Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities April 2001 through September 2002

Report No. 02-01811-28 **December 10, 2002**

VA Office of Inspector General
Washington, DC 20420

VA Office of Inspector General

Combined Assessment Program Reviews

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

- Healthcare inspectors evaluate how well the facility is meeting quality standards in specific core areas and the level of patient satisfaction with overall treatment.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

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

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities April 2001 through September 2002

1. This report summarizes the conditions, recommendations, and suggestions made in reports of Combined Assessment Program (CAP) reviews at Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities published during the period April 2001 through September 2002.

2. In the period covered by this summary, the Office of Inspector General (OIG) issued 40 reports of CAP reviews of VHA medical facilities. The purpose of these reviews was to evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls. We also provided fraud and integrity awareness training for about 7,350 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. Each of the 31 conditions discussed in this summary report was found at more than one medical facility. We noted that five of the areas were identified as in need of significant improvement in our prior summary report (October 10, 2001), and are still in need of top management attention: contract community nursing homes, contracts for clinical services, controlled substances accountability, Government purchase cards, and management of supplies inventories.

4. This report is provided to help ensure that VHA top management, and the Directors of the Veterans Integrated Service Networks (VISNs) and medical facilities address the issues identified. We may continue to review the issues reported here in future CAP reviews as well as covering new areas of inquiry.

RICHARD J. GRIFFIN
Inspector General

Introduction

Background

During the period April 2001 through September 2002, 40 reports were issued on CAP reviews completed at VA medical facilities. Generally, the CAP reviews were conducted during 1-week site visits.

Scope of CAP Reviews

The scope of the CAP reviews at each of the medical facilities visited included some of the areas listed below. The CAP team leaders selected the areas reviewed at each medical facility. This report summarizes the issues for which recommendations or suggestions were made in the selected areas of coverage that were reported in more than one CAP report:

- Access to Care
- Accounts Receivable
- Accrued Services Payable and Undelivered Orders
- Agent Cashier
- Community-Based Outpatient Clinics (CBOC)
- Contract Community Nursing Homes (CNH)
- Contracts for Clinical Services
- Contracts for Non-Clinical Services
- Controlled Substances Accountability
- Credentialing, Privileging, and Background Investigations
- Dietetics and Canteen Food Services
- Employee Training
- Environment of Care
- Government Purchase Cards
- Homemaker/Home Health Aide Program
- Infection Control
- Information Management Security
- Informed Consent for Clinical Procedures
- Informed Consent for Research
- Management of Equipment Inventories
- Management of Supplies Inventories
- Means Tests and Medical Care Cost Fund Coding, Billing, and Collection
- Medical Record Documentation
- Medical Record Privacy
- Pain Management
- Patient and Employee Safety
- Patient Care and Quality Management
- Primary Care

- Reporting Abnormal Results of Tests and Procedures
- Time and Attendance of Part-Time Physicians
- Treatment of Mental Health Patients

Fraud and integrity awareness briefings were also conducted during each CAP review and about 7,350 VHA employees attended the briefings. The briefings included a film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and question and answer sessions.

CAP Reports Issued

The following are the 40 VHA medical facility CAP reports issued during the period of April 2001 through September 2002.

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Manchester, NH	1	00-02860-67	4/11/2001
Combined Assessment Program Review, VA Boston Health Care System	1	01-01253-14	10/31/2001
Combined Assessment Program Review of the Department of Veterans Affairs Medical Center Providence, RI	1	01-01516-29	5/28/2002
Combined Assessment Program Review of the VA Connecticut Health Care System	1	01-01073-140	7/19/2002
Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, NY	2	01-02123-43	1/17/2002
Combined Assessment Program Review, VA New Jersey Health Care System	3	01-00685-120	7/24/2001
Combined Assessment Program Review of the VA Medical and Regional Office Center Wilmington, DE	4	01-00222-7	10/05/2001
Combined Assessment Program Review of the VA Medical Center Durham, NC	6	01-01518-30	4/04/2002
Combined Assessment Program Review of the VA Medical Center Fayetteville, NC	6	01-02940-166	9/20/2002
Combined Assessment Program Follow-up Review, Carl Vinson VA Medical Center Dublin, GA	7	00-00358-58	5/14/2001
Combined Assessment Program Review Ralph H. Johnson VA Medical Center Charleston, SC	7	01-00507-79	6/27/2001

