods and services.

Appendices

APPENDIX I

I. List Of CAP Reports Issued

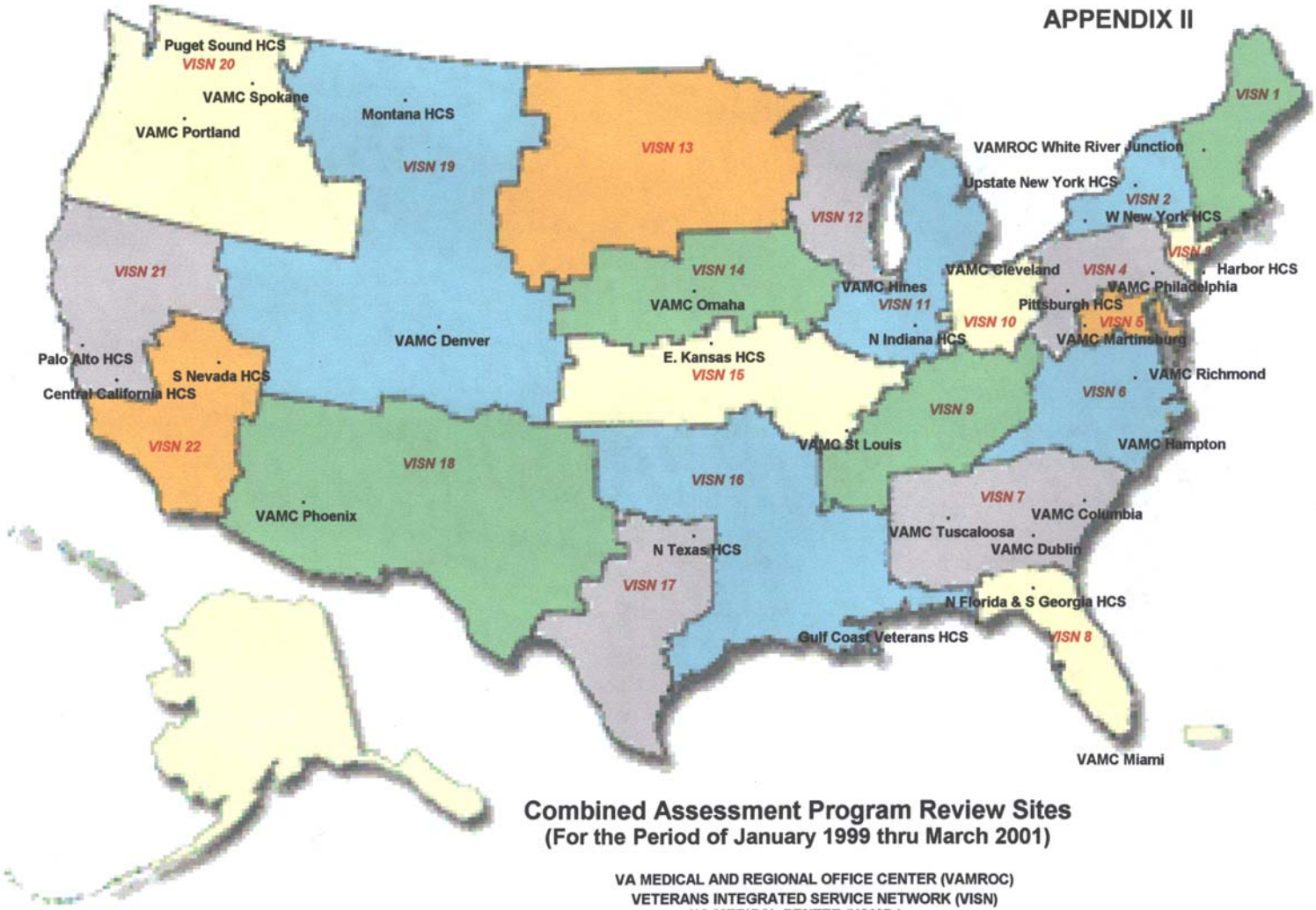
The following is a list of the 31 CAP reports issued for the period of January 1999 through March 2001:

