Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Boise, Idaho

Report No. 02–02582–36 **December 20, 2002**

VA Office of Inspector General
Washington, DC 20420

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 agency 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 week of August 26–30, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Boise, ID, which is part of Veterans Integrated Service Network (VISN) 20. The purpose of the review was to evaluate selected medical center 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 40 VAMC employees.

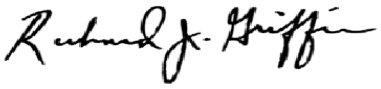
Results of Review

VAMC Boise patient care and QM activities were generally operating satisfactorily. VAMC 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 and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the VAMC needed to:

- Reduce excess medical and prosthetics supply inventories and provide training on prosthetics supply inventory management.
- Properly account for expired controlled substances.
- Improve Fiscal Service controls over accounts receivable, undelivered orders, and General Post Fund (GPF) accounts.
- Add required information to the information technology (IT) contingency plan and request background investigations for IT security clearances.
- Discontinue the practice of allowing pharmaceutical vendors to provide meals for resident physicians.
- Follow up on exceptions identified in QM reviews and analyze mortality data.
- Strengthen oversight of the Homemaker/Home Health Aide (H/HHA) Program.

VISN 20 Director Comments

The VISN 20 Director agreed with the CAP review findings and provided acceptable implementation plans. (See Appendix B, pages 13-20, for the full text of the VISN Director's comments.) We will follow up on the implementation of recommended improvement actions.



RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. VAMC Boise is an acute care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at a community-based outpatient clinic in Twin Falls, ID. The VAMC is part of VISN 20 and serves a veteran population of about 70,000 in a primary service area that includes 23 counties in Idaho and 4 counties in eastern Oregon.

Programs. The VAMC provides acute medical, surgical, and psychiatric inpatient services and has a total of 55 acute care beds. Programs include primary and specialty care, ambulatory surgery, and women's health. The VAMC also has 32 extended care beds.

Affiliations and Research. The VAMC is affiliated with the University of Washington School of Medicine and supports 24 residents in 4 medical specialties. Other affiliations include the Idaho State University College of Pharmacy and the Boise State University School of Nursing. In Fiscal Year (FY) 2002, the VAMC research program had 9 projects and a budget of $797,000.

Resources. In FY 2002, the VAMC's budget was $67.3 million, a 2 percent decrease from the FY 2001 budget of $68.7 million. Staffing through July 2002 was 372 full-time equivalent employees (FTEE), including 35 physician and 128 nursing FTEE. FY 2001 staffing was 374 FTEE, including 35 physician and 127 nursing FTEE.

Workload. In FY 2001, the VAMC treated 14,461 unique patients, a 12 percent increase from FY 2000. The FY 2001 average daily census (ADC) was 40 inpatients and 20 nursing home patients. In FY 2002 through June, the ADC was 44 inpatients and 24 nursing home patients. Outpatient workload totaled 139,843 visits in FY 2001, and the projected FY 2002 outpatient workload was 146,608 visits, a 5 percent increase.

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 system 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 of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. 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, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 25 activities:

- Accounts Receivable
- Acute Medical and Surgical Care Units
- Agent Cashier
- Behavioral Health
- Clinical Service and Nursing Home Contracts
- Controlled Substances Inspections
- Enhanced Use Leases
- Environment of Care
- Fee Basis Program
- General Post Fund Accounts
- Government Purchase Card Program
- Homemaker/Home Health Aide Program
- Information Technology Security
- Long-Term Care
- Medical and Prosthetic Supplies
- Medical Care Cost Fund
- Part-Time Physician Time and Attendance
- Patient Waiting Lists
- Pharmacy Security
- Physician Credentialing and Privileging
- Physician Productivity
- Primary Care Clinics
- Quality Management
- Unliquidated Obligations
- Vendor Gratuities for Employees

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

During the review, we also presented four fraud and integrity awareness briefings for VAMC employees. Forty 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.

The review covered VAMC operations for FYs 2000, 2001, and 2002 through August 2002 and was conducted 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 VISN and VAMC management until corrective actions are completed.

Results of Review

Organizational Strengths

Agent Cashier Operations Were Sound. All agent cashier funds were properly accounted for. Physical security was adequate, employee duties were appropriately separated, agent cashier duties were transferred annually as required, and agent cashier audits were properly conducted.