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the Central Alabama Veterans Health Care System	7	00-02083-52	5/31/2002
Combined Assessment Program Review, VA Tennessee Valley Health Care System Murfreesboro, TN	9	01-00788-108	8/08/2001
Combined Assessment Program Review of the VA Medical Center Louisville, KY	9	01-00686-44	1/24/2002
Combined Assessment Program Review of the James H. Quillen VA Medical Center Johnson City, TN	9	01-00223-136	7/16/2002
Combined Assessment Program Review VA Medical Center Cincinnati, OH	10	00-02010-113	8/15/2001
Combined Assessment Program Review Richard L. Roudebush VA Medical Center Indianapolis, IN	11	00-00709-88	5/31/2001
Report of Follow-Up to the Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, IN	11	00-01199-129	8/15/2001
Combined Assessment Program Review of the John D. Dingell Veterans Affairs Medical Center Detroit, MI	11	01-01252-37	12/20/2001
Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, WI	12	02-01159-145	8/05/2002
Combined Assessment Program Review of the VA Medical Center Minneapolis, MN	13	00-02097-46	1/29/2002
Combined Assessment Program Review VA Central Iowa Health Care System Des Moines and Knoxville, IA	14	00-01229-102	6/13/2001

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of Harry S. Truman Memorial Veterans' Hospital Columbia, MO	15	00-02066-51	7/10/2001
Combined Assessment Program Review of the VA Medical Center Kansas City, MO	15	01-01515-40	1/02/2002
Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review, Kansas City VA Medical Center	15	02-02280-112	6/03/2002
Combined Assessment Program Review of John J. Pershing VA Medical Center Poplar Bluff, MO	15	01-02120-20	7/22/2002
Combined Assessment Program Review of the Oklahoma City Veterans Affairs Medical Center	16	01-00079-104	7/02/2001
Combined Assessment Program Review of the Central Arkansas Health Care System	16	01-02122-133	7/10/2002
Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, TX	17	00-02811-89	6/29/2001
Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, TX	17	01-02327-149	7/29/2002
Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, AZ	18	01-01074-101	6/29/2001
Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, NM	18	00-02681-121	8/13/2001
Combined Assessment Program Review of the Alaska VA Health Care System and Regional Office, Anchorage, AK	20	01-02016-13	10/15/2001
Combined Assessment Program Review of the VA Northern California Health Care System	21	01-00413-85	7/02/2001

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI	21	01-01254-10	10/09/2001
Combined Assessment Program Review of the San Diego Healthcare System	22	01-02946-58	4/01/2002
Combined Assessment Program Review of the VA Long Beach Healthcare System	22	02-01171-108	7/31/2002
Combined Assessment Program Review of VA Loma Linda Healthcare System	22	02-00988-170	9/30/2002
Combined Assessment Program Review, Royal C. Johnson Memorial VA Medical and Regional Office Center, Sioux Falls, SD	23	00-02096-125	7/24/2001
Combined Assessment Program Review of the VA Medical and Regional Office Center Fargo, ND	23	00-01219-134	7/10/2002

