Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Chalmers P. Wylie VA Outpatient Clinic Columbus, Ohio

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Executive Summary

Introduction

During the week of April 15, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Chalmers P. Wylie Veterans Affairs (VA) Outpatient Clinic (OPC) in Columbus, Ohio (referred to as VAOPC in this report). The purpose of the review was to evaluate selected VAOPC 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 150 VAOPC employees.

Results of Review

VAOPC patient care and QM activities reviewed were generally operating satisfactorily. Management actively supported high-quality patient care and performance improvement. Financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. To improve operations, management needed to:

- Ensure proper inventory and storage of controlled substances.
- Ensure violent patient alerts are accessible in clinic computer systems.
- Improve cleanliness and compliance with infection control guidelines in the Canteen Service.
- Improve infection control and materials handling practices in the Supply, Processing, and Distribution Section.
- Improve security and administrative practices for Agent Cashier operations.
- Improve trending and analysis of performance improvement data.

VAOPC Director and Veterans Integrated Service Network (VISN) 10 Director Comments

The VAOPC Director agreed with the findings and recommendations and provided acceptable improvement plans. The VISN 10 Director concurred with the VAOPC Director's improvement plans. (See Appendices A and B, pages 18–27, for the full text of the VAOPC Director's and the VISN Director's comments). We will follow up on the planned actions until they are completed.

(*original signed by:*)

RICHARD J. GRIFFIN
Inspector General

Introduction

Chalmers P. Wylie VA Outpatient Clinic Profile

Organization. Located in Columbus, OH, the VAOPC is an independent ambulatory care facility that provides a broad range of outpatient health care services. It serves veterans in 16 counties in central Ohio and is the Fee Basis Clinic of Jurisdiction for 56 counties in Ohio and 1 county in Indiana. The VAOPC has community-based outpatient clinics in Zanesville and Grove City, Ohio and is the parent facility for a Veterans Readjustment Counseling Center located in downtown Columbus. The VAOPC is part of VISN 10 and serves a veteran population of about 200,000.

Chalmers P. Wylie VAOPC
Columbus, Ohio

Programs. The VAOPC provides primary care, mental health, audiology, optometry, ophthalmology (including outpatient cataract surgery), dental, prosthetics, and laboratory services, as well as limited services in cardiology, gastroenterology, renal, neurology, and dermatology. The VAOPC works cooperatively with VISN 10 medical centers to meet inpatient needs or other consultative services not available at the clinic. As a central meeting location, the clinic frequently hosts VISN 10 executive staff and representatives from other network facilities for regular council meetings and task forces.

Affiliations. The VAOPC is affiliated with Ohio State University (OSU) Colleges of Medicine, Optometry, Dentistry, Nursing and the School of Pharmacy.

Resources. In fiscal year (FY) 2001, the VAOPC's medical care budget totaled $44.5 million. The FY 2000 medical care budget was $38.5 million. FY 2001 staffing was 294 full-time equivalent employees.

Workload. In FY 2001, the VAOPC treated 20,000 unique patients, and outpatient workload totaled 173,681 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 healthcare 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 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 toured patient care and reception areas and inspected work areas. We interviewed managers, employees (including the American Federation of Government Employees representative), Veterans' Service Officers, and patients. Additionally, we reviewed clinical, financial, and administrative records. The review covered the following activities:

Agent cashier operations
Ambulatory procedure area
Contracting procedures
Controlled substance accountability
Credentialing and privileging
Employee Travel Card Program
Fee Basis Program
Gifts and gratuities to physicians
Government Purchase Card Program
Homemaker/home health aide services
Information technology security
Inventory management
Management of violent patients
Part-time physician time and attendance
Patient care environment
Quality management
Supply, processing, and distribution

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to 167 VAOPC employees. Sixty-five employees responded to the survey, but some did not respond to all of the questions, yielding different denominators for some questions. We interviewed 30 patients while on site. Both surveys generally indicated high levels of patient and employee satisfaction; however, we did identify significant issues that are addressed in this report. Survey results were discussed with VAOPC management.

During the review, we also conducted 3 fraud and integrity awareness briefings for 150 VAOPC employees. These briefings 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 VAOPC operations for FY 2001 and FY 2002 (through March 31), and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Organizational Strengths

VAOPC managers created an environment that supported high-quality patient care and performance improvement. The patient care administration, QM, financial, and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

Patients and Employees Expressed Satisfaction with the Quality of Care. We interviewed 30 outpatients to obtain their opinions about timeliness of services and quality of care. Of the 20 patients who received medications at the VAOPC pharmacy, 19 said their prescriptions were ready in 30 minutes or less. The remaining 11 patients received prescriptions by mail and were satisfied with the mail-out program. Twenty-six of 30 patients (87 percent) reported that they were seen within 30 minutes of their scheduled clinic appointment times. Twenty-nine patients (97 percent) said they would recommend medical care at the VAOPC to eligible family members or friends. Twenty-eight of the 30 patients interviewed (93 percent) rated the overall quality of care provided to them as good, very good, or excellent.

Employee satisfaction surveys were distributed to 167 clinical employees, and the findings indicated that 77 percent (50 of 65 responding) agreed with the statement that quality patient care is the first priority at this clinic. Eighty-six percent (56 of 65 responding) would recommend VAOPC medical care to eligible family members or friends. Eighty-nine percent (54 of 61 responding) rated the overall quality of care provided to patients as good, very good, or excellent.

Patient Care Areas Were Clean and Well Maintained. We toured all patient care areas and found them clean and well maintained. Ninety-four percent of employees (61 of 65 responding) believed that housekeeping efforts were adequate to support patient safety and general cleanliness. Patient examination rooms, offices, and waiting areas, especially in the Women's Clinic, were clean and attractively furnished.

The Prevention of Workplace Violence Policies and Training Program Were Complete. The VAOPC had current policies governing its prevention of workplace violence and violent behavior emergency response programs. Annual training in the prevention of workplace violence was mandatory for all employees and was a component of new employee orientation. We reviewed 10 employees' training records and found that the employees had completed this training within the past 12 months. We interviewed the same employees, and all believed that management promoted an environment of "zero tolerance" for workplace violence. The facility completed annual safety and security vulnerability assessment inspections, and areas identified as being at risk for incidents of patient violence were equipped with panic buttons. Panic buttons produce audible alarms and/or flashing lights in Police and Security Service (P&SS) and are used to summon the Code Orange[1] Emergency Response Team when a patient becomes aggressive.

[1]Code Orange is the name of the emergency response procedure and emergency response team at the VAOPC.

Additionally, P&SS was provided with a daily list of patients with appointments who had histories of violent behavior. These patients were escorted to their appointments by a P&SS employee or otherwise monitored until they exited the clinic.

Credentialing and Privileging for Physicians Was Adequate. Credentialing and privileging folders for clinic physicians were maintained properly.