Fee Basis Care Internal Controls Were Effective. VAMC staff had established reasonable fee basis prices using Medicare or negotiated rates. Vendor performance was closely monitored, and VAMC staff verified that services paid for had been received.

Contract Prices Were Supported. The prices paid for contracted clinical services and nursing home care were properly based on competitive bids and Medicare rates. VAMC staff complied with VA policy for contract administration and properly documented negotiations in Price Negotiation Memorandums.

Physician Credentialing and Privileging Was Current and Complete. QM staff had established credentialing and privileging files for each VAMC physician. All information in the files was current and complete, and staff ensured that physicians updated information as required.

Government Purchase Cards Were Effectively Managed. VAMC staff complied with VA policy on the use of Government purchase cards. Approving officials and cardholders performed approvals and reconciliations on time, and purchases were appropriate.

Physician Productivity Was High. Clinical management monitored physician productivity and documented high levels of productivity for physician staff. All staff physicians had patient care workloads that met or exceeded Veterans Health Administration (VHA) guidelines.

The Environment of Care Was Effectively Maintained. The VAMC had attractive grounds and well maintained buildings. Historic structures were well preserved and efficiently utilized. Patient care and public areas were clean, well organized, and in good repair. Hallways were clean and uncluttered. Signs posted throughout the facility provided good directions to patient care and administrative areas. All patients interviewed told us that the facility was always clean and pleasant.

Opportunities for Improvement

Supply Inventory Management – Medical and Prosthetics Supply Inventories Should Be Reduced

Conditions Needing Improvement. The VAMC needed to reduce inventories of medical and prosthetics supplies. VHA policy states that VAMCs should maintain inventories at levels that will meet current operating needs. Inventories above those levels should be avoided so funds are not tied up in excess inventory. Inventory levels for medical and prosthetics supplies should not exceed a 30-day supply.

Automated Controls Not Fully Used to Manage Medical Supply Inventories. VAMCs are required to use VA's automated Generic Inventory Package (GIP) to manage medical supply inventories. We inventoried 10 medical supply items (value = $16,255), and our physical count matched GIP inventory records for 9 items. However, all 10 items had inventory levels greater than a 30-day supply. GIP records showed several years of supply for 2 of the 10 items, and the average supply level for the other 8 items was 465 days. Of the 736 medical supply items in inventory, 607 (82 percent) had more than a 30-day supply. The value of inventory in excess of a 30-day supply was $144,065. This problem occurred because Acquisition and Materiel Management Service maintained a "cushion" of inventory in excess of 30 days instead of fully using GIP to effectively manage inventory levels.

Training Needed for Better Prosthetics Supply Inventory Management. VAMCs are required to use VA's automated Prosthetics Inventory Package (PIP) to manage prosthetics supply inventories. However, while Prosthetic and Sensory Aid (P&SA) Service staff were correctly entering transaction data into PIP, they did not know how to use PIP to generate inventory control reports. For example, they were not able to identify inventory levels or the value of inventory on hand. We performed a physical count of 15 items, compared the counts with PIP inventory records, and found that the PIP inventory records were inaccurate for 5 of the 15 items. When we asked P&SA Service staff to provide the amount and value of inventory on hand, they were unable to do so.

Because VAMC staff could not provide inventory data, we contacted officials in P&SA Service in VA Central Office (VACO). They stated that while VAMC staff apparently did not know how to extract inventory reports from PIP, they were correctly entering transactions into the PIP national database. As of July 31, 2002, the database showed that the VAMC had 1,230 prosthetics items with more than a 30-day supply. The total value of the excess inventory was $12,370. The VACO officials agreed that the VAMC staff needed to learn how to generate PIP inventory control reports and then use the information in these reports to reduce stock.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director takes action to: (a) reduce excess medical and prosthetics supply inventories, (b) obtain training for P&SA Service staff in the use of PIP, and (c) require an inventory of prosthetics stock to establish inventory levels and value. The VISN Director agreed and reported that as of November 2002 VAMC materiel management staff were working toward the goal of having 30 days or less of stock on hand. Stock levels and reorder points have been

reviewed and adjusted when needed. Staff will be reviewing long supply listings and making excess supplies available to other medical centers. In addition, the VAMC will continue working with the VISN to determine the feasibility of buying smaller quantities from larger medical centers in the VISN. Prosthetics staff have received additional PIP system training, which has provided the knowledge base necessary to effectively use PIP in managing the prosthetics inventory. The improvement actions are acceptable, and we follow up on the completion of planned actions.