CAP FINDINGS BY VISN AND BY MEDICAL FACILITY
APRIL 2001 THROUGH SEPTEMBER 2002

Veterans Integrated Service Networks																																										
	1				2	3	4	6		7			9			10	11			12	13	14	15					16		17		18		20	21		22			23	
CAP Findings	Manchester, NH	Boston Health Care System (HCS)	Providence, RI	Connecticut HCS	Albany, NY	New Jersey HCS	Wilmington, DE	Durham, NC	Fayetteville, NC	D ublin, GA	Charleston, SC	Central Alabama HCS	Tennessee Valley HCS	Louisville, KY	Johnson City, TN	Cincinnati, OH	Indianapolis, IN	Northern Indiana HCS Follow-up (FU)	Detroit, MI	Madison, WI	Minneapolis, MN	Central Iowa HCS	Columbia, MO	Kansas City, MO	Kansas City, MO(FU)	Poplar Bluff, MO	Oklahoma City, OK	Central Arkansas HCS	South Texas HCS	Central Texas HCS	Southern Arizona HCS	New Mexico HCS	Alaska HCS	Northern California HCS	Honolulu, HI	San Diego HCS	Long Beach HCS	Loma Linda HCS	Sioux Falls, SD	Fargo, ND
Access to Care								●				●																														
Accounts Receivable		●				●	●				●	●		●		●			●		●	●	●														●		●	
Accrued Services Payable and Undelivered Orders													●			●			●		●		●						●								●			
Agent Cashier	●			●		●					●	●	●	●		●						●	●						●			●	●					●	●
Community-Based Outpatient Clinics															●																							●		
Contract Community Nursing Homes	●										●			●	●	●	●		●		●	●	●				●		●					●						
Contracts for Clinical Services	●		●		●	●			●					●		●				●				●			●				●	●	●	●					
Contracts for Non-Clinical Services		●			●			●	●		●																	●				●	●	●	●	●			●	
Controlled Substances Accountability	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●		●	●	●	●	●		●	●		●
Credentialing, Privileging, and Background Investigations		●	●	●				●			●				●				●					●	●	●	●		●	●		●		●						●
Dietetics and Canteen Food Service																●	●				●	●																		
Employee Training											●						●					●																		
Environment of Care		●	●	●		●		●		●			●	●	●	●	●	●			●	●		●	●													●	
Government Purchase Cards	●	●		●	●	●		●	●		●	●	●	●	●		●			●	●		●	●	●	●	●	●	●					●		●	●	●	●	●
Homemaker/Home Health Aide Program									●		●			●			●			●		●	●							●							●			
Infection Control											●			●			●					●	●		●															●

SHADED = AREA REVIEWED AT THIS SITE
● = IMPROVEMENT NEEDED AT THIS SITE

CAP FINDINGS BY VISN AND BY MEDICAL FACILITY
APRIL 2001 THROUGH SEPTEMBER 2002

Veterans Integrated Service Networks																																																
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Information Management Security	●	●	●	●	●	●	●	●			●	●	●	●	●	●	●		●	●	●	●		●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Informed Consent for Clinical Procedures														●			●		●		●																		●										
Informed Consent for Research														●			●			●	●																												
Management of Equipment Inventories																	●				●								●								●		●										
Management of Supplies Inventories	●			●		●	●	●			●	●	●			●	●		●	●	●	●					●		●			●				●		●	●	●	●							
Means Tests and Medical Care Cost Fund Coding, Billing, and Collection	●	●	●	●	●	●	●	●			●	●	●	●	●						●		●	●	●	●	●		●		●	●	●	●			●	●	●	●	●						
Medical Record Documentation														●			●					●																										
Medical Record Privacy					●			●				●	●						●		●			●	●										●												
Pain Management	●					●	●				●		●	●	●						●		●				●		●			●		●												
Patient and Employee Safety				●									●		●		●	●	●	●		●			●		●		●	●																	
Patient Care and Quality Management						●				●	●	●	●		●		●			●	●		●			●	●			●	●			●		●	●	●								
Primary Care					●	●	●						●						●						●	●	●		●				●														
Reporting Abnormal Results of Tests and Procedures		●	●	●				●				●													●		●				●		●		●	●										
Time and Attendance of Part-Time Physicians	●	●			●	●					●		●	●		●	●		●	●					●		●		●			●				●										
Treatment of Mental Health Patients			●		●	●					●	●	●	●								●		●	●	●		●	●		●	●		●												

SHADED = AREA REVIEWED AT THIS SITE
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Summary of CAP Findings

The bullets under each of the following subjects represent recommendations and suggestions made in the 40 CAP reviews that this report summarizes.