Timekeeping Procedures for Part-time Physicians Were Accurate. The VAOPC had effective procedures and controls to monitor time and attendance for the clinic's two part-time physicians. Timekeepers knew the scheduled tours of duty for these two physicians and recorded their time accurately. Personal observations and surgery reports supported the part-time physicians' presence during scheduled tours of duty. Leave requests were completed and charged appropriately. Proper procedures were in place to promptly reschedule patient appointments if physicians were absent. Timekeepers received initial and refresher training, and all training was properly documented. Desk audits were conducted timely and deficiencies were identified and corrected.

Management Had Implemented a Policy for the Regulation of Gifts, Gratuities, and Meals from Pharmaceutical Representatives. The VAOPC had an established policy on pharmaceutical representatives' interactions with staff physicians. Representatives were required to leave product information with the Chief of Pharmacy Service, instead of meeting directly with physicians. Requests for pharmaceutical company presentations were referred to the Education Coordinator and approved by the VAOPC Director, and invitations to presentations could not be exclusively for physicians. The Director estimated that pharmaceutical company representatives made presentations to clinic employees approximately once a quarter. These presentations sometimes included lunch, which was available to anyone attending.

The Employee Travel Card Program Was Functioning Properly. The VAOPC employee travel card program had been implemented according to VA travel regulations. New travel cards were issued to every first-time traveler. Travel cards were collected and cancelled when employees left employment. The travel card coordinator closely monitored all card activity, including delinquent payments. Additionally, the coordinator verified that employees only used their travel cards for travel expenses when on official government travel.

Contract Administration Was Effectively Managed. We reviewed 15 contracts and 1 sharing agreement. Contract administration was effective and in compliance with Federal and VA regulations. Medical care contracts, including contracts with the affiliated university, were awarded based on Medicare rates or less. Records of competitively awarded contracts contained evidence of free and open competition among bidders. Additionally, we reviewed three contracts for homemaker/home health aide (H/HHA) services. The contracts were maintained at the Central Acquisition and Management Hub at the VA Medical Center (VAMC), Chillicothe, Ohio. Our review found that the H/HHA interdisciplinary team provided specific, detailed expectations for community health agency (CHA) vendors, which were formalized by the contracting officer at the VAMC Chillicothe.

Opportunities for Improvement

Controlled Substances – Inspection Procedures, Training, and Pharmacy Security Needed To Be Strengthened

Conditions Needing Improvement: Veterans Health Administration (VHA) policy requires a comprehensive inspection program to account for Schedule II – V controlled substances. VAOPC management needed to establish a stronger program to ensure that controlled substances are safeguarded and accounted for, controlled substances inspections are properly conducted, unusable controlled substances are destroyed quarterly, narcotics inspectors are properly trained, and pharmacy security is enhanced. Unless these issues are addressed, the potential for diversion or theft of controlled substances will remain unacceptably high. Our review of pharmacy internal controls revealed the following weaknesses:

- Required biannual inventories of controlled substances had not been performed in the last 12 years.

- Monthly unannounced controlled substances inspections only covered drugs kept in the pharmacy vault and did not include other controlled substances storage areas such as three clinical storage areas and nine crash carts located throughout the clinic.

- There were large discrepancies between the computerized perpetual inventory record of Schedule IV and V drugs which tracked doses (pills, capsules, etc.) and the manual perpetual inventory record, which tracked bulk quantities (containers or bottles).

- Monthly drug inspections did not properly account for Schedule IV and V drugs kept in the pharmacy vault. These drugs were being counted by container, not by dose. This counting method did not account for open or partially filled containers, which may have had missing doses, and made diversion or theft of narcotics extremely easy.

- Destructions of expired, excess, and unusable controlled substances were not conducted quarterly. The two most recent destructions occurred in November 2000 and August 2001. Because no drugs had been destroyed since August 2001, there was a large quantity of controlled substances awaiting disposal.

- There was no formal training program for narcotics inspectors. Training was conducted on an informal "on the job" basis and was not documented.

- Access to controlled substances in the pharmacy exceeded, by three to five employees daily, the maximum allowable nine employees within a 24-hour period.

- P&SS employees had not performed routine tests of the pharmacy's motion detector or panic button systems. Additionally, the clinic's security alarm system control panel could not distinguish between the pharmacy and agent cashier areas.

- A recent case of missing narcotics could not be adequately investigated by the Columbus Police Department because of the failure to adequately control, account for, and secure controlled substances. This theft was also not reported to the OIG, as required by VA policy.

Recommended Improvement Action 1. We recommended that the VAOPC Director ensure that:

a. Biannual inventories of all controlled substances are accomplished.
b. Monthly unannounced controlled substances inspections include all controlled substances stored anywhere in the clinic.
c. Pharmacy inventory records, both manual and computerized, track doses of controlled substances.
d. Monthly drug inspections utilize dose measurements.
e. Expired, excess, and unusable controlled substances are destroyed quarterly.
f. A formal training program for controlled substances inspectors is established.
g. Access to scheduled drugs in the pharmacy is limited.
h. A differentiating alarm for the pharmacy is installed and tested.
i. Missing controlled substances are reported to the OIG.

The VAOPC Director agreed with the findings and recommendations and reported the following implementation plans: biannual inventories will be scheduled, unannounced inspections will include all areas where controlled substances are kept; a perpetual inventory will include exact tablet counts of all controlled substances; monthly controlled substances inspections will require exact tablet counts; expired, excess, and unusable controlled substances will be destroyed quarterly beginning June 2002; a formal training program for narcotics inspectors was established; alarms for Pharmacy and the Agent Cashier are differentiated and the alarms in both areas will be tested monthly; and reports of missing controlled substances will be forwarded to the OIG. Regarding recommendation (g); due to rotating coverage of the late shift, a memo was sent to the Clinic Director requesting permission to exceed the maximum allowable 9 employees per 24 hour shift, which was approved. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Management of Violent Patients – Systems to Alert Employees Needed Improvement

Conditions Needing Improvement: Even though the VAOPC had a well-developed workplace violence prevention program, managers needed to strengthen its employee alert system. We reviewed the medical records of eight patients with histories of violent episodes. We were unable to locate violent patient alerts[2] in the Veterans Health Information Systems Technology

[2] An alert is a warning that appears on the computer screen when a patient's name is entered. When the patient has acted aggressively or threatened an employee or another patient, the alert is placed in the patient's record to warn employees of the patient's potential for violent behavior. The message instructs the employee to contact security and will not allow the employee to continue accessing the patient's record until the employee responds "yes" to the warning prompt.

Architecture (VISTA)[3] system or the Computerized Patient Record System (CPRS)[4] for three of these patients. One of the three patients was involved in an incident that required a Code Orange, and resulted in an employee injury. In the remaining five records, we were able to locate alerts in VISTA, but not in CPRS. Employees incorrectly assumed that when an alert was activated in VISTA, it automatically activated in CPRS. VAOPC employees need assurance that warning systems are functioning and will accurately inform them about patients who have histories of violent behavior and who have the potential to harm themselves or others.