Controlled Substances Accountability – Inspection Procedures Should Be Strengthened and Credits Obtained for Returned Drugs

Conditions Needing Improvement. The VAMC needed to address weaknesses in accounting for expired controlled substances, reporting the results of controlled substances inspections, and obtaining credits for controlled substances returned to the distributor. VHA policy requires that expired controlled substances be accounted for and that staff document disposition or destruction of these drugs. Policy also requires that controlled substances inspectors be adequately trained and that the inspection process be independent of Pharmacy Service. We identified three deficiencies that required corrective action.

Expired Controlled Substances Not Accounted For. We requested and observed an unannounced controlled substances inspection. During the inspection, we noted that controlled substances inspectors did not inventory drugs that were awaiting disposal and did not instruct Pharmacy Service staff to remove expired controlled substances from inventory. In the inpatient and outpatient pharmacy vaults we found 16 bottles of various controlled substances (740 pills and capsules) that were not recorded in pharmacy inventory documents. According to Pharmacy Service staff, these drugs had probably been returned from wards and were intended for shipment to a vendor for destruction. They did not know why the drugs had been stored in the vaults but stated that some could have been there for as long as 2 years. Because these drugs were not shown on pharmacy inventory records and had not been disposed of, they could have been diverted without any chance of detection. This problem occurred largely because the inspectors did not know they were required to account for all controlled substances, including those awaiting disposal.

Independently Prepared Inspection Reports Needed. Controlled substances inspectors did not prepare inspection reports and did not attest to the accuracy of completed reports. Instead, they gave their inspection results to Pharmacy Service staff who prepared the reports. This practice could have allowed Pharmacy Service staff to hide discrepancies or systemic problems, even when inspectors had identified them. To ensure that inspection results are independently assessed and reported, VAMC management should appoint a Narcotics Inspection Coordinator who is not connected with Pharmacy Service.

Controlled Substances Return Credits Not Obtained. When a VAMC returns certain drugs that are no longer needed to the pharmaceutical prime vendor, the VAMC receives credits to be applied against future purchases. From October 2001 to July 2002, Pharmacy Service returned drugs with credit values totaling $19,921 without obtaining these credits from the prime vendor.

After we told Pharmacy Service and Fiscal Service management about this problem, they contacted the prime vendor and obtained the $19,921 in credits.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director takes action to: (a) account for controlled substances awaiting disposal, (b) train controlled substances inspectors on inspection procedures, (c) make the inspection process independent of Pharmacy Service, and (d) obtain credits for returned drugs to future purchases.

The VISN Director agreed and reported that as of November 2002 Pharmacy Service has developed policy and procedures for accounting for controlled substances awaiting disposal. Controlled substances inspectors have been instructed to include controlled substances awaiting disposal in their inspections. Controlled substances inspection procedures have been revised to ensure independence from Pharmacy Service by improving inspector training, making the inspection coordinator responsible for preparing inspection reports, and requiring inspectors to help prepare and attest to the accuracy of inspection reports. In addition, credits owed to the VAMC for drugs returned to the vendor have been collected, and logs have been established to better track the status of credits. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Fiscal Service – Controls over Accounts Receivable, Undelivered Orders, and General Post Funds Should Be Improved

Conditions Needing Improvement. Fiscal Service staff needed to aggressively pursue accounts receivable, promptly cancel unneeded obligations, and carefully monitor GPF accounts.

Stronger Debt Collection Efforts Needed. VA policy requires that accounts receivable be aggressively pursued to collection. The first demand letter should be sent as soon as the debt is identified. If the debtor does not respond, second and third demand letters should be sent at 30-day intervals. If no response has been received after 90 days (30 days after the last letter), VAMC staff should consider referring the debt to private collection agencies, the VA Regional Counsel, or the Department of Justice for enforced collection. For accounts receivables owed by other Federal agencies, VAMC staff should send a fourth demand letter to the delinquent agency's Chief Financial Officer if no payment is received after the third notice.