1. Access to Care (findings at 2 of 3 medical facilities)

- Reduce excessive waiting times for outpatient ultrasound appointments.
- Reduce excessive waiting times for two primary care providers at one CBOC.
- Reduce waiting times for Eye Clinic and Podiatry Clinic appointments.

2. Accounts Receivable (findings at 13 of 24 medical facilities)

- Vigorously pursue debt collection, including debts owed by other Federal Departments and Agencies.
- Pursue delinquent debts of current and former employees.
- Document write-offs of employee accounts receivable.
- Aggressively pursue accounts receivable to collection or write-off.

3. Accrued Services Payable and Undelivered Orders (findings at 7 of 20 medical facilities)

- Improve the review of pending obligations.
- Cancel unneeded obligations.

4. Agent Cashier (findings at 15 of 22 medical facilities)

- Improve audit procedures and timeliness of audits.
- Ensure appropriate separation of duties.
- Ensure that Fiscal Service managers conduct the Fiscal Quality Review of the Agent Cashier's activities in the first quarter of each year.
- Ensure that combinations to Agent Cashier doors, alarm systems, and safes are changed annually.

- Replace the wall containing the Agent Cashier's customer window with one of solid masonry construction, and install suitable partitions in interstitial spaces to prevent up-and-over access.

- Use convenience checks only when a Government purchase card cannot be used.

- Eliminate the window between the Agent Cashier's office and an adjoining office or replace it with bulletproof glass.

5. Community-Based Outpatient Clinics (findings at 2 of 3 medical facilities)

- Ensure that the reasonableness of CBOC contract costs is independently evaluated, including obtaining adequate cost and pricing data for contracts exceeding $500,000.

- Reassign the CBOC Contracting Officer's Technical Representative (COTR) position to someone not affiliated with the contractor.

- Prepare sole source justifications and price negotiation memorandums (PNMs) when applicable.

- Ensure that adequate price analyses are performed for capitated CBOC rates and, where indicated, rates are renegotiated.

6. Contract Community Nursing Homes (findings at 13 of 20 medical facilities)

In our prior CAP summary report, dated October 10, 2001, 14 of 17 VA facilities (82 percent) reviewed had findings related to the CNH program. Our most recent results suggest that additional emphasis from VHA top management is necessary in this area to ensure that our veterans in contract facilities are receiving adequate care.

- Increase the frequency of CNH inspections.

- Strengthen oversight of CNHs.

- Follow up on correction of deficiencies found during CNH inspections.

- Ensure that CNH contract costs do not exceed the Medicare rate plus 15 percent.

- Ensure physician involvement in approvals of new and renewed CNH contracts.

- Ensure CNH patients receive annual physical examinations.

- Increase the frequency of visits by medical facility staff to patients in CNHs to, at least, every 30 days.

- Increase the frequency of visits by a registered nurse to patients in CNHs to, at least, every 60 days.

7. Contracts for Clinical Services (findings at 14 of 28 medical facilities)

In our prior CAP summary report we identified the lack of support for contract prices as a major deficiency at 6 of 14 facilities (43 percent) reviewed with clinical services contracts. This most recent report shows that the same deficiencies continue to occur. VHA's top management should re-emphasize that VA contracting staff needs to ensure that contract prices achieved are adequately supported.

- Ensure that Contracting Officers obtain cost data and/or document PNMs in contract files.

- Ensure that COTRs effectively monitor contractor performance.

- Ensure that clinical services contracts include required clauses that facilitate performance monitoring.

- Forward pending clinical services contracts to the VHA Office of Medical Sharing and Purchasing for approval.

- Adjust prices on existing contracts as necessary based on cost and pricing data obtained.

- Pursue recovery of overcharges resulting from the failure to use cost and pricing data.

