



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Medical Center San Juan, Puerto Rico

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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Executive Summary

Introduction

During the period February 25–March 7, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center San Juan, Puerto Rico. The purpose of the review was to evaluate selected health care system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 798 employees.

Results of Review

Patient care and QM activities reviewed were generally operating satisfactorily. Management actively supported high quality patient care and performance improvement. The QM program was comprehensive and provided effective oversight of the quality of care. Financial, administrative, and management controls reviewed generally required management attention.

To improve operations, the Medical Center Director should:

- Improve procedures for determining veterans' eligibility to receive eyeglasses.
- Improve fiscal controls over payments for eyeglasses.
- Implement QM reviews of mailed-out eyeglasses and ensure that medical records properly document the veterans' need for eyeglasses.
- Improve supply inventory management.
- Strengthen controls over the Government Purchase Card Program.
- Improve contracting procedures.
- Improve monitoring of the purchase prices paid for items on contracts.
- Improve automated information systems (AIS) security.
- Improve Outpatient and Mail-Out Pharmacy Service prescription processing times.
- Improve the disposition of unusable and expired controlled substances.
- Strengthen timekeeping controls over part-time (PT) physician time and attendance.
- Improve documentation of follow-up actions on Boards of Investigation (BOIs).
- Improve coordination of the peer review process.
- Improve clinical and administrative procedures in the Homemaker/Home Health Aide Program (H/HHA).

Medical Center Director Comments

The Medical Center Director agreed with the CAP review findings and provided acceptable improvement plans. The Director also agreed with the estimated monetary savings. (See Appendix A, pages 25 - 46, for the full text of the Director's comments.) We may follow up on the implementation of planned improvement actions until they are completed.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Based in San Juan, Puerto Rico, the medical center is a tertiary care hospital that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Arecibo, St. Thomas, and St. Croix and two satellite outpatient clinics in Ponce and Mayaguez. The medical center is part of VISN 8 and serves a veteran population of about 140,000 in Puerto Rico and 4,800 in the U.S. Virgin Islands.

Programs. The medical center provides medical, surgical, mental health, geriatric, and advanced rehabilitation services. The medical center has 348 hospital beds and 120 nursing home beds and operates several regional referral and counseling programs in the San Juan, Arecibo, Ponce, St. Thomas, and St Croix Vet Centers. The medical center also has sharing agreements with the Fort Buchanan and Roosevelt Roads military bases, the Puerto Rico Army and Air National Guard, the Coast Guard, and the FedsHeal Program.

Affiliations and Research. The medical center is affiliated with the University of Puerto Rico, Universidad Central de Bayamon and Ponce Schools of Medicine, and with Interamerican University, Technological College of San Juan, Universidad Metropolitana, Universidad Sagrado Corazon, and University of Puerto Rico Schools of Nursing, and supports 135 medical resident positions in 23 training programs. In fiscal year (FY) 2001, the medical center Research Program had 118 projects and a budget of over \$1 million. Important areas of research include Hematology-Oncology, Infectious Diseases, and Pulmonary.

Resources. In FY 2001, medical care expenditures totaled over \$231 million. The FY 2002 medical care budget is over \$234 million, 1.3 percent more than FY 2001 expenditures. FY 2001 staffing totaled 2,536 full-time equivalent employees (FTEE) and 261 part-time employees, including 210 physicians (173 full-time and 37 part-time), and 571 nurses.

Workload. In FY 2001, the medical center treated 63,264 unique patients. The medical center provided 113,822 inpatient days of care in the hospital and 37,111 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 9,420 discharges, and the average daily census for the hospital was 315, and 102 for the nursing home patients. The outpatient workload was 719,276 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, and financial and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, patients, and Veterans Service Organization (VSO) representatives; and reviewed clinical, and financial and administrative records. The review covered the following activities:

QM	Crash Carts
Utilization Review	Controlled Substances Accountability
Credentialing and Privileging	AIS Security
Waiting Times in Outpatient Pharmacy	Service Contracts
Prescription Refills	Government Purchase Card Program
Homemaker/Home Health Aide Program	Generic Inventory Package Implementation
Spinal Cord Recreation Program	Part-Time Physician Time and Attendance
Emergency Room Holding Unit	Prosthetics Service Procurements
Workers' Compensation Program	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The survey indicated high levels of patient and employee satisfaction and did not disclose any significant issues. The survey results were provided to medical center management.

We mailed survey questionnaires to 434 medical center employees prior to our site visit. We received 141 completed surveys. Of the employees who responded, 93 percent felt that the quality of care provided to patients was excellent, very good, or good. Furthermore, 90 percent of the employees felt that quality patient care was the medical center's first priority.

We interviewed 29 patients, including inpatients and outpatients. Ninety-three percent of the patients rated the quality of care provided at the medical center as excellent, very good, or good, and 97 percent reported that they would recommend treatment at the facility to an eligible family member or friend.

During the review, we also presented five fraud and integrity awareness briefings for medical center employees. A total of 798 employees attended these briefings, which covered procedures

for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

We also reviewed the Workers' Compensation Program (WCP) and interviewed medical center staff responsible for the program. We found a total of 99 cases on the WCP rolls at the time of our review, and WCP payments for the first 2 quarters of FY 2002 totaled about \$1.4 million. Forty-five of the WCP cases were determined by the Department of Labor (DOL) to be chronic or severe with no potential for return to work, 12 cases were awaiting a decision from DOL, 14 cases were awaiting a second opinion from the Office of Workers' Compensation Program Regional Office in New York, and 28 cases had potential for rehabilitation, or were suitable for potential job offers.

Our review covered medical center operations for FY 2001 and FY 2002 through January 2002 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by the medical center management until corrective actions are completed.

Results of Review

Opportunities for Improvement

Prosthetics Eligibility – VA Criteria Were Not Properly Applied in Determining Veterans' Eligibility for Eyeglasses

Conditions Needing Improvement. Procedures were not in place to ensure that clinicians made a medical determination that veterans were eligible for eyeglasses prior to being referred to the contractor for examinations and eyeglasses. We found that 30 of 82 (36 percent) veteran records reviewed did not meet the eligibility criteria to receive eyeglasses. Better application of eligibility criteria and the use of fee-basis providers for basic eye examinations could save the medical center over \$460,000 a year.

VA policy concerning veteran eligibility for eyeglasses requires the following:

- The veteran's visual impairment results from the existence of another condition for which the beneficiary is receiving VA care, or results from treatment of that medical condition.
- The veteran must not have had eyeglasses issued in the last 2 years.
- Replacement eyeglasses are authorized when a change of at least $\pm .5$ diopter in sphere, cylinder, and/or power are required.

Also, there must be evidence in the veteran's medical record supporting the need for additional eyeglasses and extras, such as tinting or transitional lenses. Veterans with normal occurring visual impairments, such as near or far-sightedness, are not eligible for eyeglasses.

We reviewed a sample of 82 cases where veterans had received an examination and one or more pairs of eyeglasses from the contractor. Both the veteran's Consolidated Patient Medical Record and Computerized Patient Record System (CPRS) were reviewed along with records maintained by the contractor. We found that 30 of the 82 cases reviewed (36 percent) did not meet the eligibility criteria for the veteran to receive eyeglasses.

- 8 cases did not have medical conditions affecting vision; 6 were direct consults to the contractor.
- 7 cases did not have a change of at least $\pm .5$ diopter in sphere, cylinder, and/or power.
- 9 cases received bifocals for reading only.
- 6 cases did not contain sufficient medical record documentation to support a second pair of eyeglasses.

These conditions occurred because the medical center did not have procedures in place to ensure the veteran was eligible for eyeglasses prior to being referred to the contractor for an examination. Physicians frequently wrote consults for eyeglasses at the veteran's request. About half of the consults were sent directly to Prosthetics Service, and then to the contractor,

without a determination that the veteran had basic eligibility. The remaining consults were generally written by Primary Care Clinic physicians and reviewed by a case manager.

Case managers were not fully applying VA criteria to screen patients receiving consults. As a result, consults were forwarded to Prosthetics Service and subsequently to the contractor for examinations and eyeglasses without a clear determination of basic eligibility. Case managers were only screening for two criteria: (1) whether the veteran had received eyeglasses in the last 2 years, and (2) whether the veteran had an illness related to the eyes. If the veteran had no eye illness and had not received eyeglasses in the past 2 years, the consult was sent to Prosthetics Service and then the contractor. If the veteran had an eye-related illness, the veteran was referred to Ophthalmology Service. Case managers utilized data from VA's National Prosthetics Patient Database (NPPD) to determine if the 2-year requirement was complied with. The data from NPPD was not current because of the 4 to 5-month delay in entering data into the system.¹

Veterans examined by the contractor and veterans examined by Ophthalmology Service received different standards of care. The veterans examined by Ophthalmology Service were subject to more stringent reviews concerning the issuance of two pairs of eyeglasses or tinting or other extras. The contractor was not aware of the criteria concerning issuing two pairs of eyeglasses or extras. The veterans examined by the contractor frequently received two pairs of eyeglasses and extras. Those seen by Ophthalmology Service did not normally receive two pairs of eyeglasses and extras were not ordered by the physician unless clinically necessary.

Improved controls over the eligibility process could significantly reduce the cost of eyeglasses and ensure that veterans receive the same standard of care. The negotiated eyeglass contract took effect on October 1, 2000, and had an estimated total cost of \$1.9 million for the initial year and 2 option years. The estimated number of examinations performed and eyeglasses issued were 1,800 and 10,700, respectively, per year. During the first 16 months of the contract, the medical center spent \$1.65 million for eyeglasses and examinations. If expenditures against this contract continue at the current pace, the total will nearly double to about \$3.7 million over the contract's 3-year term.

Based on the number of eyeglasses issued during the first 4 months of FY 2002, we estimated that 16,000 pairs of eyeglasses will be issued during the FY at an average cost of \$60 per pair. The estimated annual cost of eyeglasses would be \$960,000. Our calculations indicate that if VA criteria had been followed in the above circumstances, the number of pairs of eyeglasses issued would be reduced by approximately 5,800 pairs, or 36 percent, for a total savings of \$348,000 annually (5,800 X \$60).

The medical center could also reduce costs by conducting all eye examinations in-house, instead of just for veterans with eye-related illnesses. Prior to negotiating the eyeglass contract, Ophthalmology Service used fee-basis ophthalmologists to conduct eye examinations, for those veterans without eye-related illnesses, at a cost of \$35 per examination. Under the current eyeglass contract, the medical center pays the contractor \$50 per examination performed by optometrists. Based on the activity of the first 16 months of the contract, we estimate that the contractor will perform an average of 7,600 examinations per year. We discussed this issue with

¹ See condition addressing funds expended in current FY on page 6.

the Chief of Staff and Chief, Ophthalmology Service and were told that they believed that fee basis examinations could still be obtained for \$35 per examination. We estimate that \$114,000 (7,600 X \$15) could be saved annually by using fee-basis ophthalmologists to conduct examinations for those currently conducted by contract. By conducting eye examinations in-house, medical center management will also have better control over the eyeglasses and extras being issued, resulting in additional savings.