As of August 2002, the VAMC had 55 accounts receivable valued at $212,666, of which 28 (51 percent) were more than 90 days old (value = $20,330). Of the 28 delinquent debts, 7 (value = $16,314) were owed by the Department of Defense (DoD) and 15 (value = $3,292) were owed by current VAMC employees. These 22 debts totaling $19,606 were highly collectible. The remaining six debts (value = $724) were owed by ex-employees or small businesses and were less collectible. Fiscal Service staff should aggressively pursue the 22 highly collectible debts by contacting the appropriate DoD financial officials and VAMC employees and arranging payment. If the other six debts cannot be collected, they should be properly written off.

Unneeded Obligations Not Canceled. To make the funds available for other VAMC needs, Fiscal Service staff needed to promptly review and cancel obligations for delinquent undelivered

orders. As of August 6, 2002, the VAMC had 53 current-year undelivered orders (value = $38,124) that were more than 90 days old. This occurred because Fiscal Service staff had not established controls to ensure that undelivered orders were reviewed monthly to identify and cancel obligations that were no longer needed.

Stronger GPF Account Administration Needed. VA facilities may accept donations from individuals, corporations, and other institutions for VA-approved patient activities, research, and other approved purposes. VAMCs should require prospective donors to provide letters specifying how donations are to be used. The VAMC Director or his designee should review proposed donations to ensure that they are appropriate and can be properly accepted. Fiscal Service staff should monitor GPF accounts to ensure that funds are properly accounted for and that expenditures are for the intended purposes. We reviewed the VAMC's 38 GPF accounts (value = $199,637) and identified 3 deficiencies that required corrective action:

- VAMC staff did not always obtain donation letters. Of the 38 GPF accounts, 3 did not have donation letters accompanying the initial donation to the account.

- VAMC management had not appointed fund control point officials to monitor deposits and expenditures for any of the 38 GPF accounts. A responsible official should be appointed for each GPF account (or for a group of similar accounts, depending on the level of account activity). For example, the Chief of Voluntary Service could be appointed as the control point official for GPF accounts relating to patient recreation activities.

- GPF account activity was not always documented. For example, the purpose of an $87,300 expenditure from one GPF account was not documented in account records. Fiscal Service staff were ultimately able to explain the expenditure. However, documentation of this expenditure should have been maintained with other documentation pertaining to this account.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director implements controls to: (a) aggressively pursue accounts receivable, (b) write off accounts receivable that cannot be collected, (c) promptly cancel obligations for delinquent undelivered orders, and (d) strengthen GPF account administration.

The VISN Director agreed and reported that as of November 2002 a process has been implemented to ensure that the collection status for employee accounts receivable is documented and reviewed monthly. Repayment plans will be established as appropriate. The VAMC has reported the DoD accounts receivable to VACO as problem debts, and discussions have been held with DoD. The VAMC anticipates resolving the DoD debts by January 1, 2003. All debts more than 90 days old will be reviewed and will be written off as appropriate. In addition, obligations for undelivered orders will be reconciled and adjusted monthly. For new GPF donations, donor letters, Director approvals, and control point official delegations of authority will be maintained in permanent GPF account files. The implementation actions are acceptable, and we consider the issues resolved.

Information Technology Security – The Contingency Plan Should Be Complete and Background Investigations Requested

Conditions Needing Improvement. We reviewed IT security controls to determine if they were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that Information Management Service (IMS) staff had conducted risk assessments, implemented virus detection procedures, and provided initial and refresher security awareness training to all employees. However, we identified two IT security and accountability deficiencies that needed corrective action.

Contingency Plan Not Complete. The IT contingency plan did not include all required information. VHA policy requires facilities to develop and implement IT contingency plans. These plans should be designed to reduce the impact of disruptions in services, provide critical interim processing support, and resume normal operations as soon as possible. IT security plans should include detailed technical information about each IT system, system security requirements, and staff to be contacted in an emergency. The VAMC contingency plan was incomplete because it did not identify and prioritize critical IT functions that would need attention during an emergency and did not include the names, phone numbers, or pager numbers of staff to be contacted in an emergency. Because of these deficiencies in the contingency plan, timely and appropriate action might not be taken during an emergency and data could be lost or damaged.