- Ensure that contracting staff negotiate prices for noncompetitive contracts and prepare PNMs as required.

8. Contracts for Non-Clinical Services (findings at 11 of 16 medical facilities)

- Improve documentation of price determination and contract award decisions.

- Adequately monitor contractor performance.

- Recover past overcharges and adjust future contract prices.

- Negotiate prices for noncompetitive contracts as required by Federal Acquisition Regulations and prepare PNMs.

9. Controlled Substances Accountability (findings at 35 of 36 medical facilities)

In our prior CAP summary report we found deficiencies in controlled substances accountability at 20 of 23 facilities reviewed (87 percent). In this period, we found deficiencies at 35 of 36 facilities (97 percent) reviewed. Because of the scope, variety, and repeat nature of the deficiencies, VHA top management should improve the accounting for controlled substances as well as hold employees accountable for deficiencies found.

- Properly conduct controlled substances inspections.
- Ensure physical security weaknesses are corrected.
- Maintain complete accountability records for all Schedule II-V controlled substances.
- Follow up on any discrepancies identified during inventories or inspections.
- Develop a reliable system to account for the custody and quarterly destruction of controlled substances that conforms to VHA policy.
- Connect all doors that access the pharmacy to the security system and store the bypass key in a lockbox that requires two persons to access it.
- Store unusable and expired controlled substances in sealed containers in the pharmacy vault.
- Ensure that the Chief Narcotics Inspector follows up on assigned inspections so that they are accomplished monthly.
- Include unusable and expired controlled substances in monthly inspections.
- Develop and document a formal training program for controlled substances inspectors.
- Ensure that inspectors check expiration dates on all controlled substances.
- Complete each monthly inspection within 1-day.
- Perform inventories of all bulk stock of controlled substances at least every 72 hours.
- Reduce excessive inventories of controlled substances.

- Update controlled substances inspection and inventory verification policies and procedures to reflect current VHA policy.

- Store Schedule III controlled substances in locked steel cabinets.

- Include in monthly inspections all controlled substances maintained by the non-profit research corporation.

- Review and trend reports of monthly inspections.

10. Credentialing, Privileging, and Background Investigations (findings at 17 of 24 medical facilities)

- Ensure that new employees' fingerprints are routinely submitted to the Office of Personnel Management (OPM) to initiate background investigations no more than 14 days after the employees enter on duty.

- Ensure timely receipt of background investigation results from OPM by following up on late OPM reports.

- Monitor newly implemented policies and procedures for background investigations for continuity and effectiveness.

- Conduct background investigations in a timely manner.

- Develop a separate credentialing and privileging process for top managers who are also active practitioners, rather than having them reviewed by their own medical staffs.

- Conduct additional training for cognizant employees on initiating and processing background investigations.

11. Dietetics and Canteen Food Services (findings at 4 of 5 medical facilities)

- Include the Canteen Service as part of environmental inspections of the medical center.

- Improve supervision over food preparation and storage.

12. Employee Training (findings at 3 of 6 medical facilities)

- Provide violence prevention training.

- Improve training for pharmacy technicians.

- Improve documentation of training.

13. Environment of Care (findings at 17 of 22 medical facilities)

- Clean and sterilize the Magnetic Resonance Imaging facility.
- Provide clean and odor-free patient care and public areas.
- Improve building maintenance.
- Improve living conditions in the domiciliary.
- Ensure that the sterile products room meets the standards of the Joint Commission on the Accreditation of Healthcare Organizations and the Occupational Safety and Health Administration.
- Improve oversight of the Nursing Home Care Unit (NHCU) environment.
- Provide a privacy curtain for Nuclear Medicine Service.
- Install feminine hygiene dispensers.
- Analyze storage and space issues to eliminate working environments cluttered with equipment and supplies.
- Ensure that operating room (OR) and engineering employees meet regularly to expedite requested repairs in the OR suite.
- Ensure that environmental deficiencies identified are corrected.
- Routinely monitor and restock soap dispensers and related items.
- Periodically inspect and test ice machines to ensure safe and sanitary operation.