During our review, top management met with key medical center staff concerning the issues we raised and the procedures for issuing eyeglasses. Those participating were the Chief of Staff, the Chiefs of Ophthalmology and Prosthetics Services, the Associate Chief of Staff (ACOS) for Rehabilitation, the Health Care Executive Administrator, and staff. As a result of this meeting, a procedural framework for the issuing of eyeglasses was developed to correct identified problems.

Recommended Improvement Action 1. The Medical Center Director should revise procedures to ensure that:

- a. Case managers review all consults to determine eligibility.
- b. Prosthetics Service does not accept consults that have not been approved by case managers.
- c. All patients receive the same standard of care.
- d. QM management reviews of contractor examinations are conducted to ensure that the issuance of a second pair of eyeglasses was appropriate, bifocals were contraindicated, or that transitional or progressive lenses were justified.
- e. Medical center staff and/or fee-basis providers conduct eye examinations.

The Director agreed with the findings and recommendation and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Prosthetics Fund Controls – Appropriate Fiscal Year Funds Were Not Used and Professional Services Were Paid From Prosthetics Funds

Conditions Needing Improvement. We found that controls over payments for eyeglasses needed improvement:

- Funds were expended from the current FY appropriation for supplies and services received in the previous FY.
- Professional service fees were paid from Prosthetics funds.

Funds Were Expended From the Current FY Appropriation for Supplies and Services Received in the Previous FY. Our review of payments to the eyeglass contractor for the first 4 months of FY 2002 found that \$144,935.50 in FY 2001 transactions had been charged to the FY 2002 appropriation. As cited in 31 United States Code, Section 1502(a), annual appropriations are available only to meet bona fide needs of the FY for which they are appropriated. Since the eyeglasses and examinations were received in FY 2001, the expenditure should have been made to that year's appropriation in lieu of the FY 2002 appropriation. This condition was caused

because Prosthetics Service was not issuing purchase orders for eye examinations or eyeglasses at the time the order was submitted to the contractor, but instead was doing so after the contractor notified Prosthetics Service that the examination had been completed and/or the lenses provided. We found that Prosthetics Service was issuing multiple purchase orders at one time; then, the contractor charged the purchase card and sent the medical center an invoice for multiple purchase orders. This practice does not ensure: (1) effective fiscal or programmatic control over the program, (2) expenditures were charged to the correct FY appropriation, (3) timely billing by and payments to the contractor, and (4) timely updating of the NPPD.

Additionally, at the time of our review, Prosthetics Service was about 5 months behind in processing notifications from the contractor and issuing the related purchase orders. The value of the services provided, but not billed because purchase orders had not been issued, was about \$344,000. The bulk processing of purchase orders resulted in the contractor splitting Government purchase card billings to keep them below the purchase card limit. In addition, this practice resulted in the NPPD not being kept current because it was not updated until a purchase order was issued. The NPPD is used by Prosthetics Service to track all prosthetic appliances issued to a veteran, and is used by the case manager to determine when the veteran was last given eyeglasses.

Professional Service Fees Were Paid from Prosthetics Funds. Our review showed that prosthetics funds were inappropriately used to pay for eye examinations performed by the contractor. The contractor's invoices included both the cost of the examination and the cost of the eyeglasses. A Prosthetics Service Government purchase card was used to reimburse the contractor, which resulted in the costs of examinations being charged to Prosthetics Service cost centers. Eye examinations are medical services and should have been charged to cost center 8413 (contractual and fee services). We estimate that since inception of the contract, approximately \$500,000 for eye examinations has been improperly charged to Prosthetics Service cost centers (\$50 X 10,000 examinations).

Recommended Improvement Action 2. The Medical Center Director should ensure that:

- a. Prosthetics Service issues purchase order numbers at the time orders are placed.
- b. Expenditures are charged to the correct FY appropriation.
- c. Accounting records are adjusted to reflect the expenditure in the appropriate FY.
- d. NPPD is kept current.
- e. Controls are in place to allow obligations/expenditures to be made only to the authorized appropriated fund account.

The Director agreed with the findings and recommendation and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Prosthetics Quality Management – QM Reviews Were Not Performed of Mailed-Out Eyeglasses and Medical Records Did Not Support the Veteran’s Need for Eyeglasses

Conditions Needing Improvement. Our review showed that:

- QM reviews were not performed for eyeglasses mailed out by the contractor.
- Medical records did not always contain documentation to support a veteran’s need for eyeglasses.

QM Reviews Were Not Performed. Prosthetics Service is required to contact a minimum of 10 percent of the veterans that received mailed-out eyeglasses to determine whether veterans received their eyeglasses, the prescriptions were correct, and the eyeglasses and the examinations were satisfactory. While about 90 to 95 percent of all eyeglasses were mailed out by the contractor, Prosthetics Service was not conducting QM reviews. According to the Prosthetics Service supervisor, they were not aware of the QM requirement.

Medical Records Were Not Documented to Support a Veteran’s Need for Eyeglasses. Medical records reviewed often lacked any documentation concerning a veteran’s eye condition. Medical records frequently indicated that eye conditions were not assessed during clinic examinations, yet a consult was ordered for eyeglasses. The examination overprint in some medical records under the eye assessment section indicated no problem or “N/A”. In some cases, consults were ordered and the record did not contain any documentation that the veteran had an eye condition or why the consult was ordered. At the time of our review the medical center had not started entering consults into CPRS. In most cases, there were no progress notes assessing the veterans’ eye conditions. In a review of 25 medical records we found no progress notes, or evidence of consults, or contractor eye examinations. The Medical Records Section staff indicated there was a backlog of drop mail to be filed. According to the Chief, Medical Records Section, the backlog in filing mail occurred because no one was assigned permanently and students were doing the filing, as they were available.

Recommended Improvement Action 3. The Medical Center Director should ensure that:

- a. Prosthetics Service conducts QM reviews of mail-out orders for eyeglasses.
- b. Medical Records Section employees file all drop mail into the appropriate patients’ records in a timely manner.

The Director agreed with the findings and recommendation and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Need Improvement

Conditions Needing Improvement. Logistics Section was not effectively using the Generic Inventory Package (GIP) to manage inventory levels. Logistics Section staff had implemented GIP in three primary inventory points: Supply Warehouse, Supply Processing and Distribution (SPD), and Implants. However, our review showed that:

- Inventory balances significantly exceeded a 30-day supply level.
- The value of inventory exceeding a 30-day supply was about \$963,000.
- GIP did not accurately reflect current inventory levels.

The Days of Stock On Hand reports for the 12-month period ended January 31, 2002, showed that the three primary inventory points had inventories valued at about \$1.5 million. The GIP reports showed that 85 percent of all inventory line items exceeded a 30-day supply, ranging from 78 percent for SPD to 96 percent for the Supply Warehouse and Implants. The table below shows the number and value of the items stored in the three primary inventory points and the values of the excess inventory.

On-Hand Inventory Value According to GIP Records
(As of January 31, 2002)

Primary Inventory Points	Inventory Levels Per GIP		Items Exceeding a 30-day Supply		
	Items	Value	Items	Percent	Value of Excess
Supply Warehouse	486	\$679,350	465	96	\$ 569,400
SPD	1,133	571,530	889	78	416,250
Implants	137	267,570	131	96	247,000
Total	1,756	\$1,518,450	1,485	85	\$1,232,650

We tested the accuracy of the inventory balances for the three primary inventory points and found that balances were not correct for 47 percent of the line items, and errors ranged from 30 percent for the Supply Warehouse to 55 percent for both SPD and Implants. Analysis of our samples disclosed that even though balances were inaccurate, they did not materially affect the value of the Supply Warehouse or SPD inventories. Our sample found that the Supply Warehouse inventory was overstated by 7.1 percent and the SPD inventory by 2.8 percent. Our review did find a material difference in the Implants inventory. The Implants inventory was overstated by 45 percent.

In order to estimate the number of line items and the value of stock exceeding a 30-day supply, we adjusted the GIP balances for items received and issued since the GIP report was produced and the count variances identified in our samples. Based on these results, we estimated that 1,236 of the 1,756 inventory line items (70 percent) exceeded a 30-day supply, by approximately \$963,000. Our results are shown in the following table.

Estimated Value of Inventory Stock In Excess of 30-day Supply

Primary Inventory Points	No. of Items Exceeding 30-Day Supply	Percent of Total Line Items	Value
Supply Warehouse	437	90	\$466,000
SPD	730	64	423,000
Implants	69	50	74,000
Total	1,236	70	\$963,000

The overstock of inventory items was attributable to several factors:

- Managers were not effectively using GIP to manage inventory.
- Transaction register reports were not used to track items received and issued.
- Bar coding was not used to track inventory.

Management action is needed to ensure that inventory records are accurate and kept current, and that inventories are not excessive. Inventory counts need to be taken for all primary inventory points and GIP records updated. GIP records should also be updated for items received and issued. Management also needs to review the inventory controls over Implants to ensure that controls are effective and that all items are properly accounted for.

Recommended Improvement Action 4. The Medical Center Director should ensure that:

- Inventory records are accurate and kept current.
- Inventories are taken for all primary inventory points and GIP records updated.
- GIP is updated for items received and issued.
- Inventory levels are reduced to a 30-day supply.
- Inventory controls over Implants are effective and that all items are properly accounted for.

The Director agreed with the findings and recommendation and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Should Be Strengthened

Conditions Needing Improvement. To preserve the integrity of the Government Purchase Card Program, controls need to be strengthened. We found that:

- Purchase cardholders split transactions to stay within their single purchase limits.
- Purchase cardholders did not have procurement warrants for their spending limits.
- Monthly and quarterly audits of purchase cardholder accounts were either not accomplished or were incomplete.
- Purchase cardholders and approving officials did not receive appropriate training.

- Purchase cardholders did not reconcile transactions timely.
- Purchase card transactions were not approved timely.
- Purchase cardholders did not use mandatory sources in some purchases.
- Purchase cards were not cancelled timely.

Purchase Cardholders Split Transactions to Stay Within Their Single Purchase Limit. During the period October 1, 2000, through January 30, 2002, we identified 117 multiple transactions made on the same day to the same vendor, valued at about \$536,000. We found that 4 cardholders had split 24 (21 percent) transactions, valued at about \$189,000, to stay within their single purchase limits. Approving officials were not appropriately monitoring the cardholders' transactions to ensure they stayed within their purchase limits as required by VA policy.

Purchase Cardholders Did Not Have Procurement Warrants for Their Spending Limits. A review of 19 cardholders with purchase limits that exceeded the micro-purchase threshold of \$2,500 showed that 4 (21 percent) cardholders did not have procurement warrants. The cardholders had single purchase limits ranging from \$25,000 to \$175,000. The Chief, Contracting Section, sent letters to three cardholders, giving them temporary single purchase limits above the micro-purchase threshold that were dated January 8, 1998, June 25, 1998, and February 8, 2000, with single purchase limits of \$25,000. However, the three cardholders had not received the appropriate training for the limits. The remaining purchase cardholder had received the appropriate training in December 2000; however, the procurement warrant had not been issued by the Chief, Contracting Section. VA policy requires that cardholders with purchase limits that exceed the micro-purchase threshold hold appropriate procurement warrants. The Chief, Contracting Section agreed to take action to correct these discrepancies.