Recommended Improvement Action 2. We recommended that the VAOPC Director ensure that alerts of violent patient behavior are available to employees in VISTA, CPRS, and any administrative patient records.

The Director agreed with the findings and recommendations and reported that two task groups are working on these issues. The first task group is examining the process of reviewing each violent patient incident to determine if a flag is required. The second group is looking at the issue of having these flags "migrate" between VISTA warnings in the appointment management package (clerks see but not clinicians) and CPRS (clinicians see but usually not clerks). The information from each task group will be incorporated into a clinic policy. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Canteen Service Area – Cleanliness and Food Safety Issues Required Attention

Conditions Needing Improvement: Canteen Service areas were overcrowded, dirty, and contained appliances that were inoperable and awaiting repair. Ceiling tiles and light covers throughout the kitchen areas, especially over the grill and ovens, and in the customer self-service area were soiled and discolored. The metal backsplashes on the walls behind the grills and fryers had accumulations of grease and cooking residue. Trash receptacles throughout the kitchen and self-service food areas were uncovered. Grease and dust were found in the air intake vent in the self-service area, and the floors and areas surrounding the self-service carts needed cleaning. The Canteen Vending Room located on the first floor had stained floors and the vending machines were soiled.

We noted the following food safety issues that needed correction:

- A double sink, with the only garbage disposal, was used to rinse dirty pots and pans, wash fresh produce, and rinse raw meat. While the Canteen Service manager told us that the sink was sanitized before and after each task, a potential for cross contamination existed. Food should be handled separately from soiled pots and pans.

[3]VISTA is the computer system used by clinic clerks to schedule patient appointments and to register patients' arrivals for appointments.
[4]CPRS is VHA's electronic system for medical record maintenance.

- Raw food items were left uncovered in the refrigerator. All foods should be stored covered and dated.

- A container of sugar was found under a sink. Dry goods should be stored away from water sources.

- In the self-service area, multiuse condiment containers for catsup, mustard, and mayonnaise were not labeled to identify their contents.

- A countertop-mounted manual can opener was soiled with accumulated food particles. Can openers should be cleaned after each use.

Recommended Improvement Action 3. We recommended that the VAOPC Director ensure that:

a. Canteen Service food items are handled, stored, and labeled in compliance with food safety guidelines.
b. Canteen Service areas are cleaned to comply with infection control guidelines.
c. Soiled ceiling tiles and light covers are replaced.
d. Canteen Service areas are included in environmental rounds, and issues identified receive corrective actions.

The VAOPC Director agreed with the findings and recommendations and reported that food preparation and cleaning processes are separated; all food items are labeled, covered, dated, and properly stored; cleaning will be accomplished on a regular schedule; soiled ceiling tiles and light covers will be replaced; and environmental rounds of the canteen will occur monthly. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Supply, Processing, and Distribution – Clean Environment Standards Needed To Be Enforced

Conditions Needing Improvement: VHA policy requires that Supply, Processing, and Distribution (SPD) Section employees adhere to strict standards to ensure a safe and sanitary clinical environment. SPD employees process and distribute sterile supplies required for clinic and ambulatory surgical procedure areas; provide aseptic control of assigned areas; and decontaminate, clean, and sterilize surgical instruments and mobile medical equipment. SPD, located on the third floor of the VAOPC, consisted of the decontamination area, the preparation area where supplies and instruments are readied for sterilization, the sterilization area, and the sterile supply storage area. Additionally, there were spaces designated throughout the OPC for storage of sterile supplies that were needed for patient care. We observed the following conditions that did not meet VHA environmental standards:

- Employees were allowed to enter the SPD preparation area without protective boots. SPD employees did not have these boots readily available, but had to order them from the SPD storage area located in the pharmacy.

- The sterile storage area contained several expired packages of sterile surgical instruments. There were no climate control instruments installed in SPD to measure temperature and humidity. Sterile items must be stored under conditions limiting the potential for exposure to contaminants such as moisture.

- The floor in the SPD preparation area had not been cleaned or waxed in several weeks.

- Clinic SPD areas, for example those located in the laboratory and pharmacy, contained corrugated boxes that were conducive to pest infestation.

- Dust had accumulated on an electrical panel box, and an oxygen cylinder rack was rusted to the floor in the pharmacy sterile supply storage area.

- SPD storage areas throughout the clinic were cluttered and had supplies stored too close to the ceiling. Distance from ceilings (18 inches) must be maintained to keep sterile products from the heat of light fixtures or possible moisture from leaky overhead fire sprinklers.

- The VAOPC Ambulatory Surgical Procedure Suite, located on the second floor, did not have a flash autoclave. Flash autoclaving is a rapid, intense sterilization process for surgical instruments needed for immediate use in surgical procedures. The flash autoclave was located in the SPD sterilization area on the third floor. This spatial separation meant that surgical instruments sterilized in the flash autoclave had to be transported through public hallways and elevators to the Ambulatory Surgical Procedure Suite creating a risk of contamination.

Recommended Improvement Action 4. We recommended that the VAOPC Director ensure that:

a. All persons in SPD sterile processing areas wear protective clothing, including boots.
b. SPD areas are cleaned regularly to comply with VHA regulations.
c. Climate control measurement instruments are installed.
d. Corrugated containers are removed from SPD storage rooms.
e. A flash autoclave is located in the Ambulatory Surgical Procedure Suite.

The VAOPC Director agreed with the findings and recommendations and reported that SPD employees will wear protective clothing; cleaning of SPD will comply with VHA regulations; climate control measurement instruments will be installed; and containers will be removed from storage rooms. Regarding recommendation (e), two options are being considered. The first is the purchase of two additional cataract surgical instrument sets, bringing the total number of instrument sets to six. This is the number of cataract surgeries that can be done in a single day. The second option is the purchase of an additional flash autoclave to be located in the Ambulatory Surgical Procedure Suite. The decision will depend on the option that is the most cost effective. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Agent Cashier Operations – Physical Security and Unannounced Audits Needed Enhancement

Conditions Needing Improvement: VAOPC managers needed to ensure that funds and accountable documents under the control of the agent cashier were properly protected and not accessible to other employees. VHA policy states that envelopes containing copies of cashbox keys and safe combinations should be kept in a safe or vault under the custody of the Director and should be opened only in the presence of the Director or Assistant Director and the Fiscal Officer. Unannounced audits should be performed by at least two VAOPC employees who are skilled in fiscal or audit techniques and who are not agent cashier employees. Employee Reimbursement Vouchers for replenishment of funds are to be authorized and properly signed. Controls needed to be strengthened in the following areas:

- P&SS employees did not respond quickly to a panic alarm drill and were unaware of the alarm's exact location. Instead, they responded to the pharmacy area. Security personnel could not distinguish between an alarm activated in the pharmacy and one activated in the agent cashier area.