Background Investigations Needed. Staff with access to VA data did not have the required background investigations. VHA policy requires that the VAMC request Office of Personnel Management background investigations on all individuals with programmer or systems access to VA data. We reviewed the personnel files for 10 employees with system or programmer access to determine if Human Resources Management Service (HRMS) had requested background investigations as required. Investigations had not been requested for 9 of the 10 employees. This problem occurred because IMS had assigned access sensitivity levels that were too low for the levels of clearance granted. IMS had designated the sensitivity level for these nine employees as non-sensitive or moderate when the correct level was critical-sensitive. If IMS had assigned the correct sensitivity level in these instances, HRMS would have known to request the background investigations.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VAMC Director: (a) amends the IT contingency plan to identify and prioritize critical functions and include contact information on emergency personnel and (b) directs IMS to assign correct sensitivity levels when granting security clearances. The VISN Director agreed and reported that as of November 2002 the VAMC has assigned staff to prepare the necessary additions to the IT contingency plan. Revised access sensitivity level designations have been forwarded to HRMS, and the background investigations have been initiated. The implementation actions are acceptable, and we consider the issues resolved.

Vendor Gratuities – Vendor-Provided Meals for Resident Physicians Should Be Discontinued

Conditions Needing Improvement. About 25 physicians, mostly residents, met 3 times a week during lunch hour for presentations on medical topics. Pharmaceutical company representatives usually provided lunch, although they took no part in the presentations. This practice would have been acceptable on an occasional or infrequent basis, but because the meals were provided regularly and because the vendors either were conducting, or had expectations of conducting, business with the VAMC there was an appearance of impropriety.

Because the meals were provided three times a week, the aggregate value exceeded dollar limitations on the value of gifts that a Government employee may accept in a year. Government ethics regulations state that employees occasionally may accept unsolicited gifts provided that the value of the gifts for any one person does not exceed $50 in a calendar year. VAMC staff estimated the value of the meals at $5 each, or $15 per week. In a year, a physician could conceivably receive about $650 in free meals. Because of the appearance of impropriety and the potential for violating Government ethics regulations, VAMC management should end the practice of allowing vendors to routinely provide free meals for resident physicians.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director discontinues routine vendor-provided meals for resident physicians. The VISN Director agreed and reported that the issue has been discussed with senior VISN officials and that the VISN will develop a policy that is consistent with Government ethics regulations by April 2003. The implementation actions are acceptable, and we consider the issues resolved.

Quality Management – QM Exceptions Should Be Followed Up and Mortality Data Analyzed

Conditions Needing Improvement. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files. We concluded that the QM program was comprehensive and provided appropriate oversight of patient care. However, as discussed below, managers did not consistently present data, state specific actions, or follow through on identified action items, and mortality data were not analyzed to identify trends or patterns.

Action Items Not Consistently Identified and Tracked to Resolution. VAMC managers did not consistently follow up on items identified in quality reviews, such as utilization management. For example, the rate of admission appropriateness did not meet the VHA goal, but responsible VAMC managers had not discussed this exception and had not developed a plan to improve the VAMC's performance. The results of quality reviews need to be addressed with appropriate action items that are assigned to specific managers and tracked to resolution.

In addition, medication usage activities were not consistently presented to the Pharmacy and Therapeutics (P&T) Committee. The Medication Usage Evaluation (MUE) Committee, a subcommittee of the P&T Committee, did not report regularly to the P&T Committee, nor were the MUE Committee minutes attached to the P&T Committee minutes. The Quality Manager agreed that improvement was needed and reported that VAMC management had been considering a committee reorganization that would address the deficiencies found by our review.

Mortality Data Analyses Needed. Although QM staff were reviewing mortality data, they were not thoroughly analyzing patient deaths to determine if there were patterns or trends related to specific locations, providers, or times of day. The Quality Manager was not aware of this requirement, and agreed to implement procedures for performing the analyses.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VAMC Director takes action to: (a) identify and monitor QM action items to resolution and (b) analyze mortality data. The VISN Director agreed and reported that as of November 2002 QM reporting requirements have been revised to clearly identify issues needing improvement, action officials, actions taken, and follow-up. In October 2002, the P&T Committee made the medication usage committee report a standing agenda item, and the reports will be attached to P&T Committee minutes. In addition, a project was initiated to define mortality data elements and the responsibilities for data collection, stratification, and analysis. The results of the first quarterly mortality data analysis will be reported to the Medical Executive Committee in January 2003. The implementation actions are acceptable, and we consider the issues resolved.