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review VA Healthcare Network Upstate New York at Syracuse	2	00-02023-36	03/26/2001
Combined Assessment Program Review of VA Puget Sound Health Care System	20	01-00071-59	03/16/2001
Combined Assessment Program Review of VA Palo Alto Health Care System	21	00-02063-52	02/26/2001
Combined Assessment Program Review of VA Eastern Kansas Health Care System	15	00-02068-24	02/24/2001
Combined Assessment Program Review, Hunter Holmes McGuire VA Medical Center Richmond, VA	6	00-02679-41	02/22/2001
Combined Assessment Program Review of VA Medical Center Miami, FL	8	00-02974-35	01/31/2001
Combined Assessment Program Review of VA Medical Center Spokane, WA	20	00-02062-22	01/19/2001
Combined Assessment Program Review of VA Montana Healthcare System and Regional Office	19	00-01222-11	12/20/2000
Combined Assessment Program Review of VA Pittsburgh Healthcare System	4	00-02022-17	11/30/2000
Combined Assessment Program Review of VA Western New York Healthcare System	2	00-01230-120	09/25/2000
Combined Assessment Program Review of VA North Texas Health Care System	17	00-01065-117	09/08/2000
Combined Assessment Program Review of VA Medical Center Hampton, VA	6	00-01225-109	08/31/2000
Combined Assessment Program Review of VA Medical Center Portland, OR	20	00-01217-105	08/18/2000
Combined Assessment Program Review William Jennings Bryan Dorn Veterans Hospital Columbia, SC	7	00-01202-107	08/18/2000
Combined Assessment Program Review of VA Medical Center Tuscaloosa, AL	7	00-02003-108	08/18/2000
Combined Assessment Program Review of VA New York Harbor Healthcare System	3	00-01223-104	08/03/2000

APPENDIX I

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of VA Central California Health Care System	21	00-01227-94	07/14/2000
Combined Assessment Program Review of VA Gulf Coast Veterans Health Care System Biloxi/Gulfport, MS	16	00-00933-88	06/19/2000
Combined Assessment Program Review of VA Medical and Regional Office Center White River Junction, VT	1	00-01062-84	06/05/2000
Combined Assessment Program Review of VA Northern Indiana Health Care System Ft. Wayne and Marion, Indiana	11	00-01199-72	05/25/2000
Combined Assessment Program Review of VA Medical Center Denver, CO	19	00-00473-63	05/04/2000
Combined Assessment Program Review of the Carl T. Hayden VA Medical Center Phoenix, AZ	18	00-01072-64	05/04/2000
Combined Assessment Program Review of VA Medical Center Omaha, NE	14	00-00025-37	04/03/2000
Combined Assessment Program Review of VA Medical Center Dublin, GA	7	00-00358-44	03/20/2000
Combined Assessment Program Review of VA Medical Center Philadelphia, PA	4	99-00161-24	12/21/1999
Combined Assessment Program Review of VA Medical Center Hines, IL	12	99-00173-18	11/22/1999
Combined Assessment Program Review of VA Medical Center St. Louis, MO	15	99-00695-8	10/28/1999
Combined Assessment Program Review of VA Medical Center Cleveland, OH	10	9IGCAP504	09/24/1999
Combined Assessment Program Review of Southern Nevada Veterans Healthcare	22	9IGCAP503	06/30/1999
Combined Assessment Program Review of North Florida and South Georgia Veterans Health System	8	9IGCAP502	04/22/1999
Combined Assessment Program Project Medical Center Martinsburg, WV	6	9IGCAP501	03/31/1999

APPENDIX II



Combined Assessment Program Review Sites
(For the Period of January 1999 thru March 2001)

VA MEDICAL AND REGIONAL OFFICE CENTER (VAMROC)
VETERANS INTEGRATED SERVICE NETWORK (VISN)
VA MEDICAL CENTER (VAMC)
HEALTH CARE SYSTEM (HCS)

APPENDIX III

III. Report Distribution

VA Distribution

Secretary (00)
Under Secretary for Health (105E)
General Counsel (02)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Acting Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Principal Deputy Assistant Secretary for Policy and Planning (008)
Assistant Secretary for Congressional and Legislative Affairs (009)
Associate Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Legislative Affairs (009L)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (90)
Director, Management and Financial Reports Service (047GB2)
Assistant Deputy Under Secretary for Health (10N)
VHA Chief Information Officer (19)

Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office
Congressional Committees (Chairman and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives

This report will be available in the near future on the VA Office of Audit web site at http://www.va.gov/52/reports/mainlist.htm. *List of Available Reports.* This report will remain on the OIG web site for 2 fiscal years after it is issued.