Monthly and Quarterly Audits of Purchase Cardholder Accounts Were Either Not Conducted or Were Incomplete. We found that four of the six monthly purchase card audits for the period September 2001 through February 2002 were properly documented. However, one of the two remaining audits did not review one of the three purchase transactions sampled and the other audit was not completed. Medical center staff responsible for oversight of the monthly audits were not aware that the monthly audits were not being completed.

Quarterly audits are required of all cardholder accounts not reviewed in the monthly audits. We reviewed records for the first quarter FY 2002 and found that only 22 of 93 (24 percent) cardholders were audited. Local policy requires a review of 20 purchase card transactions per cardholder, or less if the cardholder does not have 20 transactions during the quarter. We found that the four medical center staff assigned to conduct the quarterly audits never received more than nine transactions for review. Fourteen of the 22 audits conducted did not review all required transactions. Documentation from two of the employees showed that they performed incomplete reviews of the purchase cardholder transactions, while the other two employees did not document their reviews. Additional training for the reviewers and monitoring of the audits by the Purchase Card Coordinator would improve the monthly and quarterly audits.

Purchase Cardholders and Approving Officials Did Not Receive Appropriate Training. Review of the training records for 93 cardholders and 32 approving officials showed that 5 cardholders and 6 approving officials had not received required purchase card training. VA policy requires the Purchase Card Coordinator to ensure that cardholders and approving officials receive appropriate training before they are issued a purchase card. Contracting Section management agreed to provide appropriate training for the 11 employees.

Purchase Cardholders Did Not Reconcile Transactions Timely. We identified 279 transactions totaling about \$267,000 as of January 30, 2002, that were not reconciled. One cardholder was responsible for 213 (76 percent) of the 279 transactions, which ranged up to 110 days old. VA policy requires cardholders to match payments with charge information in the Integrated Funds Distribution Control Point Activity Accounting, and Procurement system within 10 days after delivery and dispute or reconcile every charge as appropriate, before it is 30 days old. The approving official and Purchase Card Coordinator are taking action to ensure that the transactions are reconciled.

Purchase Cardholders Did Not Use Mandatory Sources for Some Purchases. We reviewed 48 purchase orders for 9 merchants, totaling about \$503,000, to determine if purchases were made from mandatory sources. The Federal Acquisition Regulation (FAR) requires cardholders to promote competition to the maximum extent practicable to obtain supplies and services from the source whose price is the most advantageous to the Government. We found that mandatory sources were not used in 6 of 18 purchase orders, valued at about \$42,800, for one merchant. We identified nine line items in the six purchase orders with potential cost savings of about \$13,600, had they been purchased from mandatory sources. Medical center management agreed that the mandatory sources should have been used for the purchases, as the purchases were for the replenishment of stock and there was no justification on the purchase orders for emergency purchases.

Purchase Cards Were Not Cancelled Timely. At the time of our review two purchase cards for separated employees were still active. VA policy requires that the Purchase Card Coordinator cancel the purchase card upon the employee's separation. The Purchase Card Coordinator took immediate action to cancel the purchase cards. The Purchase Card Coordinator was unaware that the cardholders had separated from the medical center. Local policy on Employee Clearance Upon Separation does not require the purchase cardholders to be cleared by the Purchases Card Coordinator as a part of the clearance process.

Recommended Improvement Action 5. The Medical Center Director should ensure that:

- a. Cardholders do not split purchase orders to stay within their single purchase limits.
- b. Purchase cardholders with single purchase limits greater than the micro-purchase limit have procurement warrants for their spending limits.
- c. Monthly audits and quarterly audits are conducted as required.
- d. Appropriate training is provided to all cardholders and approving officials.
- e. Reconciliations of purchase card transactions are performed in the required timeframe by all cardholders.

- f. Purchase cardholders obtain supplies or services from mandatory sources.
- g. Procedures are revised to require that purchase cardholders are cleared by the Purchase Card Coordinator during the clearance process.

The Director agreed with the findings and recommendation and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed

Noncompetitive Contracting – Contracting Procedures Need to Be Improved

Conditions Needing Improvement. Three noncompetitive contracts under the Small Business Administration's 8(a) program were awarded to the same contractor and contained substantially similar performance requirements. However, the three contracts should have been combined into one contract, and solicited competitively as required by FAR. FAR requires that contracts under the 8(a) program be awarded competitively if the estimated total value of the contract will exceed \$5 million for this classification of acquisition. We found the estimated total value of the three contracts was about \$7.2 million.

We also reviewed seven noncompetitive contracts valued at \$3.3 million, and found that the contracting officers accepted vendor pricing without negotiation and did not prepare Price Negotiation Memorandums (PNMs) for any of the contracts. A VISN review dated March 29, 2000, concluded that PNMs were missing from files, and recommended PNMs be prepared as required by FAR. We found that six of the seven contracts were awarded after the VISN recommendation. FAR requires that the contracting officer document in the contract file the principal elements of the negotiated agreement. The PNM should include, among other explanations, the most significant facts and considerations controlling the negotiated agreement, including any significant differences between the contractor and VA.

Recommended Improvement Action 6. The Medical Center Director should ensure that:

- a. Contracts with substantially similar work requirements are combined into one contract to promote competition.
- b. Contracting officers negotiate prices for noncompetitive contracts, prepare PNMs, and file the PNMs in the applicable contract folders.

The Director agreed with the findings and recommendations and provided appropriate implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Pacemaker Contract – Improved Monitoring of the Purchase Prices Paid for Items on Contracts will Reduce Costs

Conditions Needing Improvement. The medical center was overcharged about \$36,000 for pacemakers because the supplier for the Federal Supply Schedule (FSS) contractor charged VA prices above those in the contract. This occurred because the purchase cardholder was unaware that a national contract existed for pacemakers, and the medical center's Business Office failed to ensure that VA was receiving contract prices.

We selected a judgmental sample of five transactions from the FSS pacemaker contract during the period July through December 2001. We compared the items in the five transactions with the FSS contract and found that the medical center was overcharged in one instance, paid the same amount as the contract terms in another, and the remaining three items were not included in the contract. In the case of the one overcharge, the medical center paid \$3,875 for a pacemaker with a contract price of \$2,656.

Based on our results, the Business Office Manager contacted the contractor and requested that the contractor determine (VA was unable to track all purchases) if the medical center had been overcharged on other purchases. The contractor informed the Business Office Manager that the medical center had been overcharged a total of \$36,600 for products that were in the FSS contract. The contractor agreed to reimburse the medical center for the overcharges.

The medical center needs to ensure that purchase cardholders use available FSS contractors whenever possible, and ensure that the medical center receives the FSS contract prices for items purchased. Additionally, the Business Office Manager needs to ensure that cardholders are aware of all FSS contracts for the items they routinely purchase. Medical center management should also conduct a complete review of purchases made from the pacemaker contractor to identify any other overcharges, and obtain reimbursement from the contractor for all overcharges.

Recommended Improvement Action 7. The Medical Center Director should ensure that the Business Office:

- a. Provides all purchase cardholders with complete copies of existing contract price lists related to their purchases, and ensure purchase cardholders pay contract prices.
- b. Conducts a complete review of purchases made from the pacemaker contractor to ensure that purchase cardholders paid contract prices.
- c. Obtains reimbursement from the pacemaker contractor for all overcharges.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needs Improvement

Conditions Needing Improvement. Medical center managers had not implemented policies or taken actions necessary to ensure AIS security. We found that:

- Major AISs were not accredited and minor information systems were not certified or accredited.
- The Information Security Officer (ISO) had not received training and the appropriate level of access to monitor major AISs.
- Contingency plans were not comprehensive.
- Quarterly reviews of computer access levels were not performed.
- The Veterans Health Information System and Technology Architecture (VISTA) risk assessment understated system risk.
- A separation of duties policy had not been developed.
- Monitoring of employee access to employee records was ineffective.
- Procedures were not in place to detect copyright infringements.
- Computer back-up tapes were not stored off-site.
- Procedures for disposal of equipment containing sensitive information were not adequate.
- Background investigations of Information Management Service (IMS) staff were not performed.
- Procedures had not been developed to address disgruntled employees or employees subject to a reduction in force action.

VHA policy requires that all of the activities above be done in order to enhance the overall security of the AIS environment.

Certification and Accreditation of all AIS Were Needed. Medical center management had not certified major AISs [i.e., VISTA, Local Area Network (LAN), Microsoft Exchange, and Private Branch Exchange], and had not certified or accredited minor AISs used in Nuclear Medicine, Cardiology, and Laboratory Services. VA policy requires each AIS in use at the facility to be fully certified and accredited. Certification ensures that necessary controls are in place and are operating effectively to secure the system. Accreditation ensures that the Director understands and accepts the risk inherent in operating the AIS. In order for certification and accreditation to take place, each AIS must have an associated security plan, contingency plan, risk assessment, and a document detailing expected rules of behavior for using the system.

The Medical Center Director had requested clarification of IMS's certification documentation of certain items for the major AISs and was expected to accredit these systems once this certification information had been satisfactorily provided. For the minor AISs used in Nuclear Medicine, Cardiology, and Laboratory Services, security plans and risk assessments were needed in order for certification and accreditation to take place. IMS staff told us that they would concentrate on the documentation requirements for the minor AISs once the major AISs had been certified and accredited. Without required certifications and accreditations, medical center management does not have assurance that controls designed to ensure the security of these AISs are operating as intended.

The ISO Had Insufficient Training and Level of Computer Access. The ISO was not trained in the audit features of the major AISs. Additionally, the ISO had an insufficient level of system access to carry out the functions of monitoring and oversight. The ISO reported he had been given only basic user access and was not provided additional access once he became the ISO. VA policy requires that the ISO be sufficiently trained to carry out oversight and monitoring responsibilities. The ISO function can be strengthened if the ISO is trained in the audit functions of VISTA and LAN, and is given sufficient access to carry out his responsibilities.

Contingency Plans Were Not Comprehensive. AIS contingency plans had not been sufficiently developed and implemented to reduce the impact of disruptions in services, provide critical interim processing support, and provide the ability to resume normal operations. The AIS contingency plans generally did not:

- Identify a disaster recovery team or specify roles key personnel would play in the disaster recovery process.
- Identify an alternate processing facility that could be used during disaster recovery.
- Identify equipment and software configurations.
- Prioritize specific tasks and computer applications to be installed in a disaster recovery situation.
- Identify an off-site storage location for the contingency plan.

Contingency plans that are not comprehensive will be of little use in a catastrophic situation. The recovery process will be slowed and the delivery of essential health care could be affected.

Quarterly Reviews of Computer Access Levels Were Not Performed. VA policy requires that computer access be monitored quarterly to determine the continued need for such access as well as the level of access needed. IMS staff did not perform quarterly reviews of the continued need for computer access levels. As a result, inappropriate and unnecessary access accounts remained open. At the time of our review, 720 VISTA users were not employees of the medical center. Non-medical center staff with access included VA Regional Office employees, employees of other VA organizations, residents, students, and contractors. Because IMS staff was not performing the required quarterly reviews there was no assurance that all 720 individuals still needed VISTA access.