- Envelopes containing the safe combination, a key to the cashier's office, and keys to each of the cash boxes were kept in a four-drawer file cabinet in the Director's office. However, the envelopes and their contents were not secure because other clinic employees could easily access the file cabinet.

- The primary agent cashier, who was a Fiscal Service employee, trained auditors and assisted them throughout unannounced audits. Additionally, non-agent cashier Fiscal Service employees were excluded from participating in unannounced audits. VHA policy requires a separation of duties, and prohibits agent cashiers from participating in actual audit functions and requires that at least one Fiscal Service employee other than an agent cashier, be assigned to unannounced audits.

- Cashier Reimbursement Vouchers were not properly signed. VA regulations require that these vouchers be signed by the agent cashier and then forwarded to a certifying officer for review and certification.

Recommended Improvement Action 5. We recommended that the VAOPC Director ensure that:

a. Panic buttons and alarms work properly and that P&SS employees can determine the exact location of alarms.
b. A safe or vault is obtained for storing keys and combinations to the cashier's office.
c. Fiscal Service employees other than the agent cashier are assigned to conduct unannounced audits.
d. Cashier Reimbursement Vouchers are properly signed.

The VAOPC Director agreed with the findings and recommendations, but took exception with item d. The Director reported that panic buttons and alarms will be tested monthly and each security officer has been trained to respond to appropriate alarms; a new safe has been installed

in the Director's Suite and keys and combinations to the cashier's office have been properly secured; and a memorandum has been initiated to appoint auditors to perform unannounced audits. Regarding item d, the Director stated that cashier reimbursement vouchers are electronically mailed to the Austin Financial Service Center and the facility's fiscal officer. Managers believed that keeping copies of electronically mailed vouchers, which were not signed, was sufficient documentation for their files. The VAOPC changed its process while we were on site and the fiscal office now keeps signed copies of cashier reimbursement vouchers on file. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Quality Management – Performance Improvement Data Needed Trending and Analysis to Identify Opportunities for Improvement

Conditions Needing Improvement: External Peer Review Program data and utilization review data were not analyzed over time to identify trends and opportunities to improve patient care. Utilization review data did not include outcome indicators, such as readmissions to community hospitals or morbidity and mortality data. Four of the facility's VHA National Performance Measure results (table) were below the VHA national results or goals for FY 2001.

Measure	Columbus VAOPC Results	VHA Results FY2001	VHA Goal
Percent of patients screened for high risk factors for hepatitis C such as blood transfusion prior to 1992, illicit injection drug use, and tattoos.			
a. Mental health	57	NA	60
Percent of patients using tobacco who have been counseled 3 times in 12 months to cease tobacco use.			
a. Primary care	29	62	68
b. Mental health	67	N/A	68
Average processing time for compensation and pension examinations 35 days.	39	33.22	35

Reviews of cardiopulmonary arrest (code blue) episodes did not occur timely. Ideally, analyses of codes should occur within 24 hours of the events to identify opportunities for improvement. However, code blue reviews were not conducted until days or weeks after the events diminishing the chance to identify areas for improvement. Additionally, because cardiopulmonary arrests occur rarely at the VAOPC, conducting "mock" or practice code blues regularly is an important method of maintaining the code blue response team's competence. While clinical managers told us that mock codes were conducted, they were infrequently scheduled. The last mock code occurred 10 months before our inspection.

Recommended Improvement Action 6. We recommended that the VAOPC Director:

a. Develop processes to collect and trend performance improvement data and use the data to make patient care decisions.

b. Review cardiopulmonary arrest episodes timely and perform mock Code Blues regularly. Real and mock code blue episodes need to be analyzed by the response team to identify opportunities for improvement.

The VAOPC Director agreed with the findings and recommendations and reported that quarterly performance improvement and utilization review data will be trended and analyzed by quality management, clinical, and administrative employees; cardiopulmonary arrest episodes will be reviewed promptly; and mock code blue episodes will be performed quarterly. The VISN Director agreed with the VAOPC Director's improvement plans. The improvement plans are acceptable and we will follow up on the completion of planned actions.

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

Conditions Needing Improvement: Interdisciplinary patient assessments were not properly documented in the medical records, reassessments to continue or cease homemaker/home health aide (H/HHA) services were not performed, and delivery of H/HHA services was not verified. VHA, in providing comprehensive care for enrolled veterans, has made long-term care an important focus. Congress reinforced this goal in its passage of the *Veterans Millennium Health Care and Benefits Act* (the Millennium Act), Public Law 106-117, in Section 101. VHA provides leadership in this critical area of healthcare by developing an innovative, flexible approach to home and community-based care that is fully integrated into the healthcare system, and uses resources efficiently and effectively to meet the needs of an aging and chronically ill population. One such program is the H/HHA Program. This program provides H/HHA visits to eligible beneficiaries using contract nursing home funds. VA facilities are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs. Expenditures for a patient receiving H/HHA services cannot exceed 65 percent of the average nursing home per diem rate.

VHA Directive 96-045, *Continuum of Home Health Care within the VHA* and VHA Directive 96-031, *Purchase of Homemaker/Home Health Aide Services* govern the H/HHA Program. These directives outline the need for ongoing oversight and monitoring of quality of care, workload, and fund management issues.

The VAOPC authorized $204,163 in H/HHA serviced for veterans during FY 2001. At the time of our inspection, the facility contracted with 13 community health agencies (CHAs) to provide H/HHA services to 40 patients at an approximate monthly cost of $17,014.

We interviewed the H/HHA Coordinator (who also served as the Geriatrics and Extended Care Line Manager), the community health nurse, and five enrolled patients. We also reviewed 10 H/HHA patients' medical and administrative records and documentation from CHAs regarding services provided to each patient. The following areas needed improvement:

- Patient assessments were not properly documented. Five of the 10 medical records reviewed lacked interdisciplinary assessments by referring physicians, nurses, social workers, and other clinicians as required.

- Reassessments to continue or cease H/HHA services were not performed. We did not find evidence to show that the physician, nurse, social worker, and CHA routinely accomplished evaluations for the continuation of services every 3 months.

- Delivery of H/HHA services was not verified. Telephone communication between H/HHA Program employees, veterans, and CHAs to substantiate delivery of services was documented, but was initiated by H/HHA employees infrequently.[5]

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that: (a) interdisciplinary assessments for H/HHA services include input from the referring physicians, registered nurses, social workers, and other clinicians as necessary; (b) the continued need for H/HHA services is reassessed minimally every 3 months; and (c) telephone contacts or visits to veterans are conducted to assess patient satisfaction with services and verify if CHA visits occurred as scheduled. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Access to Care – Timely Access to Specialty Clinics and Primary Care Services Needed Improvement

Conditions Needing Improvement: Patients, veterans' service officers, and employees told us that there were lengthy delays for specialty clinic appointments. Some referrals for specialty clinics require that the patient be seen at VAMCs Chillicothe, Dayton, or Cincinnati. Of the 18 patients interviewed who were referred to specialists by their primary care providers, 6 (33 percent) were not seen within 30 days of the referrals. Some patients reported delays of several months to 1 year. We interviewed 25 patients who had pressing medical needs and had attempted to schedule appointments with their primary care providers. Eleven (44 percent) of these patients were not seen within 7 days.