Homemaker/Home Health Aide Program – Clinical and Administrative Oversight Should Be Improved

Conditions Needing Improvement. VAMC management needed to improve clinical and administrative oversight of the H/HHA program. VHA has made long-term care an important element of its effort to provide comprehensive care for VA patients. Congress reinforced the importance of long-term care in the Veterans Millennium Health Care Act (Public Law 106-117, Section 101). VHA's policy is to develop an innovative, flexible approach to provide home and community-based care that is fully integrated into the VA healthcare system and uses resources efficiently and effectively to meet the needs of an aging and chronically ill patient population. As part of this policy, VHA medical facilities are required to implement the H/HHA and several other non-institutionally based programs to provide long-term care.

The H/HHA program allows VHA medical facilities to contract with private providers for home health care and other in-home assistance for eligible beneficiaries. VHA medical facilities are required to coordinate and review the appropriateness of home care referrals, determine the most appropriate in-home services for individual patients, and monitor costs. In FY 2001, the VAMC authorized $188,465 for H/HHA services. As of August 2002, the VAMC used 3 community health agencies (CHAs) to provide H/HHA services for 55 patients. To assess H/HHA program processes and controls, we reviewed medical records for 10 patients and interviewed program officials and 5 patients. The following three areas needed improvement:

Stronger Program Oversight Needed. The VAMC did not have an H/HHA policy or an interdisciplinary steering committee to oversee program operations, workload, fund management, and quality of care.

Patient Assessments Not Properly Documented. An initial interdisciplinary assessment reflecting the clinical need and administrative eligibility for H/HHA services should be documented in the patient's medical record. Five of the 10 medical records reviewed did not have this documentation.

Better Evaluation of H/HHA Services Needed. In making assessments of patients' needs for continued care, H/HHA staff did not document that they had used CHA performance improvement (PI) data and quarterly patient assessments. Program officials stated that CHAs submitted patient assessments and PI data every 60 days. However, this information was not documented in any of the 10 medical records.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director: (a) establishes an H/HHA policy and a steering committee to oversee program operations, (b) requires staff to document interdisciplinary assessments for all H/HHA patients, and (c) directs staff to review CHA PI data and patient assessments quarterly. The VISN Director agreed and reported that as of November 2002 an H/HHA policy has been drafted and that the Extended Care Council has been designated to oversee the H/HHA program. Quarterly reports on H/HHA activities will be presented to the committee beginning in January 2003. New procedures are being developed to require complete patient assessments and other required H/HHA documentation. CHA patient assessments will be reviewed quarterly and documented in patient medical records. As of January 2003, CHA PI data will be reviewed quarterly and the results reported to the Extended Care Council. The implementation actions are acceptable, and we consider the issues to be resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center Boise, Idaho

Report Number: 02-02582-36

Recommendation	Explanation of Benefit	Better Use of Funds
1a	Better use of funds by reducing excess medical and prosthetics supply inventories.	$156,435
2d	Better use of funds by obtaining credits for unused drugs.	19,921
N/A	Better use of funds by collecting delinquent accounts receivable.	19,606
	Total	$195,962

Appendix B

VISN 20 Director Comments

Department of Veterans Affairs

Memorandum

Date: November 4, 2002

From: Northwest Network Director, VISN 20 (10N20)

Subj: Response to OIG CAP Recommendations – Boise VAMC (Project No. 2002-02582-R4-0145)

To: Assistant Inspector General for Auditing (52)
THRU: Director, Boise VAMC (531)

1. VISN 20 staff and management and staff at the Boise VA Medical Center have reviewed the recommendations from the recent OIG CAP inspection for Boise. Responses to each of the recommendations are attached for your review.

2. Please refer questions regarding responses to Grant Ragsdale, Administrative Assistant, Boise VAMC, at (208) 422-1303.