In reviewing these accounts, we found that 188 of the 720 users had never accessed VISTA, including one account established in 1987. We also identified 86 generic accounts used reportedly for training purposes. VA policy prohibits the use of generic accounts because actions performed through their use cannot be traced to a unique individual. Use of generic accounts weakens overall system security and exposes the medical center data to potential unauthorized or malicious actions of employees. These accounts were not terminated because IMS staff were not conducting the required quarterly reviews of computer access.

A Separation of Duty Policy Had Not Been Developed. Medical center management had not developed a separation of duty policy to appropriately separate incompatible duties within IMS. According to IMS, management computer specialists supporting various automated packages (e.g., Pharmacy, Laboratory, and Nursing) also had access to operational data contained within VISTA

and could make changes to the data, if desired. Additionally, VISTA and LAN system managers had global permissions and were not restricted from making any changes they wanted. Federal information security policy requires that a separation of duty policy be developed and enforced to identify and separate incompatible functions. Without such a policy, medical center data is vulnerable to deliberate modification, destruction, and/or release of sensitive information.

Monitoring of Inappropriate Access to Employee Computer-Based Records Was Ineffective. Although monitoring was performed of access to employee computer-based records, the monitoring performed was infrequent and never determined why an employee accessed another employee's record. The ISO reported that he monitored access to employee records, but not on a daily basis. He stated that the last time he monitored access was about a week prior to our site visit and that he had never questioned any employee regarding why the record was accessed because of the large volume of accesses and difficulty in determining inappropriate access. Monitoring of access to employee computer-based records is an important internal control procedure that is designed to detect inappropriate access to sensitive records. Neither VA policy, nor medical center procedures prescribed how monitoring of accesses to employee records was to be performed. The medical center should develop monitoring procedures to ensure that employee access to other employee records is appropriate.

Procedures Were Not in Place to Detect Copyright Infringements. Annual audits were not performed of computer workstations to identify software and ensure proof of ownership for each piece of software, as required by VA policy. The LAN system manager stated that the medical center had installed software enabling the ISO to audit each computer workstation at pre-determined intervals, but the software had not been used for that particular purpose. As a result, the ISO or IMS staff had not ensured that medical center staff were in compliance with applicable software licensing agreements and copyright infringement laws.

Computer Back-Up Tapes Were Not Stored Off-Site. Medical center management did not ensure that LAN computer back-up tapes were stored off-station. According to the LAN system manager, there was a set of LAN back-up tapes in the main computer room, but not a set at an off-site location, as required by VA policy. By storing LAN back-up tapes in the main computer room, IMS staff had not averted the risk that the back-up tapes would not also be destroyed by the same catastrophic event affecting the main computer room. Back-up tapes for the VISTA system were stored off-site.

Procedures for Disposal of Equipment Containing Sensitive Information Were Not Adequate. Medical center management had not designated in writing an official to certify that equipment with storage media had been properly cleaned (degaussed) of all sensitive information before disposal, as required by VA policy. Consequently, accountability and responsibility for this function had not been formally assigned and did not provide management assurance that the equipment was properly cleaned before disposal.

Background Investigations of IMS Personnel Were Not Performed. Medical center management did not ensure that employees working in sensitive positions had the appropriate background investigations. We found that both the Chief and Assistant Chief, IMS did not have the required background investigations. Since IMS staff sometimes function outside the confines of general

management control, it is imperative that this personnel control is working effectively to help ensure the continued security and integrity of the AIS. Without required background investigations, the medical center is at risk of employing persons of questionable background and exposing patients, staff, and property to increased risk.

Procedures Had Not Been Developed to Address Disgruntled Employees or Employees Subject to Reductions-in-Force. The development of procedures dealing with disgruntled employees or employees subject to a reduction-in-force action would strengthen overall AIS security. We found that medical center management had not established formal procedures to address disgruntled employees and employees subject to a reduction-in-force, as required by VA policy. Consequently, medical center data was vulnerable to malicious modification, destruction, and/or unofficial release of sensitive information.

Recommended Improvement Action 8. The Medical Center Director should ensure that:

- a. All AISs are certified and accredited.
- b. The ISO is trained in the AIS audit features and has the appropriate computer access level.
- c. Contingency plans include all of the appropriate elements and are distributed to appropriate staff.
- d. Quarterly reviews of employee access levels to AIS resources are conducted and access terminated when no longer required.
- e. The practice of using generic access accounts is stopped.
- f. A separation of duty policy is developed.
- g. Monitoring procedures are developed to ensure that employee access to other employees' records is appropriate.
- h. Annual computer workstation audits are conducted to identify unlicensed software.
- i. Computer back-up tapes are stored in a secure off-site location.
- j. An official is designated to certify that AIS equipment is properly cleaned (degaussed) of sensitive information before disposal.
- k. Required employee background investigations are performed for all IRM employees assigned to sensitive positions.
- l. Procedures are developed to address disgruntled employees or employees subject to a reduction-in-force action.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Outpatient and Mail-Out Pharmacy Service – Prescription Processing Times Should Be Improved

Conditions Needing Improvement. Pharmacy Service controls to ensure patients received timely and complete medication orders needed strengthening. In meetings with VSO representatives, interviews with outpatients, and reviews of patient representative reports, the following problems were cited:

- Patients frequently did not receive mail-out prescriptions before their medications ran out.
- Some patients did not receive all prescribed medications before leaving the dispensing window.

Mail-Out Prescription Timeliness. Patient complaints related to mail-out prescription timeliness increased at a 300 percent rate during the first quarter of FY 2002. The patient representative report for all of FY 2001 showed that only 28 veterans had complained of excessive waiting times to receive their mail-out prescriptions. However, the number of complaints had increased to 30 veterans in just the first quarter of FY 2002. VSO representatives told us that many veterans who opted to receive their medications by mail had not received them within the 10 day standard, and often ran out of their medications before the refill medications arrived. We were informed by 5 of 15 (33 percent) outpatients surveyed that, on occasion, they had used all of their medications before receiving their refills. Although the primary cause of the increase in patient complaints was unclear, pharmacy managers told us that several factors contributed to pharmacy mail-out delays including: the lack of an automated telephone medication refill system; refill request cards were in English and some veterans were unable to read the refill card instructions; patient education regarding the refill procedures was insufficient; and the revised postal address system in Puerto Rico led to confusion and delays in mail delivery.

The medical center should review the patient complaint reports for FY 2001 to date, to identify trends in the complaints and take necessary corrective actions.

Delivery of Prescribed Medications at the Dispensing Window. Some veterans did not receive all prescribed medications from the outpatient pharmacy because of inefficient prescription processing procedures. The pharmacy implemented the Optifill-II™ system, an automated prescription bottle filler, in April 2000. All prescriptions for controlled substances not located in the Optifill-II™ machine should have been routed to the computer located in the controlled substances vault. However, the computer software needed to perform this function was not purchased. As a result, the prescriptions for controlled substances kept in the vault were not transmitted, and the prescriptions were hand-delivered by the intake clerk to the vault. The Chief, Pharmacy Service acknowledged this system weakness. He told us that he had submitted a request to purchase the software that linked Optifill-II™ to the controlled substances vault computer. Because of this delay, some patients did not receive their controlled substances, along with their other medications, from pharmacists at the dispensing window.

Additionally, Pharmacy Service's tube delivery system between the controlled substances vault and the dispensing area had been inoperable since April 2001. This system could have been used to deliver prescriptions to the vault or medications to the dispensing window, and would have served to improve timeliness and efficiency. We also found that Pharmacy Service technicians did not ensure that patients received all of their prescriptions before the patients left the window.

Recommended Improvement Action 9. The Medical Center Director should ensure that:

- a. Patient complaint reports related to Pharmacy Service for FY 2001 to date are reviewed to identify trends in the complaints and take necessary corrective actions.

- b. Necessary software is purchased and installed to link the Optifill-II™ with the controlled substances vault computer.
- c. Pharmacy Service's tube delivery system between the controlled substances vault and the dispensing area is repaired and placed back in service.
- d. Pharmacy Service technicians verify that all patient medications are delivered to the patient before the patients leave the dispensing window.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Unusable and Expired Controlled Substances – Disposition of Controlled Substances Should Be Improved

Conditions Needing Improvement. Our review of unusable and expired controlled substances disposition records for the 12-month period ending October 2001, showed that the medical center did not properly execute and document the disposal of unusable and expired controlled substances. VA policy requires that unusable controlled substances are to be: turned in to contracted agents for disposition; witnessed and attested to by the Chief, Acquisition and Materiel Management Service, a representative or an authorized agent (contractor), the Chief, Pharmacy Service, or designee, and a controlled substances inspecting official; and disposed of at least quarterly. Pharmacy Service staff did not dispose of unusable and expired controlled substances timely, and there was no evidence that the disposition was independently witnessed by an inspection official. Dispositions were accomplished at approximately 5-month intervals. When controls are not followed, the potential for waste, fraud, abuse, and drug diversion is increased.

Recommended Improvement Action 10. The Medical Center Director should ensure that unusable and expired controlled substances are disposed of in accordance with VA policy.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Part-Time Physician Time and Attendance – Timekeeping Controls Should Be Strengthened

Conditions Needing Improvement. Our review of PT physicians' time and attendance showed that controls over timekeeping could be strengthened in several areas:

- PT physicians did not have designated core hours.
- Refresher training and desk audits of unit timekeepers were not accomplished.
- Subsidiary time and attendance reports were incomplete or not used.

PT Physicians Did Not Have Designated Core Hours. We randomly selected 10 of the medical center's 82 PT physicians to determine if they had designated core hours. Our review of the PT physicians' tours of duty and discussions with unit timekeepers, payroll clerks, and service chiefs disclosed that none of the 10 PT physicians had designated core hours. VA policy requires that at least 25 percent of PT physicians' regular biweekly tours of duty are designated as core hours.

Refresher Training and Desk Audits of Unit Timekeepers Were Not Accomplished As Required. We interviewed seven unit timekeepers to determine if the Employee Accounts Section provided refresher training to timekeepers and conducted semiannual desk audits of unit timekeepers. Through interviews with the timekeepers, we determined that no annual refresher training had been provided within the past 2 years, and desk audits were not being conducted semiannually, as required. Our review of desk audits found that the last desk audit was completed March 9, 2001. The Employee Accounts Section is required to conduct annual refresher training for all unit timekeepers, and conduct desk audits of all timekeepers on a semiannual basis, or more frequently where indicated.

Subsidiary Time and Attendance Reports Were Incomplete or Not Used. PT physicians did not use the Subsidiary Time and Attendance Report - Part-Time Physicians (VA Form 4-5631a) to record their time and attendance data on a daily basis. Medical center management told us that VA Form 4-5631a was not required as of August 15, 1996. However, medical center management had misinterpreted a letter from the Deputy Secretary of Veterans Affairs, dated July 30, 1996, which stated, "I have noted that previous agency policy requiring employees on flexitime to use sign-in/sign-out sheets ran counter to this concept, and have decided to prohibit the use of such sheets in VA." The letter applied to employees on flexitime, not PT physicians. Due to this misunderstanding, medical center management did not require PT physicians to complete VA Form 4-5631a.