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that appointment times for specialty clinics and primary care services are monitored and processes are improved to expedite services for patients. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Customer Service – Communication With Patients and Patient Representative Services Needed Improvement.

Conditions Needing Improvement: VAOPC managers informed us that employees recently completed customer service training designed to improve their interactions with patients. However, patients and veterans' service officers told us that front-line clerical employees who assist patients with clinic check-in, scheduling clinic appointments, and other services often

[5]In 2 of 10 cases, telephone calls by H/HHA employees to the veterans receiving H/HHA services were only documented once during the past year. One veteran in our sample did not receive a telephone contact from an H/HHA employee. Telephone calls by H/HHA employees to the CHAs were documented only one time in four of the cases reviewed, and documentation was not found in two additional cases.

displayed inconsiderate and disrespectful behavior during their interactions with patients, family members, and visitors. Employee survey results indicated that employees believed that there were too few clerks to adequately perform clerical functions. We verified that, at the time of our visit, there were four vacant clerk positions.

Patient representative responsibilities were rotated among top managers and clinical managers. A posted schedule of who was covering the patient representative function at a given time was not available and patients reported that they were not receiving appropriate follow-up on their concerns. The veterans' service officers also brought this issue to our attention.

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that: (a) vacant clerk positions are filled; (b) processes are developed to monitor and reinforce customer service principles; and (c) designated persons are scheduled to cover patient representative functions during specific clinic hours, and the duty schedule is displayed to inform patients whom they should contact with their concerns. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Information Technology Security – The VAOPC Contingency Plan Needed To Be Updated and Security Procedures Improved

Conditions Needing Improvement: VHA facilities are required to develop and implement automated information system (AIS) contingency and recovery plans to reduce the impact of disruptions in services, to provide critical interim processing support, and to resume normal operations as soon as possible in case of system failure. Additionally, facilities should have a comprehensive security program in place and a means for monitoring the security program's effectiveness. The VAOPC generally met guidelines for protecting AIS resources from unauthorized access, disclosures, modifications, destruction, and misuse. However, there were four issues that warranted management attention:

- The clinic's contingency and recovery plan was not a master plan because it did not incorporate all services and divisions operating in the clinic.

- The contingency plan's personnel listing had not been updated to reflect changes in key positions. For example, the names of the Information Security Officer and the Alternate were missing.

- Clinic officials had not requested background investigations for employees in critical computer and automated data processing (ADP) positions.

- Information Resources Management employees having network technology (NT) system administrator access did not apply proper audit settings for "Security Policy Changes" and "Use of User Rights" for the operating system. NT is an object-oriented operating system, and sensitive areas such as security policy changes must be manually set to be specifically audited.

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that: (a) the contingency plan is revised and updated to incorporate service-level plans and personnel changes in key positions, (b) background investigations are requested on individuals in critical computer and ADP positions, and (c) employees with system administrator access invoke the audit settings for "Security Policy Changes" and "Use of User Rights" for the NT operating system. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Medical Supply Inventories – Improved Inventory Controls Would Reduce Costs and Result in More Effective Management

Conditions Needing Improvement: Inventories of medical supplies could be better managed if a comprehensive inventory system were implemented. SPD inventory reports were inaccurate, which caused an excess of supplies in some cases and insufficient supplies in others.

VHA policy requires that managers maintain only enough medical supply inventories to meet current needs and to avoid committing resources to excess inventories. SPD inventories in the warehouse had a total value of $21,416, but $19,177 (90 percent) represented stock on hand greater than 30 days. VAOPC employees did not use reports for inventory management. Instead, they estimated stock levels and attempted to anticipate demand when reordering supplies.

Neither warehouse nor SPD employees utilized the automated Generic Inventory Package (GIP) inventory system. In the warehouse, employees entered purchases into VISTA and manually adjusted inventory levels based on these purchases. The primary SPD storage area in the pharmacy had not been inventoried or bar-coded for GIP. Eleven of 17 secondary SPD areas also were not bar-coded for GIP, and 7 had not been totally inventoried. The system used to label supply shelves was not accurate. Supplies on several shelves did not match shelf labels, and some shelves were not labeled.

VAOPC managers were aware of inventory control problems and were in the process of implementing GIP in the primary and secondary SPD areas. However, there were no plans to implement GIP in the warehouse.

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that: (a) full implementation of GIP in all SPD areas continues and warehouse supplies are added to GIP, (b) accurate inventory records are established, and (c) excess SPD stock is reduced. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Fee Basis Compensation and Pension Examinations – A Contract with the University Could Reduce Costs

Conditions Needing Improvement: A formal contract with OSU may be more cost effective in providing compensation and pension (C&P) examinations to veterans. The VAOPC had an informal arrangement with OSU to provide these examinations under a fee-basis payment

schedule. Of the 1,447 C&P examinations provided in FY 2001, OSU provided 1,225 (85 percent) of all requested examinations, with the remainder provided by VAOPC employees and another area hospital at a total cost of $1,154,658, or an average cost of $943 per fee-basis examination. The VAOPC does not have the space, the specialty equipment, or the medical personnel to provide timely C&P examinations. Before OSU assumed most of the C&P examinations workload, the clinic was averaging 60 to 90 days to complete them. VA criteria call for C&P examinations to be completed within 35 days. In FY 2001, OSU averaged 39 days to complete C&P examinations, a significant improvement. In addition, based on our discussions with clinic employees, the arrangement appeared satisfactory. OSU provides veterans with a one-stop examination, and offers the capability to perform specialty procedures such as magnetic resonance imaging, and pulmonary and vascular testing. The convenience of one-stop examinations also reduces time and travel expenses for veterans.

As advantageous as the arrangement with OSU appears to be, we believe that clinic officials may be able to reduce costs even further if they pursue a formal fee-for-services contract with OSU. Because of the high number of C&P examinations already referred to OSU, the VAOPC may be in a position to leverage this into better rates under a formal contract based on discounted Medicare rates.

Suggested Improvement Action 6. We suggested that the VAOPC Director pursue the feasibility of negotiating a formal fee-for-services contract with OSU to perform C&P examinations. The VAOPC and VISN Directors agreed to implement the suggested improvement action.

Government Purchase Card Program – Controls Needed To Be Strengthened

Conditions Needing Improvement. VA facilities are required to use Government purchase cards for small purchases of goods and services. Required program controls include separation of duties and training documentation. The VAOPC Purchase Card Program Coordinator was both a cardholder and an approving official, and another cardholder was also an approving official. This violated separation of duties controls. In addition, purchase card training was not adequately documented for 18 of 36 cardholders and for 1 approving official.