/ S /
Leslie M. Burger, MD, FACP

Attachment

Appendix B

Supply Inventory Management – Medical and Prosthetics Supply Inventories Should be Reduced

Recommendation	Concurrence	Implementation Plan / Explanation
Supply Inventory Management – Medical Supply Inventories Should Be Reduced	Concur	A&MMS concurs 1. It is correct that as of the date sample was taken we did have stock above 30 days on hand. Our average level has been consistently 34.5 days of stock on hand. As we continue to work towards the goal of average stock on hand of less than 30 days our Materiel mgmt section will review stock levels and reorder points and make adjustments were necessary to bring them in line with a lower stock level. 2. Also the Supply Tech will review long supply lists and excess long supply to other stations. 3. This station will continue to work with the VISN to develop a method where we can buy smaller quantities from larger stations in our VISN. 4. We will continue to use the GIP automated inventory system to replenish and fill orders and look for ways to improve on the system that we are presently using. Our goal is to get to the 30 days or less stock on hand and still maintain levels that will support the Medical Center.

Obtain training for P&SA Service staff in the use of PIP	Concur	Staff have pursued and received additional PIP training following the IG visit. **Completed 10/02**
Require an inventory of prosthetics stock to establish inventory levels and value.	Concur	Staff have pursued and received additional PIP training following the IG visit. The training has provided knowledgebase necessary to complete IG recommendations. **Completed 10/02**

Controlled Substances Accountability – Inspection Procedures Should Be Strengthened and Credits Obtained for Returned Drugs

Recommendation	Concurrence	Implementation Plan
Account for controlled substances awaiting disposal	Concur	Controlled Substance Inspectors have been instructed to inventory controlled substances awaiting disposal and to advise Pharmacy Service staff to remove expired narcotics from inventory. Pharmacy Services has developed a policy and procedure for accounting for controlled substances returned for destruction. Substances are now logged into the computer drug accountability program for destruction, witnessed, assigned a log number, bagged and sealed. Staff have been re-educated on the policy and procedure and the log of controlled substances returned for destruction will be made available to the narcotic inspectors at the time of inspection. – **Completed 10/02**
Train Controlled substance inspectors on inspection procedures	Concur	The controlled substance inspection process has been revised enhance inspector training and to require inspectors to participate in preparation of reports of inspection and attest to their accuracy. **Completed 10/02**
Make the inspection process independent of Pharmacy Service	Concur	The Narcotics inspection coordinator, the secretary to the Chief of Staff will receive the reports of inspection, prepare the report for the Chief of Staff and Director's signature and retain all inspection report copies. **Completed 10/02**

Obtain credits for returned drugs to future purchases	Concur	The process of obtaining credits for returns through the Prime Vendor from October 2001, to July 2002 was occurring and continues to occur. Pharmacy did establish that the $19921 in credits had been received and this information has been communicated to the IG team. Pharmacy Service has developed a log of credits to provide for more accurate tracking of the status of credits and to insure that all credits are properly obtained. **Completed 10/02**

Fiscal Service – Controls on Accounts Receivable, Undelivered Orders, and General Post Funds Should be Improved

Recommendation	Concurrence	Implementation Plan
Aggressively pursue accounts receivable	Concur	The majority of the debts for current employees are health insurance payment liability incurred while the employee has been on LWOP status. A process has been implemented to insure the status of collection of all employee debts is documented and reviewed monthly. Repayment plans will be initiated whenever appropriate. DOD (Mountain Home Air Force Base) – has been a historically slow payer. On-going collection efforts have been documented and outstanding receivables identified to Central Office as problem debts. We have established an ongoing dialog with DOD and hope to bring all outstanding debts to resolution prior to the end of the Calendar year. **January 1, 2003**
Write off accounts receivable that cannot be collected	Concur	All debts over 90 days will be reviewed for appropriateness. All debts meeting established write-off criteria will be written off. **Completed 10/02**
Promptly cancel obligations for delinquent undelivered orders	Concur	Undelivered Orders will be reconciled and adjusted monthly. (A schedule of all mandated reconciliation's and audits will be posted and annotated when reviews have been completed.)