14. Government Purchase Cards (findings at 27 of 36 medical facilities)

In the prior CAP summary, we reported deficiencies in the use of Government purchase cards (GPCs) at all 19 facilities reviewed. In this report, we found deficiencies at 27 of 36 facilities (75 percent) reviewed. While this is an improvement over the prior period, it is unacceptable that 75 percent of facilities show the need to improve the management of purchase cards. Because of the scope, variety, and repeat nature of the deficiencies, VHA's top management should reemphasize the need for accountability in the Government purchase card program.

- Ensure that acquisition personnel, including purchase cardholders, use the designated Federal Supply Schedule before making open market purchases.

- Ensure that purchase cardholders do not avoid single purchase limits and competitive procurement requirements by "purchase splitting."[1]
- Ensure that purchase cardholders and approving officials reconcile and certify invoices timely.
- Ensure that program coordinators are not also designated as approving officials.
- Provide purchase cardholders and approving officials adequate, documented training and/or appropriate warrants.
- Conduct monthly and/or quarterly required audits of purchase card transactions.
- Ensure that only VA employees are authorized to use GPCs.
- Do not use GPCs to purchase telecommunications services.
- Appoint a separate dispute officer and a separate billing official.
- Ensure that interim warrants are properly granted and used.
- Ensure that the program coordinator trends the results of monthly audits to identify deficiencies.
- Provide appropriate warrants to purchase cardholders with purchase limits in excess of $2,500.

15. Homemaker/Home Health Aide Program (findings at 9 of 12 medical facilities)

- Document that interdisciplinary assessments are completed for all patients referred to the program.
- Obtain and review quarterly performance improvement and patient assessment reports to evaluate the quality of care and need for continued service.
- Reconcile all bills and notify the program coordinator of discrepancies between services authorized and services actually provided.
- Establish a Homemaker/Home Health Aide Program oversight function.
- Support all provider rates with cost data.

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

- Discuss quality of care issues at quarterly oversight committee meetings.

16. Infection Control (findings at 7 of 8 medical facilities)

- Improve infection control and safety in Supply Processing and Distribution (SPD).
- Improve patient care decisions by trending infection control data.
- Offer flu and pneumonia vaccinations to all NHCU patients on admission.
- Conduct adequate pre-admission infection control screenings.
- Insure deficiencies noted in SPD are corrected and air-handling equipment is clean and working properly.
- Ensure that infection control data is current and used to identify performance improvement opportunities.

17. Information Management Security (findings at 35 of 37 medical facilities)

- Comply with VA information management security policies, procedures, and guidelines to ensure adequate protection of electronic data and data center operations.
- Correct the vulnerabilities that occurred in the four general security risk areas: access controls, security management, segregation of duties, and service continuity.
- Prepare an overall facility information technology security plan.
- Require that each personal computer system is password protected and can only be booted from the hard drive.
- Ensure that contingency plans are developed to address all critical systems' needs.
- Ensure that major information systems are certified and accredited.
- Appoint a full-time Information Security Officer (ISO) who reports to the Director or Associate Director.
- Monitor access to computer-based employee-patients' records.

- Periodically review authorized users to determine if they still have a legitimate need for access.
- Direct Information Resources Management Service (IRMS) staff to perform a risk assessment to identify current vulnerabilities.
- Remind all employees to log off computers when leaving their workstations.
- Require IRMS employees to back up server configurations on a computer at the back-up facility.
- Require the Chief, IRMS to install warning banner software on all computers.
- Identify IRMS day-to-day duties that are incompatible with the ISO function.
- Ensure that contingency plans for all major computer systems are developed, as well as security plans for the local area network and phone board exchange.
- Develop and implement a policy on automated information systems security and incident reporting.
- Ensure that sensitivity levels are accurately assigned and required security clearances are obtained timely.