Recommended Improvement Action 11. The Medical Center Director should ensure that:

- a. All PT physicians designate at least 25 percent of their regular biweekly tours of duty as core hours.
- b. PT physicians' time and attendance is monitored to ensure they are on duty during their core hours unless they are on approved leave or excused absences.
- c. Employee Accounts Section conducts annual refresher training for timekeepers and semiannual desk audits.
- d. Subsidiary Time and Attendance Reports (VAF 4-5631a) are completed by all PT physicians and turned in to the unit timekeepers.

The Director agreed with the findings and recommendations and provided acceptable implementation plans. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Quality Management – Improved Documentation of Follow-Up Actions on Boards of Investigation Is Needed

Conditions Needing Improvement. We found no evidence that corrective action plans for BOIs were implemented. QM employees ensured that appropriate BOIs were conducted. Board members expressed judgments regarding the motivations and credibility of the witnesses, reached meaningful conclusions, and made appropriate recommendations. However, we did not find documentation of follow-up actions in the 11 BOIs we reviewed, nor did we find evidence that effectiveness of corrective action plans was evaluated. Risk Management and QM Coordinators agreed with our findings and told us that the top management team had expressed their intent to correct this deficiency.

Recommended Improvement Action 12. The Medical Center Director should ensure that a procedure is developed to implement BOI recommendations and track actions until issues are resolved.

The Director agreed with the finding and recommendation and stated that a Standard Operating Procedure has been developed for the Review of the Effectiveness of the Actions in Boards of Investigation. The improvement actions are acceptable and we will follow up on the planned actions until they are completed.

Peer Review Process – Improved Coordination Is Needed

Condition Needing Improvement. Peer review results were not coordinated with QM staff. Peer reviews could originate from multiple sources, including QM incident reports, surgical case reviews, tort claim reviews, monthly mortality reviews, pharmacy committee, or the Chief of Staff. According to the QM Coordinator, peer review results frequently were not sent to the QM staff. Therefore, all peer review results were not tracked or trended, which could result in missed opportunities to identify issues needing corrective actions.

Suggested Improvement Action. The Medical Center Director should ensure that managers implement a procedure for tracking and trending peer reviews to improve the coordination of the peer review process.

The Director agreed with the suggested improvement action and stated that they were in the process of developing a standard operating procedure for reporting peer review results to Service Chiefs; and exploring alternatives to properly track and trend peer reviews. The improvement actions are acceptable.

Homemaker/Home Health Aide Program – Clinical and Administrative Procedures Could Be Improved

Conditions Needing Improvement. Clinical documentation and administrative oversight of the H/HHA Program needs improvement. The H/HHA Program was designed to provide functionally impaired veterans with in-home support such as bathing, dressing, and mobility. The goal of the program is to keep patients in their homes, rather than in nursing homes, for as long as possible. The patients interviewed all reported that they received good service, and that having a homemaker had kept them out of the nursing home. However, the sole provider of VA homemaker services in Puerto Rico was a community health agency (CHA) with a history of deficiencies and limited resources to care for additional patients. We identified the following conditions that required management attention:

- The medical center suspended placement of patients to the CHA for the second and third quarters of FY 2001. The CHA was not in compliance with mandatory training and competency requirements. The medical center needs to continue to monitor the CHA until the deficiencies are corrected.
- The CHA could not provide services to all eligible veterans. At the time of our visit, the medical center had six patients receiving services, with five others on a waiting list. We found that the medical center did not have a procedure for prioritizing those veterans most in need.
- Referrals for H/HHA services were not consistently based upon clinical eligibility. In our review of six medical records, we found that clinical eligibility had not been established for two patients. One had no activities of daily living dependencies and the clinical assessment for the other was incomplete.
- Medical records did not adequately document the patients' participation in the H/HHA Program. An enrollment note template was the only information related to the H/HHA Program found in the patients' medical records. We reviewed the medical records for six patients and found that each began receiving services in November 2001; however, all notes were written on January 10, 2002, 2 months after their placement on 3-month H/HHA contracts. Other providers were not aware of patients' enrollment and progress in the program and the inadequate documentation impacted upon coordination of supportive patient care.
- Patients did not receive all authorized services. A comparison of services provided as shown on CHA invoices to services authorized by the medical center showed that two of the six veterans in our review did not receive all authorized services. Medical center staff did not monitor invoices to ensure all authorized services were provided and the patients' medical records contained no explanations or justification regarding these deficiencies.

Suggested Improvement Action. The Medical Center Director should ensure that:

- a. The CHA is monitored until all past performance problems are resolved.
- b. Procedures are developed to prioritize patients on the CHA waiting list.
- c. Patients meet clinical and administrative eligibility criteria before receiving H/HHA services.
- d. Documentation of H/HHA services and patient progress is improved.
- e. The CHA provides patients all authorized services.

The Director agreed with the suggested improvement action and stated that the Homemaker Program Coordinator and COTR will continue monitoring invoices to ensure that services billed are those received by patients in accordance with the contract; and, CHA representatives will continue to have quarterly regular meetings with the COTR, ACOS Geriatrics and Extended Care, and Social Work Team Leader to discuss pending issues, review administrative issues and patient satisfaction with services provided. The improvement actions are acceptable.

Appendix A

Medical Center Director Comments



**DEPARTMENT OF VETERANS AFFAIRS
VA MEDICAL CENTER
#10 Casia Street
San Juan, Puerto Rico 00921-3201**

In Reply Refer To: **672/00**

August 20, 2002

Assistant Inspector General for Auditing (52)
Office of Inspector General
810 Vermont Avenue, NW
Washington, DC 20420

Subject: DRAFT REPORT: Combined Assessment Program Review – VA Medical Center San Juan, Puerto Rico (Project No. 2002-00868-R3-0059)

We have reviewed your memorandum dated July 19, 2002, on the above mentioned draft report. We state agreement with the estimated dollar impact presented and have the following comments for the recommendations stated in the report:

OIG Recommended Improvement Action 1. *The Medical Center Director should revise procedures to ensure that:*

- a. Case managers review all consults to determine eligibility.*
- b. Prosthetics Service does not accept consults that have not been approved by case managers.*
- c. All patients receive the same standard of care.*
- d. QM management reviews of contractor examinations are conducted to ensure that the issuance of a second pair of eyeglasses was appropriate, bifocals were contraindicated, or that transitional or progressive lenses were justified.*
- e. Medical center staff and/or fee-basis providers conduct eye examinations.*

SJVAMC Response – Concur with the findings and the recommendations.

- a. Case managers review all consults to determine eligibility.*

Action Taken:

Since March 2002 all consults are reviewed by case managers to determinate clinical eligibility. To assure compliance, the consults are stamped and certified by the case manager indicating the patient's eligibility status.

Appendix A

b. Prosthetics Service does not accept consults that have not been approved by case managers.

Action Taken:

Once the case managers review the consults, they are forwarded to Prosthetics personnel to determinate prosthetic eligibility and entitlement. Consults without the required stamp are returned to the case managers for action.

c. All patients receive the same standard of care.

d. QM management reviews of contractor examinations are conducted to ensure that the issuance of a second pair of eyeglasses was appropriate, bifocals were contraindicated, or that transitional or progressive lenses were justified.

e. Medical center staff and/or fee-basis providers conduct eye examinations.

Action Taken:

Since May 2002, a contract was made with an ophthalmologist for Fee Basis services with a \$35.00 cost per exam in an effort to decrease the cost per service in eye exams and eyeglasses and to maintain a same standard of care to all patients. No exams are being referred to the eyeglasses contractor.

OIG Recommended Improvement Action 2. *The Medical Center Director should ensure that:*

- a. Prosthetics Service issues purchase order numbers at the time orders are placed.*
- b. Expenditures are charged to the correct FY appropriation.*
- c. Accounting records are adjusted to reflect the expenditure in the appropriate FY.*
- d. NPPD is kept current.*
- e. Controls are in place to allow obligations/expenditures to be made only to the authorized appropriated fund account.*

SJVAMC Response – Concur with the findings and recommendations.

- a. Prosthetics Service issues purchase order numbers at the time orders are placed.*
- b. Expenditures are charged to the correct FY appropriation.*
- c. Accounting records are adjusted to reflect the expenditure in the appropriate FY.*
- d. NPPD is kept current.*

Actions taken:

Since March 2002, all new orders for eyeglasses are sent to the contractor with a PO number. As a result of this measure, accounting records are adjusted reflecting the expenditure in the appropriate FY and the NPPD is kept updated. The report collects the current data on eyeglasses expenditures therefore, the patient's record reflects if he/she was issued eyeglasses avoiding multiple issues of eyeglasses to the same patient.

Appendix A

e. Controls are in place to allow obligations/expenditures to be made only to the authorized appropriated fund account.

Action taken:

As a result of the contract with a Fee Basis ophthalmologist, Prosthetic Service no longer refers patients to the contractor for eye exams.

OIG Recommended Improvement Action 3. *The Medical Center Director should ensure that:*

- a. Prosthetics Service conducts QM reviews of mail-out orders for eyeglasses.*
- b. Medical Records Section employees file all drop mail into the appropriate patients' records in a timely manner.*

SJVAMC Response – Concur with the findings and the recommendations.

- a. Prosthetics Service conducts QM reviews of mail-out orders for eyeglasses.*

Action Taken:

The Chief Prosthetics with the collaboration of the Quality Manager developed a Performance Improvement indicator that will help to measure aspects of services given to 10% of the veterans that received mailed-out eyeglasses to determine: Correct prescription and Patient Satisfaction with eyeglasses and with examination. Enclosed, find the questionnaire that will be conducted via telephone by Prosthetics personnel.

The data obtained will be collected on a monthly basis and reported quarterly to the Performance Improvement Board.

Areas to improve will be identified and will be discussed with the Chief Ophthalmology Section and the contractor. Opportunities to improve will be implemented as appropriate within the contract.

Target Date: August 2002.

- b. Medical Records Section employees file all drop mail into the appropriate patients' records in a timely manner.*

Action Taken:

The backlog of loose correspondence pending to be filed was solved in May 2002. Permanent staffs were assigned to this ongoing function. At present there is no file backlog.

OIG Recommended Improvement Action 4. *The Medical Center Director should ensure that:*

- a. Inventory records are accurate and kept current.*
- b. Inventories are taken for all primary inventory points and GIP records updated.*
- c. GIP is updated for items received and issued.*

Appendix A

d. Inventory levels are reduced to a 30-day supply.

e. Inventory controls over Implants are effective and that all items are properly accounted for.

SJVAMC Response – Concur with findings and recommendations.

a. Inventory records are accurate and kept current

Action Taken:

1. Staffing needs to support and maintain the GIP in an accurate manner was submitted to the Executive Resources Board as part of the Business Office and Logistics re-organization. Supervisory positions were approved for the Supply, Processing and Distribution (SPD) area and will be available for all tours of duty.
2. Employee position descriptions will be modified to reflect Generic Inventory Package (GIP) duties, responsibilities and accountability.
3. Storage and Dispatch areas will be restricted secured to prevent non-assigned employees from entering the area and/or to issue items.
4. Document accountability will be kept in order to monitor employee performance whether proper computer entries are being made in an accurate manner.