Strengthen GPF account administration	Concur	All new donations presented to the agent cashier will have appropriate donor documentation, evidence of the Director's approval and an approved delegation of authority for the control point official. This packet will be made a permanent part of the GPF folder. **Completed 10/02**

Information Technology Security – The Contingency Plan Should Be Complete and Background Investigations Requested

Recommendation	Concurrence	Implementation Plan
Amend IT Contingency plan to identify and prioritize critical functions and include contact information on emergency personnel	Concur	a. The Boise VAMC Systems Manager has been tasked with identifying critical IT functions. **Completed 10/02** b. The Information Management Committee has been tasked with prioritizing implementation of critical IT functions in the event of an emergency. **Completed 10/02** c. The TMS Chief has been tasked with identifying names, phone numbers and pager numbers of staff to be contacted in an emergency. **Completed 10/02**
TMS to assign correct sensitivity levels when granting security clearances	Concur	a. Revised sensitivity level designations have been relayed to HRMS. b. HRMS has been tasked with initiating background investigations. **Completed 10/02**

Appendix B

Vendor Gratuities – Vendor- Provided Meals for Resident Physicians Should Be Discontinued

Recommendation	Concurrence	Implementation Plan
Discontinue routine vendor-provided meals for resident physicians	Concur	This issue has been discussed with senior VISN leadership. VISN 20 will develop and adopt a VISN wide policy consistent with government ethics regulations. Policy will be developed by **3rd quarter FY 03.**

Quality Management – QM Exceptions Should be Followed Up and Mortality Data Analyzed.

Recommendation	Concurrence	Implementation Plan
Identify and monitor QM action items to resolution	Concur	1. QM staff agreed there was a lack of action and follow-up detail in some of their reports to various Services and Committees 2. Beginning **November 1, 2002,** QM staff will ensure issues identified in their reports (which require improvement actions) are clearly identified in the minutes with actions taken, assigned responsibilities and follow-up.
Present medication usage activities to Pharmacy and Therapeutic Committee	Concur	1. The Chair of the medication usage committee is a member of P&T 2. The Chair of the P&T Committee will ensure the medication usage committee report is a standing agenda item, and attached to the minutes 3. This will occur beginning **October 2002.**
Mortality Data Analyses Needed	Concur	1. Patient Safety Coordinator has been assigned the responsibility for stratifying mortality data 2. The data to be collected during death review will include: Resident/ Attending, Age, Date/time, Unit, Nurse at time of death, Diagnosis, Code

		Status, Autopsy, Organ Donor, Code, Peer Review Findings 3. The data will then be analyzed by the Patient Safety Coordinator and presented to Medical Executive Committee on a quarterly basis with concerns/recommendations as appropriate. 4. The mortality data project will begin **October 1, 2002**: and the first report to the Medical Executive Committee **January 2003.**

Homemaker/Home Health Aide Program – Clinical and Administrative Oversight Should be Improved

Recommendation	Concurrence	Implementation Plan
Establish an H/HHA policy and steering committee to oversee program operations	Concur	1. The need for a separate Homemaker/ Home Health Aide Directive was discussed with the IG Inspector. This policy was written on **September 4, 2002**. It is in the concurrence stage. 2. The Extended Care Council will be the Interdisciplinary Steering Committee for the H/HHA program. Mary Nelson has been reporting monthly to the ECC. A quarterly report to include program operations, workload, fund management, quality of care, and patient satisfaction will be given at ECC. 3. 1st Qtr, FY '03 data will be reported at the January '03 meeting.

Require staff to document interdisciplinary assessments for all H/HHA patients	Concur	1. The initial interdisciplinary assessment is the Nursing Care Referral Form (VAF 10-7108). This form was filled out but not always completely. Also, an attachment that verifies the administrative eligibility was not always attached. 2. Effective **1st Qtr FY '03** referrals for H/HHA services will be not be accepted unless filled our completely and with the administrative eligibility attached.
Review CHA PI data and patient assessments quarterly	Concur	1. The contractor, RN Case Managers and Mary Nelson (Admin Asst., HBPC) review H/HHA patients clinically every 6 months. VHA Directive 10-96-031 states these reviews should be quarterly. Effective **November 1, 2002**, we will review H/HHA patients on a quarterly basis (according to the individual patients quarterly recert date) and documentation will be made in the patient's record by the RN Case Manager that continued care is needed and approved. A progress note template titled, "H/HHA Recert" will be developed by RN Case Managers and HBPC Administrative Assistant. 2. Effective **January 1, 2003**, we will review the CHA's quarterly PI data and will report in minutes form in the HBPC Administrative Assistant's office. This will part of the quarterly report to ECC.

Appendix C

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