Suggested Improvement Actions. We suggested that the VAOPC Director ensure that: (a) adequate separation of duties is enforced in the Government Purchase Card Program, and (b) purchase card training records are updated to include complete documentation for cardholders and approving officials. The VAOPC and VISN Directors agreed to implement the suggested improvement actions.

Chalmers P. Wylie VA Outpatient Clinic Director Comments

RECOMMENDATIONS FOR IMPROVEMENT:

Controlled Substances - Inspection Procedures, Training, and Pharmacy Security Needed to Be Strengthened

DIRECTOR COMMENTS

Concur With Recommendations

(a) Biannual inventories of all controlled substances are accomplished.

The biannual inventory has been completed and a schedule has been established.

(b) Monthly unannounced controlled substances inspections include all controlled substances stored anywhere in the clinic.

The procedure for unannounced controlled substance inspections has been modified to include inspection of all areas (pharmacy and patient care areas) where controlled substances are kept.

(c) Pharmacy inventory records, both manual and computerized, track doses of controlled substances.

A perpetual inventory with exact tablet count for all controlled substances is performed every 72 hours, and now includes an exact tablet count of all controlled substances.

(d) Monthly drug inspections utilize dose measurements.

The monthly drug inspections now require an exact tablet count of all controlled substances.

(e) Expired, excess, and unusable controlled substances are destroyed quarterly.

Guaranteed Returns, a company specializing in removing outdated, excess, unusable stock from pharmacies, and which has a VA contract, began quarterly pickups in June 2002.

(f) A formal training program for narcotics inspectors is established.

A formal training program was established and is being used by inspectors.

(g) Access to scheduled drugs in pharmacy is limited.

Due to rotating coverage of late shift, a memo was sent to the Clinic Director requesting permission to exceed the maximum allowable 9 employees per 24 hour period.

(h) A differentiating alarm for the pharmacy is installed and tested.

All panic buttons and alarms are again tested monthly, to include those identified in the report - the Pharmacy and Agent Cashier. These alarms had consistently been tested on a monthly basis until a year ago when the Physical Security experts from VACO recommended they be tested semiannually.

Distinguishing between the alarms in the Pharmacy and Agent Cashier has been resolved through education. These two locations have the same type of alarm, but are different than the alarms throughout the rest of the facility. Each security officer has been briefed and trained to respond, i.e., if and when an alarm is activated, one officer goes immediately to the pharmacy and the other officer goes to the Agent Cashier. These two locations are directly across the hall from each other; therefore a quick response is gained, regardless of location.

(i) Missing controlled substances are reported to the OIG.

Reports of missing controlled substances are forwarded to the OIG.

Management of Violent Patients - Systems to Alert Employees Needed Improvement

DIRECTOR COMMENTS

Concur With Recommendations

There are currently two task groups working on these issues. The first group is reviewing the process of initiation of notification of a violent patient/incident and review of the incident to determine if a flag is required. The work of this group will result in a clinic policy. The group consists of the facility Information Security Officer (ISO), the MH&BS Care Line Manager and the QA Coordinator/Risk Manager. Clinic-wide training will be initiated once the policy is written and approved. Presently, staff initiates a Report of Contact (ROC) for violent incidents involving patients and the Security Specialist reviews and refers to the Director for approval to flag the patient as violent in the system.

The second group is looking at the issue of having these flags "migrate" between VISTA warnings in the Appointment Management package (clerks see but not clinicians) and CPRS (clinicians see but usually not clerks). Questions have arisen in discussion of this issue in regard to best and safest way to effect this exchange. This group consists of the IRM Programmer, the Clinical Applications Coordinator, Chief HIMS, Chief Information Officer and the Security Specialist. Both groups are continuing to meet. Information from each will need to be coordinated into the final clinic policy and training for staff.

Per IRM Programmer (as of May 20, 2002) working on the alert issue:

"The pop-up windowing used for the "Deceased Patient" alert in the CPRS GUI has an opening where local alerts can be hooked. I've been writing the code to check for and pass any flags from the Flags and Alerts package we use." **ONGOING**

Canteen Service Area - Cleanliness and Food Safety Issues Required Attention

DIRECTOR COMMENTS

Concur With Recommendations

The following is a summary of specific corrective actions implemented to address issues noted within the Canteen during the CAP Survey held on April 15 –19, 2002. Please note that many issues were resolved during

the CAP survey visit. All other issues were reviewed with the Canteen Chief and Regional Canteen Manager during a face-to-face meeting on April 24, 2002 to develop a correction plan.

Additionally, the clinics Environment of Team established a process to conduct unannounced inspections of the Canteen on a monthly basis beginning in June 2002 to assess operations, identify issues needing improvement and provide support to the Canteen Program. Members of the team include a dietician, infection control nurse, engineer, housekeeping supervisor and labor representative. A quarterly external review is also scheduled by a team from VAMC Chillicothe comprised of EMS, Dietary and Infection Control staff. The first team review was completed on 7/12/03.

Recommendation - Canteen Service food items are handled, stored, and labeled in compliance with food safety guidelines

DIRECTOR COMMENTS

Concur With Recommendations

(a) Food Preparation: Canteen Chief has separated food preparation and cleaning process using the double sink. Sink is sanitized and food is washed/prepared in the morning and is not used again for food preparation during the day. Pots and pans are cleaned as needed during the remainder of the day using the sink and sanitized at the end of the day. **(COMPLETED)**

(b) Storage of Raw Food Items: Issue discussed with Canteen Chief. Canteen Manager to ensure that all raw food will be consistently covered and dated when stored in the refrigerator. **(COMPLETED)**

(c) Storage of Dry Goods: Need to store dry goods away from water sources was discussed with Canteen Manager who will ensure proper storage in future. **(COMPLETED)**

(d) Labeling on Condiment Containers: Canteen Chief advised of the need for identifying labels for catsup/mustard. Labels are now being used on containers. **(COMPLETED)**

(e) Clean Can Opener: Need to continuously clean can opener after each use was reviewed with canteen manager. **(COMPLETED)**

Recommendation: Canteen Service areas are cleaned to comply with infection control guidelines.