Target Date: September 30, 2002.

b. Inventories are taken for all primary inventory points and GIP records updated.

Action Taken:

1. Wall-to-wall inventories will be made to establish the accuracy of the inventories.

Target date: September 30, 2002.

2. Spot-check inventories will be made monthly thereon after in order to monitor accountability and progress.

Target date: October 30, 2002.

c. GIP is updated for items received and issued.

Action Taken:

1. GIP training was completed on July 2002. Barcode scanner/printer training is needed for all employees. This training requires hardware equipment, which is expected to be in operational conditions.

Target date: November 4, 2002.

2. Employees assigned will be held accountable in maintaining a computer (transaction register) and paper trail for all items being received and issued. Training for this action item will be provided.

Appendix A

Target date: October 31, 2002.

d. Inventory levels are reduced to a 30-day supply.

The 30-day limit imposed by GIP is a very difficult challenge for the San Juan VAMC. There are several factors, which makes this very hard to achieve:

- Geographical location. We are not connected to the US mainland.
- Political status. Not being a state, the Medical Center has to comply with local government regulations, which increases times at port and release of shipments not only for VA, but also for all local vendors.
- Puerto Rico is considered international instead of domestic at customer service departments for many companies in the states. Shipments to Puerto Rico are thus delayed at some companies more than others.
- Our Medsurg Prime Vendor has been subjected to the same predicaments in supplying our demands and in addition, some companies are refusing to supply them based on local government LAW-75. This law states that product lines are protected from other distributors, thus no one-company represents all products from a specific manufacturer. Companies located in the states are very careful not to violate this law by selling to unauthorized local vendors, including our Prime Vendor. OA&MM and NAC are aware of this problem and have been consulted in the past.

Alternatives are being sought to solve these problems and we expect to comply by December 31, 2002.

Action Taken:

1. An assessment of the supply chain and logistical problems associated with the geographical location of Puerto Rico VA Medical Center will be made in order to comply with the 30-day limitation. By contrast, the San Juan VAMC has been using 90-days or more on a “per-item” situational basis rather than a “standard” method for all items. The maximum allowed under the old system (LOG-I) of 54-days had been used in the past and yet proved not being enough since FSS vendors are located in the states while local procurement is mostly open market.

Target date: December 31, 2002.

2. Arrangements with VA Central Office and VISN-8 officials will be made in order to develop a supply chain for the San Juan VAMC on a 30-day basis.

Target date: December 31, 2002.

e. Inventory controls over implants are effective and that all items are properly accounted for.

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Action Taken:

Primary Inventory for implants will be eliminated from the Logistics Section and property will be transferred over to the end-user who will then re-order on as needed basis through the Prosthetics Service via a prosthetic request form and entered into the Prosthetic Inventory Package (PIP). The prosthetic department has a waiver from the GIP mandate and no longer belongs to the Logistics Section. They became a separate service back in January 2002. All implants must be handled through the Prosthetics computer package and not through the GIP in order to account for in both the PIP and patient record.

Target date: August 31, 2002.

OIG Recommended Improvement Action 5. *The Medical Center Director should ensure that:*

- a. Cardholders do not fragment purchase orders to stay within their single purchase limits.*
- b. Purchase cardholders with single purchase limits greater than the micro-purchase limit have procurement warrants for their spending limits.*
- c. Monthly audits and quarterly audits are conducted as required.*
- d. Appropriate training is provided to all cardholders and approving officials.*
- e. Reconciliations of purchase card transactions are performed in the required timeframe by all cardholders.*
- f. Purchase cardholders obtain supplies or services from mandatory sources.*
- g. Procedures are revised to require that purchase cardholders are cleared by the Purchase Card Coordinator during the clearance process.*

SJVAMC Response – Concur with the findings and the recommendations.

- a. Cardholders do not fragment transactions to stay within their single purchase limits.*

Action Taken:

1. To ensure that this is monitored, the Medical Center Purchase Card Coordinator has created a report in VISTA, which when downloaded and analyzed using Access, has permitted her to determine possible cases of fragmenting or splitting the purchase.

When a case of fragmenting is identified, a message is sent to the cardholder, approving official and service chief. In the months of June and July 2002 no cases were identified.

If the Purchase Card Coordinator finds cardholders that make various purchases to a same vendor on the same day but the total is less than their single purchase limit, she sends messages inquiring why this is occurring with the purpose of determining if this can be avoided or if not, that it is properly documented.

2. In the training offered and handout materials given to the cardholders this is clearly explained. To emphasize and remind cardholders we have sent additional electronic mail

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messages for all to read. The Purchase Card Coordinator will continue sending these types of reminders as part of a continued education process for our cardholders.

b. Purchase cardholders with single purchase limits greater than the micro-purchase limit have procurement warrants for their spending limits.

Action Taken:

1. The cardholder, who had the training but had not received the appropriate warrant, has been issued the same.
2. For the three cardholders who did not have the training or the warrant they obtained the latest version of the Simplified Acquisition Procedure Training in CD-Rom format. Business Office gave each one the required training CD-Rom and additional materials necessary for their studies. The Head Contracting Officer is their proctor. Test is scheduled for October 22, 2002. Those who do not pass the test will have their procurement warrant to exceed the \$2,500 limit revoke.

c. Monthly audits and quarterly audits are conducted as required.

Action Taken:

1. The Fiscal Internal Auditor is permanently assigned the review of the monthly Austin purchase card validation questionnaire. He is responsible for distributing the questionnaire to the corresponding accounting technician, monitoring that the audit is completed within the time frame provided, and keeping the audits organized and filed. Also, a log was created where he tracks when the audits were received, completed and sent to Austin.
2. The Fiscal Internal Auditor was assigned to conduct a review of all the purchase card audits for the 1st quarter FY 2002. He submitted a report assuring that all the audits were completed and documented properly. To take permanent corrective action he is permanently assigned to monitor and review all purchase card audits performed by the accounting technicians. His duties include the review of all the audit paper work and assure that they are completed, accurate and documented. After he concludes the review he submits a report to the Fiscal Officer certifying that all the audits were completed accordingly to internal policy.
3. The Fiscal internal auditor was also assigned the monthly review of the B07 Report – Monthly Credit Card Transactions. This report is reviewed to identify improper purchases.
4. A new purchase card report was created to conduct the audits. This new report list all the purchase card orders created within the quarter. This report will replaced the “Unreconciled Orders Report” used previously. This will allow us to select the total transactions to audit in the quarter according to the internal policy.
5. The monthly purchase card audit procedures are being reviewed for areas of further improvement. Another area being reviewed is the frequency of the audits, which is

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expected to change to a monthly basis instead of quarterly. This would allow taking corrective action in a shorter time.

d. Appropriate training is provided to all cardholders and approving officials.

Action Taken:

1. At the beginning of fiscal year 2002 our Purchase Card Coordinator identified a need to retrain all cardholders on the Policies, Regulations and Responsibilities of the Purchase Card Program.

These trainings began in August 2001 and continued in classroom format through April 2002. After this date they have been given on a one-to-one basis with a test given at the end of the same.

2. To this date there are no active cardholders without the appropriate trainings. The Medical Center still has four approving officials who have not taken training but are making arrangements for training to be completed by the same. Target date has been set for October 6, 2002. Approving officials who have not completed required trainings at that time would have the card belonging to their cardholders inactivated until such time as the approving official has been certified.

e. Reconciliations of purchase card transactions are performed in the required timeframe by all cardholders.

Action Taken:

1. The Purchase Card Coordinator has had in place a process to identify the cardholders who are meeting the standard and those that are not. These reports are sent on a monthly basis to the cardholder, the approving official and the Service Chief.

2. In addition, an electronic message is sent to all cardholders of what charges they have pending reconciliation with the age of the charge. An additional message is sent to the cardholder and approving official for those charges over 30 days, since these are seriously delinquent.

3. This standard for reconciliation is a part of the cardholder's performance appraisal and position description and gives the supervisor a tool to ensure that employee meet the standard.

4. The Purchase Card Coordinator has recently finished creating a report format for the Associate Director and the Chief of Staff, which will make it easy for them to identify the particular services and/or cardholders not meeting the standard. They will then be able to take action with the corresponding Service Chief.

5. Plans are being discussed to give follow up on a weekly basis to cardholders of what they have pending to reconcile.

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6. The Purchase Card Coordinator has in place a process to send a monthly report to the approving officials who did not approve reconciliation's in a timely manner. Report is also sent to the supervisor of the approving official for further action.

7. Business Office is also identifying cardholders who do not have alternate approving officials with the purpose of having one assigned. This will avoid reconciliation's not being approved in timely manner because the approving official is on leave.

f. Purchase Cardholders obtain supplies or services from Mandatory Sources.

Action Taken:

1. As mentioned previously, the Purchase Card Coordinator had implemented a training plan for all cardholders during FY 2002. One of the areas given emphasis in this training was the use of the Mandatory Sources and how to obtain information for each one. This program has improved the awareness of our cardholders of the mandatory sources.

To complete the training of cardholders in this area, Business Office is taking action to prepare trainings on Federal Supply Schedules, GSA Advantage and Source One. All of these are the instruments necessary to determine if an item exists on a mandatory source. Plans are to offer this training via a CD-Rom environment with a corresponding quiz. Trainings will begin in November 2002. Since the Medical Center has a great number of cardholders, it will take approximately 6 months to train the group.

2. The Purchase Card Coordinator will also begin an audit of what is being purchased and from whom. She will select a random sampling of each months orders and review the same. Plans are to review 25% of the purchase card orders.

Individual reports on these finding will be sent to the cardholders, approving official and corresponding Service Chief. Summary reports will be sent to Fiscal Officer and the corresponding purchase card auditors for inclusion in their records. Head of Contracting will also be sent summary report.

g. Procedures are revised to require that purchase cardholders are cleared by Purchase Card Coordinator during the clearance process.

Action Taken:

1. Our Human Resources Management Service has made changes to the "Employee Clearance Upon Separation" center memorandum to include as part of the process the requirement that employee's go through the Purchase Card Coordinator. The policy is very near completing cycle of concurrences and should be available for distribution by the end of August 2002. Once published, our Purchase Card Coordinator will give an orientation to the staff in the Business Office and Fiscal Service who process clearances.

This also will permit the Purchase Card Coordinator to discuss with the cardholder the status of all orders placed by the same and determine what is pending. A procedure has

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been established by our Purchase Card Coordinator for the revision of all open orders to ensure that actions are taken on the same after the cardholder leaves.

Due to the complexity and nature of the Purchase Card Program, it was decided that the Purchase Card Coordinator be dedicated on a full time basis to the program. Position Description has been rewritten and she is now dedicating her full efforts to the program.

OIG Recommended Improvement Action 6. *The Medical Center Director should ensure that:*

- a. Contracts with substantially similar work requirements are combined into one contract to promote competition.*
- b. Contracting officers negotiate prices for noncompetitive contracts, prepare PNMs, and file the PNMs in the applicable contract folders.*

SJVAMC Response – Concur with findings and recommendations.