18. Informed Consent for Clinical Procedures (findings at 5 of 8 medical facilities)

- Document all required elements of informed consent.
- Document informed consent for all interventional radiology and surgery procedures.

19. Informed Consent for Research (findings at 4 of 7 medical facilities)

- Adequately document the patient's informed consent.
- Maintain appropriate records of research projects, identifying all patients involved.
- File all original consent forms in patient medical records.

20. Management of Equipment Inventories (findings at 5 of 12 medical facilities)

- Validate and update equipment inventory lists annually.
- Conduct equipment inventories.
- Improve accountability for research equipment.

21. Management of Supplies Inventories (findings at 22 of 26 medical facilities)

In our previous CAP summary report we reported that 19 of 22 facilities (86 percent) reviewed had findings in this area. Despite that and the publication of a national audit report identifying the need for substantial improvement in this area, we continue to find deficiencies at almost the same rate (85 percent). Because of the scope, variety, and repeat nature of the deficiencies, VHA top management should re-emphasize the use of the Generic Inventory Package (GIP) for inventory control.

- Aggressively manage the supply inventory to improve accuracy and reduce stock.
- Improve accuracy and update GIP data.
- Eliminate stock in excess of a 30-day supply.
- Conduct a wall-to-wall physical inventory and reconcile results with GIP records.
- Separate inventory ordering, receiving, and accounting duties.
- Implement GIP in SPD.
- Ensure that Radiology Service establishes inventory controls and accurate inventory records.
- Ensure that GIP, bar-coding equipment, and prime vendors are all utilized to consistently maintain 30-day stocks of medical supplies.
- Make use of the prime vendor's inventory software for the pharmacy.

22. Means Tests and Medical Care Cost Fund Coding, Billing, and Collection (findings at 28 of 34 medical facilities)

- Ensure that the veterans' insurance companies are identified at the time of treatment and billed promptly.
- Investigate cases in which the veterans did not sign co-payment agreements, and take corrective action to prevent future occurrences.
- Ensure that all medical center and CBOC staff receive annual training emphasizing the importance of obtaining completed and signed means test certifications.
- Ensure that insurance information is verified timely and updated periodically.
- Conduct means tests for all applicants.
- Access the Benefits Delivery Network to ensure that the most current compensation and pension award information is available for billing purposes.
- Improve medical billing coding accuracy.
- Ensure coding accuracy by requiring supervisors to review representative samples of cases processed by the coding agency.
- Conduct required training for coders and health care providers to ensure compliance with coding and documentation standards.
- Fully staff the coding unit.
- Devote adequate staffing to eliminate backlogs.
- Train and improve coder validation skills.
- Improve provider documentation.
- Improve billing timeliness and follow up with insurers.
- Validate and bill backlogged cases.
- Aggressively pursue outstanding bills.
- Require MCCF staff to follow up with third-party payers after the release of the initial claims.
- Require that only the Agent Cashier receive all third-party payments.

- Follow up on identified inappropriate billings and either cancel the billings or refund inappropriate collections to the veterans.

23. Medical Record Documentation (findings at 3 of 4 medical facilities)

- Include an appropriate clinically assessed and documented preventive index in charts.
- Ensure adequacy of patients' primary care records.

24. Medical Record Privacy (findings at 9 of 13 medical facilities)

- Put written procedures in place for breaches of medical record privacy.
- Make employees aware of the VISN security incident reporting policy.
- Provide shredders for patient care areas with computers and printers.
- Develop appropriate policies to ensure that confidential patient information is not placed at risk of disclosure.
- Issue reminders and increase employee training efforts to ensure patient information is protected from unauthorized view or access.
- Transport medical records in locked containers.
- Allow medical records to be transported only by persons trained to maintain the privacy and security of the records.
- Train staff to not leave sensitive information displayed on computer screens.
- Prevent unauthorized access to facility data systems (e.g., patient medical records).
- Secure computer workstations and patient records throughout the medical center.
- Provide employees with annual information security awareness training, including the subject of auditory privacy.