DIRECTOR COMMENTS

Concur with Recommendations

(a) Kitchen Floor: Housekeeping instructed to increase cleaning schedule immediately following CAP survey during April to ensure floor is clean. **(COMPLETED)**

(b) Appliance Operation: Appliances noted during survey to be inoperable have been repaired. All appliances are currently in good working order. **(COMPLETED)**

(c) Clean Metal Backsplashes: Canteen Chief advised of need to consistently maintain cleanliness of backsplashes. Plan implemented to ensure cleanliness. **(COMPLETED)**

(d) Ensure Trash Receptacles are covered: Canteen Chief purchased new trash receptacles and/or lids to cover. **(COMPLETED)**

(e) Clean Air Intake Vent: Vents have been cleaned to remove grease/dust noted during survey. **(COMPLETED)**

(f) Clean floor under self-service carts: Reviewed problem with Canteen Chief and Housekeeping who noted that the coke dispensing machine does not allow the cart to be pulled out for cleaning due to multiple/permanent connections. Housekeeping worked to clean the area without moving the cart and will pay special attention to this area to maintain in clean order in the future. The coffee service cart was moved and area underneath thoroughly cleaned. **(COMPLETED)**

(g) Canteen Vending Room Floor Stained: Floor is scheduled to be replaced on July 18, 2002. **(PENDING COMPLETION)**

(h) Vending Machines Soiled: Problem reviewed with Canteen Chief. Plan developed for regular cleaning of vending machines to ensure cleanliness **(COMPLETED)**.

Recommendation - Soiled Ceiling Tiles and Light Covers Replaced (CONCUR)

DIRECTOR COMMENT

Concur with Recommendation

Ceiling Tiles and light covers were replaced during June 2002. **(COMPLETED)**

Recommendation – Canteen Service areas are included in environmental rounds, and that issues identified receive corrective action

DIRECTOR COMMENTS

Concur with Recommendations

(a) Canteen Service areas are a standing part of Environment Rounds – however frequency of rounds in the Canteen will be increased to occur monthly to provide the opportunity to identify and resolve any problems as they occur. Areas noted as a problem during the CAP survey will be given priority attention during rounds to maintain improvements noted above.

(b) As noted above, a process has been established to conduct unannounced reviews each month to assess Canteen operations. An external team from VAMC Chillicothe will visit the Canteen and provide a written report of their findings to the Director on a quarterly basis. A team from the Columbus OPC will inspect the Canteen during the other two months of the quarter to provide internal feedback regarding operations. Issues identified during these reviews will be systematically addressed and resolved to support food service within the Canteen.

Supply, Processing, and Distribution - Clean Environment Standards Needed To Be Enforced

DIRECTOR COMMENTS

Concur With Recommendation

Concur with all recommendations a-d. Regarding e: We will consider two options - purchase of two new surgical sets for cataract surgery or one new flash autoclave, whichever is most cost effective.

Agent Cashier Operations - Physical Security and Unannounced Audits Needed Enhancement

DIRECTOR COMMENTS

Concur With Recommendations (EXCEPT AS NOTED – Item d):

(a) Panic buttons and alarms work properly and that P&SS employees can determine the exact location of alarms. All panic buttons and alarms are again tested monthly, to include those identified in the report - the pharmacy and Agent Cashier. These alarms had consistently been tested on a monthly basis until a year ago when the Physical Security experts from VACO recommended they be tested semiannually.
Distinguishing between the alarms in the Pharmacy and Agent Cashier has been resolved through education. These two locations have the same type of alarm, but are different than the alarms throughout the rest of the facility. Each security officer has been briefed and trained to respond, i.e., if and when an alarm is activated, one officer goes immediately to the pharmacy and the other officer goes to the Agent Cashier. These two locations are directly across the hall from each other; therefore a quick response is gained, regardless of location. **(COMPLETED)**

(b) A safe or vault is obtained for storing keys and combinations to the cashier's office. A new safe has been installed in the Director's Suite; keys and combinations to the cashier's office have been properly secured. **(COMPLETED)**

(c) Fiscal Service employees other than the Agent Cashier are assigned to conduct unannounced audits. A memorandum has been initiated to appoint auditors (Including Fiscal Service employees) to perform the unannounced audit. **(COMPLETED)**

(d) Cashier Reimbursement Vouchers are properly signed. The report states "Cashier Reimbursement Vouchers were not properly signed. VA regulations require that these vouchers be signed by the Agent Cashier and then forwarded to a certifying officer for review and certification".

Fiscal Service suggested the OIG report should note in their findings the purpose of the unsigned forms, i.e., OF 1129 is officially titled "*Cashier Reimbursement Voucher And/Or Accountability Report*" and is therefore used for 2 different purposes. The first is to request/authorize reimbursement of funds to the agent cashier for cash disbursed. The second is to report the status of funds advanced to the Agent Cashier at the end of each month. The Accountability Report is prepared by the agent cashier and submitted via e-mail to the accountability section at the Austin FSC as well as the facility Fiscal Officer. It is then printed and maintained on file in accounting. It is this second purpose for which the forms had not been signed. After e-mailing the reports, we had not obtained the Fiscal Officer's signature on the printed report due to a mistaken assumption that the e-mail served as sufficient documentation. That process was immediately changed during the week of the OIG audit. As written, the review / recommendations from OIG indicates we are not obtaining signatures on our reimbursement forms which are used to issue payments. That is not the case. **(COMPLETED)**

Quality Management - Performance Improvement Data Needed Trending and Analysis to Identify Opportunities for Improvement

DIRECTOR COMMENTS

Concur with Recommendations

(a) Develop processes to collect and trend performance data to make patient care decisions.

The quarterly performance improvement and utilization review data is trended and analyzed by quality management, clinical, and administrative staff. Process action teams are used for selected improvements in patient care delivery. This action was completed by July 2002.

(b) Review cardiopulmonary arrest episodes in a timely manner; and perform mock Code Blues regularly. Real mock code episodes need to be analyzed by the response team to identify opportunities for improvement.

After a stat[1] page (code blue) and the stabilization and safe transport of the patient, the Stat Page Team immediately reviews the process. Mock stat pages are performed quarterly and are reviewed by the Stat Page Team. The Cardiopulmonary (CPR) Committee critiques the stat page and mock stat page reviews. This action was completed by July 2002.

Homemaker/Home Health Aide Program - Clinical Procedures Could Be Improved

DIRECTOR COMMENTS

Concur With Suggestions

(a) An interdisciplinary assessment for H/HHA services includes input from the referring physician, registered nurse, social worker, or other clinicians as necessary.

CONCUR that an interdisciplinary assessment for H/HHA services includes input from the referring physician, registered nurse, social worker, or other clinicians as necessary. THE OPC Clinical Coordinator is developing a template in CPRS for the Nursing Care Referral Form 10-7108 so that input and signatures are easier to track. **(ONGOING).**

(b) The continued need for H/HHA services is reassessed minimally every 3 months.

CONCUR that continued need for H/HHA services be reassessed minimally every three (3) months. A process is in place to assure that the RN's assessment of the veteran's need for continued, increase or decrease of services. Using the veteran's start date in the program, the agency case manager will be contacted; the call will be documented in CPRS and forwarded for co-signatures to the referring MD, RN and social worker. **(COMPLETED)**

(c) Telephone contacts and/or visits to veterans are conducted to assess patient satisfaction with services and verify if CHA visits occurred as scheduled.

