Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through December 2002

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VA Office of Inspector General
Washington, DC 20420

VA Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2002 through December 2002

1. This report summarizes the conditions, recommendations, and suggestions made in reports of Combined Assessment Program (CAP) reviews at Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities published during the period October 2002 through December 2002. The report is being issued in response to VHA's request for quarterly summarization and reporting of CAP findings. In the future, the Office of Inspector General (OIG) will provide quarterly cumulative reports of CAP findings and at the conclusion of each fiscal year, an annual cumulative summary report will be issued.

2. In the period covered by this summary, the Office of Inspector General (OIG) issued six reports of CAP reviews of VHA medical facilities. The purpose of these reviews was to evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls. We also provided fraud and integrity awareness training for about 1,900 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. Each of the conditions discussed in this summary report was found at more than one medical facility. This report is provided to help ensure that VHA top management, and the Directors of the Veterans Integrated Service Networks (VISNs) and medical facilities address the issues identified. We may continue to review the issues reported here in future CAP reviews as well as covering new areas of inquiry.

RICHARD J. GRIFFIN
Inspector General

Introduction

Background

During the period October 2002 through December 2002, six reports were issued on CAP reviews completed at VA medical facilities. The Office of Inspector General issued its first summary report of CAP findings at VA medical facilities in October of 2001 and the second summary in December 2002. The first summary, issued in October 2001, reported the repeat findings and recommendations of 31 CAP reviews. The second summary, issued in December 2002, reported the repeat findings and recommendations of 40 CAP reviews. In order to provide the Department with timely information on trends and issues found during the CAP reviews, we will report on a quarterly basis a cumulative summarization of our findings and recommendations. At the conclusion of the fiscal year an annual cumulative summary report will be made. This is the first of the quarterly summary reports.

Scope of CAP Reviews

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

- Contracting for Clinical Services
- Contracting for Non-Clinical Services
- Controlled Substance Accountability
- Environment of Care
- General Post Funds
- Government Purchase Cards
- Homemaker/Home Health Aide Program
- Information Management Security
- Management of Equipment Inventories
- Management of Supplies Inventories
- Patient Care and Quality Management
- Pharmacy Waiting Times, Security, and Prescription Refills
- Prosthetics
- Time and Attendance of Part-Time Physicians
- Vendor Visits/Gratuities

Fraud and integrity awareness briefings were also conducted during each CAP review and about 1,900 VHA employees attended the briefings. The briefings included a film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and question and answer sessions.

CAP Reports Issued

The following are the six VHA medical facility CAP reports issued during the period of October 2002 through December 2002.

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Lexington, KY	9	02-01933-3	10/16/2002
Combined Assessment Program Review, VA Medical Center Bronx, NY	3	02-01760-06	10/18/2002
Combined Assessment Program Review, VA Medical Center San Juan, PR	8	02-00868-15	11/13/2002
Combined Assessment Program Review, VA Medical Center Boise, ID	20	02-02582-36	12/20/2002
Combined Assessment Program Review, VA Medical Center Birmingham, AL	7	02-01432-39	12/24/2002
Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, AZ	18	01-02641-40	12/26/2002

CAP Findings by VISN and by Medical Facility

CAP Findings	VISN 3 Bronx	VISN 7 Birmingham	VISN 8 San Juan	VISN 9 Lexington	VISN 18 No. Arizona	VISN 20 Boise
Contracting for Clinical Services and Sharing Agreements	X	X	X	X	X	
Contracting for Non-Clinical Services	X	X	X			
Controlled Substances Accountability	X	X	X	X	X	X
Environment of Care	X			X		
General Post Funds				X		X
Government Purchase Cards	X	X	X	X	X	
Homemaker/Home Health Aide Program		X	X	X	X	X
Information Management Security	X	X	X	X	X	X
Management of Equipment Inventories				X		X
Management of Supplies Inventories		X	X	X	X	X
Patient Care and Quality Management	X	X	X		X	X
Pharmacy Waiting Times, Security and Prescription Refills			X		X	
Prosthetics		X	X			X
Time and Attendance of Part-Time Physicians	X	X	X	X		
Vendor Visits/Gratuities	X					X

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

Summary of CAP Findings

The bullets under each of the following subjects represent recommendations and suggestions made in the 6 CAP reviews that this report summarizes.

1. Contracting for Clinical Services and Sharing Agreements (findings at 5 of 6 medical facilities)

- Ensure that Contracting Officers obtain cost data and/or document price negotiation memorandums (PNMs) in contract files.
- Ensure that officials developing, soliciting, awarding, and administering contracts comply with conflicts of interest statutes.
- Ensure that Contracting Officers Technical Representatives effectively monitor contractor performance.
- Ensure that clinical services contracts include required clauses that facilitate performance monitoring.
- Pursue recovery of overcharges.