25. Pain Management (findings at 13 of 14 medical facilities)

- Justify long-term use of controlled substances in patient treatment plans.
- Develop a policy on pain management.

- Provide pain management training to employees, patients, and families.
- Improve implementation of the Pain as the 5th Vital Sign initiative.
- Include in the new pain management policy: new employee education on pain management and Pain as the 5th Vital Sign, as well as performance improvement monitoring of specific pain management procedures and outcomes.

26. Patient and Employee Safety (findings at 12 of 14 medical facilities)

- Improve evaluations of serious patient incidents.
- Require pharmacists to approve complex prescriptions filled by technicians.
- Encourage staff to report medical errors.
- Review use of restraints and improve documentation of restraint use.
- Review and improve employee safety in response to concerns about safety when traveling to and leaving work.
- Ensure that psychiatry unit security procedures are followed and tested.
- Ensure that all doors to research space are kept locked and a key card system is installed.
- Conduct a facility-wide vulnerability assessment to evaluate the adequacy of security.
- Post a police officer and/or evaluate the need for video surveillance at the domiciliary.

27. Patient Care and Quality Management (findings at 19 of 35 medical facilities)

- Include reviews of CBOCs in the QM program.
- Monitor safety and quality control.
- Review the quality of care and cost effectiveness of the surgery program.
- Utilize QM and Quality Review data for patient care improvement.
- Perform better follow-up on recommendations from boards of investigations and improve documentation of resolution and follow-up of QM reviews.

- Have the Dysphagia Team improve the dysphagia monitor, conduct timely data collection, and report results to involved clinical employees.
- Ensure that speech pathology resources are allocated to the care and follow-up of dysphagic patients.
- Establish a QM program to ensure that veterans treated at CBOCs receive the same quality of care available at the parent facility.
- Ensure that clinical staff complies with all elements of Preventive Medicine and Clinical Practice Guidelines.
- Appropriately analyze and use QM data to improve the quality of patient care.
- Ensure that administrative investigation and root-cause analysis recommendations are implemented and tracked until all issues are resolved.
- Monitor all significant QM action items to resolution, and analyze mortality data for trends.

28. Primary Care (findings at 10 of 22 medical facilities)

- Fill physician vacancies.
- Schedule all appointments within 7 days.
- Ensure that initial appointments occur within 30 days.
- Reduce waiting time for prescriptions.

29. Reporting Abnormal Results of Tests and Procedures (findings at 13 of 15 medical facilities)

- Incorporate anatomical pathology results into the View Alert (a prompt in the Computerized Patient Record System) to alert physicians to immediately review test results.
- Document communications to treating physicians of abnormal anatomic pathology findings.
- Document Imaging Service employees' communication of abnormal findings to physicians.
- Document in medical records when providers are notified of abnormal test results.

- Implement uniform procedures for notifying patients of both normal and critical test results.
- Ensure timely notification of providers when radiology results are critical.
- Complete written guidelines for reporting radiology test results to both providers and patients, and train involved staff on these guidelines.
- Ensure that critical test results are reported to providers in a way that is useful for making clinical decisions.

30. Time and Attendance of Part-Time Physicians (findings at 17 of 27 medical facilities)

- Ensure that physicians are present at the medical center during their tours of duty.
- Ensure that Surgical Service timekeepers verify physicians' attendance.
- Provide required training to all timekeepers.
- Adjust part-time surgeons' hours of work consistent with their workload levels.
- Grant physicians excused absences only when VA criteria are met.
- Train all physicians and their supervisors on VA time and attendance policies.

31. Treatment of Mental Health Patients (findings at 17 of 32 medical facilities)

- Examine patients or review their charts before prescribing narcotics.
- Update treatment plans for patients on controlled substances.
- Ensure that patient problem lists are accurate and updated routinely, and that medical diagnoses are coded correctly.
- Ensure that patients with medical concerns can schedule appointments with their primary care physicians within 7 days.

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