CONCUR Initiate telephone contact and/or visits to ensure satisfaction and to substantiate if services are being delivered as scheduled. Random calls and/or visits to veterans receiving H/HHA services will continue to check on the veteran's satisfaction. Geriatrics & Extended Care Line uses two surveys to assess H/HHA services satisfaction. The first survey is mailed to 20% of the program's unique veterans every quarter. The second survey is mailed to all veterans receiving H/HHA. **(COMPLETED)**

Access to Care - Timely Access to Specialty Clinics and Primary Care Services Needed Improvement

DIRECTOR COMMENTS

Concur With Suggestions

Concur that there are lengthy delays in specialty clinics for patients being referred to other VISN 10 facilities, but not a delay of one year. Waits and delays is a top priority for VHA such that waiting times are monitored every two weeks. A short-term plan to expedite services is now in place to hire contract physicians for Primary Care and specialty clinics to ensure waiting times will be less than 30 days.

A long-term plan to help eliminate waiting times is to increase clinical services in Columbus. Our Network Director has committed funds for FY 03 to renovate the Third Floor of the OPC to accommodate additional Primary Care Teams and add specialty clinics most needed for the veterans of Central Ohio, like Urology, Orthopedics, Cardiology, Audiology and Eye Care.

Customer Service – Communication With Patients and Patient Representative Services Needed Improvement

DIRECTOR COMMENTS

Concur With Suggestions

Concur that communication with patients needs improvement. While a few of the front-line clerks may not exhibit good customer service occasionally, most of our employees are courteous and respectful to our veterans. All our full-time employees have completed the Integrity Program "The Customer" and the results of the Outpatient Customer Service Survey of 2001 shows that the VAOPC ranked # 16 among all VA's in courtesy.

Suggestions for Improvement*:*

(a) Vacant clerk positions are filled*:* There is a very high turnover in these positions that always leads to more workload to the clerks until vacancies are filled. At this time, all vacant positions have been filled. **(COMPLETED)**

(b) Processes are developed to monitor and reinforce customer service principles. The VAOPC continues to reinforce good customer service to all employees. We monitor our progress via QUIK card comments, Internal Shopper and Phantom Shopper programs, and the National Customer Satisfaction Survey and Patient Advocate reports. The Clinic also established a Patient Service Team whose charge is to monitor trends in veterans/other stakeholder feedback regarding access, timeliness, appropriateness, and quality of healthcare services and to develop recommendations for ongoing improvement in patient/other stakeholder healthcare services based on results of feedback at the local, network, and/or national level. **(COMPLETED)**

(c) Designated persons are scheduled to cover patient representative functions during specific clinic hours, and the schedule is displayed to inform patients whom they should contact with their concerns. At the time of the CAP Survey, the Clinic's Patient Representative was on extended leave. Several employees were assigned to perform that duty until the position was filled. A permanent Patient Representative has been selected as of 6/16/02. **(COMPLETED)**

Information Technology Security - the VAOPC Contingency Plan Needed To Be Updated and Security Procedures Improved

DIRECTOR COMMENTS

Concur With Suggestions

(a) The clinic's contingency and recovery plan was not a master plan because it did not incorporate all services and divisions operating in the clinic.

CONCUR This will be referred to the facility Information Security Officer (ISO) who manages/maintains the facility contingency plan.

(b) The Clinic's contingency plan's personnel listing had not been updated to reflect changes in key positions. For example, the names of the Information Security Officer and the Alternate were missing.

CONCUR The personnel listing for the contingency plan will be kept current.

(c) Clinic officials had not requested background investigations for employees in critical computer and automated data processing (ADP) positions.

CONCUR Employee background investigations are in process and are being coordinated by Human Resources Management and the Information Security Officer. NOTE: IRM completed all required paperwork and forwarded to Human Resources.

(d) Information Resources Management employees having network technology (NT) system administrator access did not apply proper audit settings for "Security policy Changes" and "Use of User Rights" for the operating system. NT is an object-oriented operating system, and sensitive areas such as security policy changes must be manually set to be specifically audited. We are reviewing the impact of enabling these auditing features. If we determine that enabling will not adversely impact our systems/network (i.e. space available, additional maintenance and/or management required, response times), we will do so.

Medical Supply Inventories - Improved Inventory Controls Would Reduce Costs and Result in More Effective Management

DIRECTOR COMMENTS

Concur With Suggestion

Ongoing implementation of recommendations is in place.

Fee Basis Compensation and Pension Examinations - A Contract with the University Could Reduce Costs:

DIRECTOR COMMENTS

Concur With Suggestion

Contracts with the Ohio State University East and Knox Community Hospital have potential for cost savings in providing compensation and pension exams. The Clinic will pursue setting up a formal contract to provide compensation and pension exams.

Government Purchase Card Program - Controls Needed To Be Strengthened

DIRECTOR COMMENTS

Concur With Suggestions

(a) Adequate separation of duties is enforced in the Government purchase card program.

Concur. The Purchase Card Program Coordinator will no longer have the additional duties of cardholder and approving official. Due to the small size of the service, it has been a necessity for everyone to be able to perform procurement functions. The cardholder accounts were for emergency back-up usage only and were rarely used. These accounts will be closed with CitiBank. The approving official duties will be reassigned to another employee.

(b) Purchase card training records are updated to include complete documentation for cardholders and approving officials.

Concur. We are currently taking corrective action by updating the training records so that everyone has the same type of training documentation (VAF 0242). All cardholders and approving officials have had the required training. Some cardholders took the simplified acquisition class to have the authority to procure over the $2500 threshold. These cardholders were issued contacting warrants in lieu of VAF 0242. The files are being updated to reflect both documents.

Appendix B

VISN 10 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 5, 2002

From: Network Director
VA Healthcare System of Ohio (10N10)

Subj: Draft Report, Chalmers P. Wylie, VA Outpatient Clinic CAP Review

To: Assistant Inspector General, Health Inspections (54)

1. After reviewing the Combined Assessment Program Review of the Chalmers P. Wylie Outpatient Clinic, Columbus, Ohio, Draft Report, I concur with Dr. Lilian Thome's Recommendation

2. Please let us know when we can be of further assistance.

(*original signed by*:)

CLYDE L. PARKIS

Appendix C

Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (105E)
Chief of Staff, Under Secretary for Health (10B)
Office of Special Projects (10C5)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network (10N10)
Director, National Center for Patient Safety (10X)
Chief Executive Officer, Veterans Canteen Service (103)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
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Medical Inspector (10MI)
VHA Chief Information Officer (19)
Director, VA Outpatient Clinic (757/00)
Chief Quality and Performance Officer (10Q)

Non-VA Distribution

Office of Management and Budget
U. S. General Accounting Office
The Honorable Mike DeWine, Ohio, U.S. Senate
The Honorable George Voinovich, Ohio, U.S. Senate
The Honorable Patrick Tiberi, 12th District, Ohio, U.S. House of Representatives
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Committee on Appropriations, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Committee on Appropriations, U.S. House of Representatives

Non-VA Distribution (Continued)

Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives
Subcommittee on National Security, Veterans' Affairs, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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