- a. Contracts with substantially similar work requirements are combined into one contract to promote competition.*

Action Taken:

The need to compete this requirement had been identified in the Executive Resources Board (ERB) and had been recommended for FY 2003. The National Institute for the Severely Handicap (NISH), was interested in this requirement for the FY 2001 cycle. Although they met with the Associate Director, Contracting Officer and Facility Management Officer, we did not follow-up with an actual proposal. We do have a proposal for this requirement from NISH for FY 2003 requirements. We feel that NISH should be a pilot and awarded a portion of this requirement. If negotiations are successful with NISH, any remaining portion of this requirement or any additional areas to this requirement will be competed among 8(a).

- b. Contracting Officers negotiate prices for noncompetitive contracts, prepare Price Negotiation Memorandums and file the PNM's in the applicable contract file.*

Action Taken:

Chief Contracting Section has been advised of this matter and will be held accountable for the enforcement and monitoring of this requirement. The Contracting Section is being re-organized to accommodate the increasing amount of work. Procurement Analyst and Assistant position(s) will be requested to the ERB to absorb some of the administrative work in the Contracting Section. The need for additional staff was stated in our Business Plan presentation this fiscal year, but due to budgetary constraints, supplemental hiring was not possible. Contracting Staff has complained about the workload and the need to have more time to meet all the requirements of contract files. Therefore, alternatives will be explored to meet the workload demands and monitoring of this finding will be done for every contract award.

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Target Date: October-1, 2002

Recommended Improvement Action 7. *The Medical Center Director should ensure that the Business Office:*

- a. Provides all purchase cardholders with complete copies of existing contract price lists related to their purchases, and ensure purchase cardholders pay contract prices.*
- b. Conducts a complete review of purchases made from the pacemaker contractor to ensure that purchase cardholders paid contract prices.*
- c. Obtains reimbursement from the pacemaker contractor for all overcharges.*

SJVAMC Response – Concur with findings and recommendations.

- a. Provides all purchase cardholders with complete copies of existing contract price lists related to their purchases, and ensure purchase cardholders pay contract prices.*

Action Taken:

The Business Office offers training to cardholders and includes FSS information. A software education package on FSS was purchased to provide supplemental training tools. Please refer to other replies under the Purchase Card findings and recommendations item 7.

- b. Conducts a complete review of purchases made from the pacemaker contract to ensure that purchase cardholders paid contract prices.*

Action Taken:

This monitor will be included in the Purchase Card Program

Target Date: October 1, 2002.

- c. Obtain reimbursement from the pacemaker contractor for all overcharges.*

Action Taken:

We are in the process of collecting overpayments from the pacemaker contractor. The local representative for Mario Pelegrina is coordinating this with the Business office. In addition, we are going back six years to investigate whether overcharges were made during this period. We have received a commitment for payment from Mario Pelegrina. Payment should be received by 8-15-02. See enclosed copy of the letter.

Target Date: December 2002

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OIG Recommended Improvement Action 8. *The Medical Center Director should ensure that:*

- a. All AIS are certified and accredited.*
- b. The ISO is trained in the AIS audit features and has the appropriate computer access level.*
- c. Contingency plans include all of the appropriate elements and are distributed to appropriate staff.*
- d. Quarterly reviews of employee access levels to AIS resources are conducted and access terminated when no longer required.*
- e. The practice of using generic access accounts is stopped.*
- f. A separation of duty policy is developed.*
- g. Monitoring procedures are developed to ensure that employee access to other employees' records is appropriate.*
- h. Annual computer workstation audits are conducted to identify unlicensed software.*
- i. Computer back-up tapes are stored in a secure off-site location.*
- j. An official is designated to certify that AIS equipment is properly cleared (degaussed) of sensitive information before disposal.*
- k. Required employee background investigations are performed for all IRM employees assigned to sensitive positions.*
- l. Procedures are developed to address disgruntled or reduction-in-force employees.*

SJVAMC Response: *Concur with the findings and recommendations.*

- a. All AIS are certified and Accredited*

Action Taken:

The ISO in conjunction with the Assistant Chief, IMS, are in the last step of completing the certifications and accreditations of the mayor systems. The ISO will also work in conjunction with IMS personnel to complete the documentation requirement for the minor systems.

Target date: August 30, 2002

- b. The ISO is trained in the AIS audit features and has the appropriate computer access level.*

Action Taken:

Although no formal training has been provided, the ISO has received trainings in various audit features that can be used in both VISTA and Network. The Medical Center will coordinate with the Network ISO to provide formal training. The ISO will be given appropriate access upon completion of the training.

- c. Contingency plans include all of the appropriate elements and are distributed to appropriate staff.*

Action Taken:

During the process of generating the Contingency Plans a template was used from HISS however, all contingency plans will be reviewed in order to reduce the impact of

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disruptions in services, provide critical interim processing support, and provide the ability to resume normal operations as recommended

Target date: August 30, 2002.

d. Quarterly reviews of employee access levels to AIS resources are conducted and access terminated when no longer required.

Actions Taken:

Quarterly reviews of employees access levels to AIS resources are conducted and access terminated when no longer in use, the same will be documented effective immediately.

e. The practice of using generic access accounts is stopped.

Action Taken:

No generic accounts are used at the VA Medical Center with the exception of the education generic accounts that are identified in VISTA's TEST MODE. There are no active live generic accounts present in the system.

f. A separation of duty policy is developed.

Action Taken:

Prior to this IG visit this issue was identified nationally as a potential security problem IT Departments faced at every VA Facility. After careful research IMS Management made the decision to review all employees with sensitive system access (i.e., programmer access) of all IMS employees. By identifying the different variations of sensitive access and implementing restrictions we took a big step towards outlining and restricting the various functions of IMS staff. At the same time we recognized the need to have this type of access for special situations/users and created CENTER MEMORANDUM NO. 001/IMS-01-07 to address specific needs of employees who needed the special level of access to perform their jobs. Very few hospitals have taken this approach in an effort to try to separate duties without adversely affecting the existing level of support. See enclosed copy of CM 001/IMS-01-07.

g. Monitoring procedures are developed to ensure that employee access to other employees' records is appropriate.

Action Taken:

The ISO has included the monitoring of inappropriate access to employee's computer-based record as a procedure and incorporated to our AIS Security Policy. The ISO is also generating a template to be sent randomly to Service's Supervisor related to this issue. In addition, the ISO will work with the Applications Section in IMS to generate some applications that will flag some additional fields in regards to this concern.

Target Date: September 30, 2002

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h. Annual computer workstation audits are conducted to identify unlicensed software.

Action Taken:

SMS software was acquired nationally to monitor Microsoft software installations. Locally we have discussed future use of this application for Microsoft as well as other software, once proper training is given to our staff.

Currently the system in place does not allow software installation without administrative privileges limited to IMS technicians. This monitor is conducted regularly to assure compliance with Microsoft licensing requirements. IMS keeps a software library on all authorized software titles installed throughout the facility. Software is not allowed to be installed without evidence of valid license.

i. Computer back-up tapes are stored in a secure off-site location.

Action Taken:

Computer VISTA back-up tape have always been stored in an off-site location and this is stated in the contingency plans with the address and all pertaining information. The recommendation to store the LAN tapes requires the purchase of additional backup media to accommodate the exchange and network systems. As of now, we are still in the purchasing process because we wanted to resolve some issues with the existing backup equipment and at the same time wanted to purchase tapes and hard drives for our VISTA system to take advantage of volume purchasing. The week of August 12, 2002, we released the first purchase order of hard drives and today released the order for tapes. Implementation of a network backup system similar to the VISTA procedure will be implemented as soon as the new tapes arrive.

Target Date: September 30, 2002.

j. An official is designated to certify that AIS equipment is properly cleared (degaussed) of sensitive information before disposal.

Action Taken:

IMS created a local policy and procedures that identify IMS Technicians as the responsible to degauss and clean every sensitive information from any of our systems before disposal.

k. Required employee background investigations are performed for all IRM employees assigned to sensitive positions.

Action Taken:

Safeguards have been implemented in the Human Resources Staffing Section to insure that positions that have been designated as sensitive have the required background investigation completed. Processing Section in Human Resources will be responsible to

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insure that all new appointments into the following positions have the background investigation completed or if not, initiated:

- Medical Center Director
- Associate Center Director
- Chief of Staff
- DSS Manager
- Information Security Officer
- Chief, Police Service
- Chief, Human Resource Management Service
- Chief, Business Office
- Chief, Fiscal Service
- Chief, Information Management Service
- Chief, Medical Administration Service
- Chief, Pharmacy service
- Police Officer / Detective
- Computer Specialist
- Pharmacist ADPAC

l. Procedures are developed to address disgruntled or reduction-in-force employees.

Action Taken:

The ISO has incorporated in our AIS Security Policy Center Memorandum a procedure to address disgruntled or reduction-in-force employees. Human Resources Management will provide the ISO and IMS with a list of names of employees that will be removed, transferred, changed of position, reduce-in-force, etc., which will be used to deactivate these accounts and/or change privileges as required. See enclosed copy of the draft center memo.

OIG Recommended Improvement Action 9. *The Medical Center Director should ensure that:*

- a. Patient complaint reports related to Pharmacy Service for FY 2001 to date are reviewed to identify trends in the complaints and take necessary corrective actions.*
- b. Necessary software is purchased and installed to link the Optifill-II™ with the controlled substances vault computer.*
- c. Pharmacy Service's tube delivery system between the controlled substances vault and the dispensing area is repaired and placed back in service.*
- d. Pharmacy Service technicians verify that all patient medications are delivered to the patient before the patients leave the dispensing window.*

SJVAMC Response – Concur with the findings and recommendations.

- a. Patient complaint reports related to Pharmacy Service for FY 2001 to date are reviewed to identify trends in the complaints and take necessary corrective actions.*

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On FY-01 Pharmacy Service had 28 complaints related to the excessive waiting times to received mail-out prescriptions.

On FY-02 (up to July 2002) Pharmacy Service had 93 complaints related to excessive waiting times to received mail-out prescriptions. However, most of them were in 2 months December 2001 (18) and January 2002 (41) for a total of 59 (63%) complaints in only two (2) months.

Corrective actions were taken immediately, and in the following 6 months, (since February 2002 through July 2002) there are 33 complaints; it shows a significant improvement, even though improvement is still needed.

However, the mail out prescription system has several components; the order entry is performed by the pharmacist at San Juan, the dispensing process is performed at (CMOP) Charleston, South Carolina and the delivery process which is performed by Airborne delivery system and the U.S. Postal Service.

CMOP monthly delivery survey by site indicated that in January 2002, 13.96% of San Juan non-controlled substance prescriptions were delivered in more than 7 days. None of the others sites served by the same CMOP station reach even 2%. Controlled substances prescriptions for the same period of time, San Juan had a 4.41% of prescriptions delivered in more than 7 days; meanwhile the other sites receiving controlled substances prescriptions from the same CMOP station do not reach 1%.

Increasing the utilization of CMOP is one of the VISN cost containment strategies developed by the Pharmacy Benefit Management. On first 3 quarters of FY-01 SJVAMC dispensed 562,238 prescriptions by mail that number had increased significantly in FY-02. For the same period of FY-02, San Juan had processed a total of 812,903 through CMOP, which represents a 44.5% increase. It was accomplished by performing some changes to the process.