2. Contracting for Non-Clinical Services (findings at 3 of 4 medical facilities)

- Improve documentation of price determination and contract award decisions.
- Adequately monitor contractor performance.
- Negotiate prices for noncompetitive contracts as required by Federal Acquisition Regulations and prepare PNMs.

3. Controlled Substances Accountability (findings at 6 of 6 medical facilities)

- Properly conduct controlled substances inspections.
- Ensure physical security weaknesses are corrected.
- Maintain complete accountability records for all Schedule II-V controlled substances.
- Store unusable and expired controlled substances in sealed containers in the pharmacy vault.

- Include unusable and expired controlled substances in monthly inspections.
- Develop and document a formal training program for controlled substances inspectors.
- Complete each monthly inspection within 1 day.
- Reduce excessive inventories of controlled substances.

4. Environment of Care (findings at 2 of 3 medical facilities)

- Pest control needs to be improved.
- Provide clean and odor-free patient care and public areas.
- Improve patient safety by storing potentially dangerous objects and substances out of reach of patients.

5. General Post Funds (findings at 2 of 2 medical facilities)

- Obtain donation letters specifying how donations are to be used.
- Monitor deposits and expenditures.
- Document the purpose of expenditures.

6. Government Purchase Cards (findings at 5 of 6 medical facilities)

- Ensure that acquisition personnel, including purchase cardholders, use the designated Federal Supply Schedule before making open market purchases.
- Ensure that purchase cardholders do not avoid single purchase limits and competitive procurement requirements by "purchase splitting."[1]
- Ensure that purchase cardholders and approving officials reconcile and certify invoices timely.
- Provide purchase cardholders and approving officials with adequate, documented training and/or appropriate warrants.

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

- Conduct monthly and/or quarterly required audits of purchase card transactions.
- Do not purchase telecommunications services with purchase cards.
- Ensure that interim warrants are properly granted and used.
- Provide appropriate warrants to purchase cardholders with purchase limits in excess of $2,500.

7. Homemaker/Home Health Aide Program (findings at 5 of 5 medical facilities)

- Document that interdisciplinary assessments are completed for all patients referred to the program.
- Obtain and review quarterly performance improvement and patient assessment reports to evaluate the quality of care and need for continued service.
- Ensure that clinicians perform a reassessment of need for services.
- Reconcile all bills and notify the program coordinator of discrepancies between services authorized and services actually provided.

8. Information Management Security (findings at 6 of 6 medical facilities)

- Develop a consolidated information technology (IT) contingency plan.
- Monitor access to the computer room.
- Perform background checks on IRM staff.
- Ensure that major information systems are certified and accredited.
- Ensure that the Information Security Officer (ISO) is trained.
- Monitor access to computer-based employee-patients' records.
- Periodically review authorized users to determine if they still have a legitimate need for access.
- Store computer back-up tapes in a secure off-site location.
- Remind all employees to log off computers when leaving their workstations.

- Require Information Resources Management Service employees to back-up server configurations on a computer at the back-up facility.

9. Management of Equipment Inventories (findings at 2 of 3 medical facilities)

- Validate and update equipment inventory lists annually.
- Conduct equipment inventories.

10. Management of Supplies Inventories (findings at 5 of 5 medical facilities)

- Improve accuracy and update the Generic Inventory Package data.
- Eliminate stock in excess of a 30-day supply.

11. Patient Care and Quality Management (findings at 5 of 6 medical facilities)

- Monitor all significant QM action items to resolution, and analyze mortality data for trends.
- Monitor safety and quality control.
- Ensure that patient complaints go to service chiefs or quality management program staff.
- Perform better follow-up on recommendations from boards of investigations and improve documentation of resolution and follow-up of QM reviews.
- Appropriately analyze and use QM data to improve the quality of patient care.

12. Pharmacy Waiting Times, Security, and Prescription Refills (findings at 2 of 4 medical facilities)

- Verify that all patient medications are delivered to the patient before the patient leaves the dispensing window.
- Reduce waiting time for prescriptions.

- Physically strengthen the controlled substances vault.
- Provide privacy hoods for access keypads.

13. Prosthetics (findings at 3 of 4 medical facilities)

- Obtain physicians' prescriptions before issuing equipment, supplies, and accessories.
- Determine veteran eligibility for eyeglasses before ordering eyeglasses from vendors.
- Properly enter data into the national prosthetics database.

14. Time and Attendance of Part-Time Physicians (findings at 4 of 6 medical facilities)

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

15. Vendor Visits/Gratuities (findings at 2 of 4 medical facilities)

- Prohibit vendor representatives from visiting the VAMC without appointments.
- Discontinue permitting vendor's to provide meals to employees that exceed annual dollar limitations on such gifts.

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