Action Taken:

1. Medications are now processed 15 days in advance, before they were processed only 10 days in advance. As result of it the number of complaints has reduced significantly.
2. This improvement is also observed CMOP monthly delivery survey report of May 2002. It shows a significant improvement as compared to the January 2002 results. In May 2002 only 1.02% of non-controlled substances and only 0.44 % of the controlled substances prescriptions were received after 7 days.
3. Patient complaint reports were reviewed and some areas for improvement were identified. An action plan was developed, some of the actions were implemented and others are in-progress. Those are:
 - Address verification and correction
 - Local meeting with the local US Postal Service to monitor progress

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- Installation of the Audio mumps electronic refill system.
- Design for patient education on how to request refills.
- Increase supplies to 90 days on identified medications. We are presently on 23% and the goal is to reach 45% by end of FY-03

Target Date: December 2002.

b. Necessary software is purchased and installed to link the Optifill-II™ with the controlled substances vault computer.

Action Taken:

The computer software to integrate the controlled substances manual dispensing process to the Optifill automated dispensing process was installed, however it is not working yet, Optifill (Automed) personnel still working on it. The computer software enhancement is expected to be operational by September 2002.

Target Date: September 2002

c. Pharmacy Service's tube delivery system between the controlled substances vault and the dispensing area is repaired and placed back in service.

Action Taken:

The Pharmacy Service's pneumatic tube delivery system between the controlled substances vault and the dispensing area was put back to work on March 2002 during the same week of your visit. As expected the use of the pneumatic tube delivery system improved the timeliness and efficiency of the area.

d. Pharmacy Service technicians verify that all patient medications are delivered to the patient before the patients leave the dispensing window.

Action Taken:

The Pharmacy Service technicians do not ensure those patients receive all of their prescriptions before they leave the window. Staff Pharmacist are the one in-charge of verifying that every patient receives the medications ordered for him, pharmacy technicians only performs the delivery of the bags.

The use of the pneumatic tube has improved such situation and once the computer software is operational it should be corrected.

Action Taken:

1. Pharmacy have incremented the number of controlled substances dispensed by the Optifill machine to nineteen (19). As of today, approximately 80% of the total of controlled substances dispensed at SJVAMC are dispensed through the Optifill machine and 95% of the tablets and capsules.

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Most of the controlled substances prescriptions, which are still dispensed at the vault, are those that cannot be dispensed by the Optifill machine as narcotics, syringes and liquids.

2. A new verification procedure has been implemented to mark every tote with controlled substances to be dispensed at the vault to ensure that patient receiving medications dispensed by both the Optifill machine and from the vault, are delivered at the same time. The Pharmacist at the vault area verifies that all medications are included.

Target Date: September 2002

OIG Recommended Improvement Action 10. *The Medical Center Director should ensure that unusable and expired controlled substances are disposed of in accordance with VA policy.*

SJVAMC Response: - Concur with the findings and recommendations

Action Taken:

1. The Chief Pharmacy Service will ensure that the unusable and expired controlled substances are turned in to A&MMS according to VA policies quarterly. In turn A&MMS will initiate the disposition process to comply with the quarterly requirement.
2. Business Office will amend the contract for the disposition of the controlled substances to require from the contractor that upon disposition, submit the form including the name and title for the controlled substances inspecting official as well as the titles for the A&MMS and Pharmacy representatives. In addition, A&MMS will ensure that all required personnel including the controlled substances inspecting official be present to witness the process.

Target Date: August 30, 2002

OIG Recommended Improvement Action 11. *The Medical Center Director should ensure that:*

- a. *All PT physicians designate at least 25 percent of their regular biweekly tours of duty as core hours.*
- b. *PT physicians' time and attendance is monitored to ensure they are on duty during their core hours unless they are on approved leave or excused absences.*
- c. *Employee Accounts Section conducts annual refresher training and semiannual desk audits.*
- d. *Subsidiary Time and Attendance Reports (VAF 4-5631a) are completed by all PT physicians and turned in to the unit timekeepers.*

SJVAMC Response – Concur with the findings and recommendations.

- a. *All PT physicians designate at least 25 percent of their regular biweekly tours of duty as core hours.*

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b. PT physicians' time and attendance is monitored to ensure they are on duty during their core hours unless they are on approved leave or excused absences.

Action Taken:

All part time physicians are responsible for recording and certifying as correct all entries on the Subsidiary Time and Attendance Report - Part Time Physicians (VA Form 4-5631a) pertaining to time worked, leave, or excused absence. Trainings and instructions to timekeepers were completed at the San Juan VAMC as mandated in the PAID regulations.

We have identified and authorized the part time physician for which adjustable hours (core hrs.) are determined essential for meeting patients care needs as per VHA Supplement, MP-5, Part II, Chapter 7, Appendix A).

c. Employee Accounts Section conducts annual refresher training and semiannual desk audits.

d. Subsidiary Time and Attendance Reports (VAF 4-5631a) are completed by all PT physicians and turned in to the unit timekeepers.

Action Taken:

1. Refresher PAID Time & Attendance timekeeping trainings were conducted at the San Juan VAMC and Outpatient clinics. The payroll staff conducted this refresher training including all time & attendance regulations and emphasizing in the proper completion of the Subsidiary Time & Attendance Report - Part Time Physicians (VA Form 4-5631a).

2. A total of 92 timekeepers and alternate timekeepers of the San Juan VAMC, Mayaguez OPC, Ponce OPC, Vet Centers, and National Cemetery attended one of the four training sessions. These refresher trainings are scheduled to continue at least one a year.

3. The Time & Attendance desk audit forms were reviewed and updated to include the Subsidiary Time & Attendance Report for Part Time Physicians (VA Form 4-5631a). The payroll staff is in the process of completing the desk audits of all timekeepers on a semiannual basis.

4. In addition to the mandated timekeepers desk audits the San Juan VAMC Compliance Officer is requesting a monthly certification of compliance of completing the Subsidiary Time & Attendance Report for Part Time Physicians (VA Form 4-5641a). This certification is required from all clinical services with part time physicians.

OIG Recommended Improvement Action 12. *The Medical Center Director should ensure that a procedure is developed to implement BOI recommendations and track actions until issues are resolved.*

SJVAMC Response – Concur with the findings and recommendation

Action Taken:

1. A Standard Operating Procedure has been developed for the Review of the Effectiveness of the Actions in Boards of Investigation as follows:

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- BOI Team prepares final report.
 - BOI Report is sent to Medical Center Director for final recommendations.
 - Actions stated in BOI Report are requested to concerned services.
 - BOI is placed in suspense for 15 working days.
 - Follow-up is given to concerned services for requested actions.
 - Actions taken by services are sent to the Medical Center Director for closure of the BOI.
-
- BOI is placed in suspense for three (3) months after it is closed by the Medical Center Director.
 - Review is made to request additional information from concerned parties regarding effectiveness of action.
 - After additional information is received, BOI is sent to the Medical Center Director for final closure.
 - BOI is closed and filed.
2. See enclosed form that will be used for the submission of the reports.

Suggested Improvement Action. *The Medical Center Director should ensure that managers implement a procedure for tracking and trending peer reviews to improve the coordination of the peer review process.*

SJVAMC Response – Concur with the findings and recommendation.

Action Taken:

1. We are in the process of developing a standard operating procedure for reporting peer review results to Service Chiefs.
2. We are exploring alternatives of template implementation in order to properly track and trend peer reviews. Also we are reviewing literature of programs commercially available.

Target Date: October 2002

Suggested Improvement Action. *The Medical Center Director should ensure that:*

- a. *The CHA is monitored until all past performance problems are resolved.*
- b. *Procedures are developed to prioritize patients on the CHA waiting list.*
- c. *Patients meet clinical and administrative eligibility criteria before receiving H/HHA services.*
- d. *Documentation of H/HHA services and patient progress is improved.*
- e. *The CHA provides patients all authorized service*

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SJVAMC Response – Concur with the findings and recommendations.

a. The CHA is monitored until all past performance problems are resolved.

Action Taken:

1. The agency is providing the Medical Center evidence of required mandatory training and Homemaker credentials on a regular basis. They developed training modules, including mandatory trainings required.
2. Homemaker services are not initiated until this information is provided by Homemaker agency, as contract requires. COTR monitors compliance in this area before initiation of services.

b. Procedures are developed to prioritize patients on the CHA waiting list.

Action Taken:

1. The Homemaker Service Center Memo No. 11C-02-06 will be officially amended in order to include prioritization procedure to be followed.

Target Date: September 2002.

2. The Homemaker Program Coordinator will continue to evaluate patient's referrals to this program to prioritize need for service and categorize according to established priorities and document on the record.

c. Patients meet clinical and administrative eligibility criteria before receiving H/HHA services.

Action Taken:

1. The Homemaker Program Coordinator will continue to evaluate patient's referral for these services to assure they meet the clinical and administrative eligibility criteria established in Center Memo 11C-02-06.

Target Date: September 2002.

2. A Homemaker service evaluation template will be created in order to document in patient's medical record, clinical and administrative eligibility before approval of services.

d. Documentation of H/HHA services and patient progress is improved.

Action Taken:

1. Present documentation covers the period since patient is referred to the program, is evaluated for services and until services are terminated. In order to improve accessibility, coordination of services and documentation, a template will be designed. The template will include telephone interview notes explaining if services received by patients are those

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authorized and also reporting patient's satisfaction with services provided. The outcome of these services will also be documented.

Target Date: September 2002.

e. The CHA provides patients all authorized services.

Action Taken:

1. The Homemaker Program Coordinator and COTR will continue monitoring invoices to ensure that services billed are those received by patients in accordance with the contract.
2. COTR will report in program administrative committees, such as Advisory Committee for External Care, the following issues and the reports will be documented in minutes:
 - Cases referred
 - Number of patients placed
 - Number currently receiving services
 - Funds obligated
 - Invoices received and paid
 - Problem related to services rendered
 - Problems related to billing process
3. CHA representatives will continue to have quarterly regular meetings with COTR, ACOS Geriatrics and Extended Care, and Social Work Team Leader to discuss pending issues, review administrative issues and patient satisfaction with services provided.

/s/

RAFAEL E. RAMIREZ, MD, FACP
Center Director

Enclosures

cc: VISN-8 Network Director (10N8)

Appendix B

Monetary Benefits in Accordance With IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center San Juan,
Puerto Rico

Report Number: 02-00868-15

<u>Recommendation</u>	<u>Explanation of Benefits</u>	<u>Better Use of Funds</u>
1	Better use of funds by following VA criteria concerning the number of pairs of eyeglasses a veteran receives.	\$ 348,000
1	Better use of funds by using fee-basis ophthalmologists to conduct examinations.	\$ 114,000
4	Better use of funds by reducing supply inventories to 30-day levels.	\$ 963,000
5	Better use of funds by purchasing from mandatory sources.	\$ 13,600
7	Better use of funds by monitoring purchase prices paid for items on contracts.	<u>\$ 36,600</u>
	Total	<u><u>\$1,475,200</u></u>

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Appendix C

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