Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Huntington, West Virginia

Report No. 02-02939-82 **April 15, 2003**

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 VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of September 16 – 20, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (VAMC) Huntington, West Virginia. The VAMC is part of Veterans Integrated Service Network (VISN) 9. 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 147 VAMC employees, and controlled substances diversion briefings to 33 pharmacy employees.

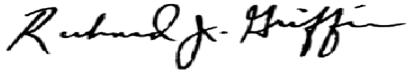
Results of Review

Patient care and QM activities reviewed were generally operating satisfactorily. Medical center 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; however, management controls needed to be improved. To improve operations, VAMC management needed to:

- Strengthen information technology (IT) management controls and security measures.
- Strengthen controls to improve contract administration and compliance with policies and procedures.
- Improve controlled substances inspector training and inspection procedures.
- Improve clinical and administrative procedures in the Homemaker and Home Health Aide (H/HHA) Program.
- Improve parking garage signage.
- Improve patient waiting times and patient seating in the Pathology and Laboratory Medicine Service (PLMS).
- Improve security over medical supplies at the Charleston Community-Based Outpatient Clinic (CBOC).

VISN 9 and VAMC Huntington Director Comments

The VISN 9 Director and VAMC Huntington Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 12 - 17, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.



RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in Huntington, West Virginia, the VAMC is a primary care facility providing inpatient and outpatient health care services. Outpatient care is also provided at three CBOCs located in Charleston and Williamson, West Virginia, and Prestonsburg, Kentucky. The Charleston and Prestonsburg CBOCs are VA-staffed while the Williamson CBOC is contractor operated. The VAMC is part of VISN 9 and serves a veteran population of about 92,450 in a primary service area that includes 23 counties in West Virginia, Kentucky, and Ohio.

Workload. In Fiscal Year (FY) 2001, the VAMC and associated CBOCs treated 24,145 unique patients, an 11 percent increase from FY 2000. The inpatient care workload totaled 3,649 discharges, the medical center's average daily census was 57.8, and the average daily census for community nursing home patients was 40.5. The outpatient workload was 198,111 patient visits.

Resources. In FY 2001, VAMC medical care expenditures totaled $80.3 million. The FY 2002 medical care budget was $86.9 million, 8 percent more than FY 2001 expenditures. FY 2001 staffing was 704.5 full-time equivalent employees (FTEE), including 52.8 physician FTEE and 113.5 nursing FTEE.

Programs. The VAMC provides acute medical, surgical, mental health, geriatric, and advanced rehabilitation services. The VAMC has 80 hospital beds and contracts for nursing home beds in the community as needed. The VAMC also has enhanced health care resources sharing agreements with the Naval Reserve Center in Huntington, West Virginia (space and laboratory services), the Federal Prisons (medical services), and the West Virginia State Veterans Home (laundry, pharmacy, and medical services).

Affiliations and Research. The VAMC is affiliated with the Marshall University School of Medicine and supports 23 medical resident positions in 5 training programs. In FY 2002, the research program had three projects and a budget of $45,760. The primary area of research is cardiology.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

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

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Community-Based Outpatient Clinics	Information Technology Security
Contract Administration	Parking Garage Signage
Controlled Substances Accountability	Part-Time Physician Time and Attendance
Environmental Cleanliness	Patient Waiting Times
Government Purchase Card Program	Quality Management Program
Homemaker/Home Health Aide Program	Vendor Representative Visits

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The survey results were provided to VAMC management.

During the review, we also presented three fraud and integrity awareness briefings for VAMC employees, and three controlled substances diversion briefings for pharmacy employees. The fraud and integrity awareness briefings were attended by 147 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 controlled substances diversion briefings were attended by 33 pharmacy employees and covered an awareness of the most commonly diverted drugs, prevention of diversion, and case specific examples of drug diversion.

Our review covered VAMC operations for FYs 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 VAMC Huntington and VISN 9 management until corrective actions are completed.

Results of Review

Organizational Strengths

VAMC management had 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.

Part-Time Physician Time and Attendance Was Effectively Monitored. The VAMC had established effective controls to ensure that part-time physician time and attendance was effectively monitored and accurately reported. There was a sign-in sheet for all part-time physicians and clinic clerical staff verified the physicians' attendance with the timekeepers.

Government Purchase Card Program Controls Were Effective. VAMC staff approved and reconciled Government purchase card transactions as required. Government purchase cards were issued only to appropriate individuals, and there were no inappropriate purchases among the transactions examined.

Pharmacy Security and Controls Were Effective. The VAMC pharmacy had effective security for access to vaults and cages containing controlled substances. A closed circuit television system was monitored and panic buttons that alert medical center police were placed at strategic sites. Access to controlled substances in the pharmacy was restricted to less than 10 employees within a 24-hour period. Controlled substances for inpatients were stored in locked automated dispensing machines until issued. All controlled substances were purchased directly by the pharmacy and all deliveries were made directly to the pharmacy. No other medical center service was directly ordering or receiving controlled substances.

Controls Over Vendor Representative Visits Were Recently Improved. During the period of August 2001 through June 2002, the affiliate, Marshall University School of Medicine, had arranged for approximately 200 free luncheons provided by pharmaceutical company representatives for residents at the VAMC. In July 2002, based on a VISN 9 directive, the VAMC implemented a policy that prohibited VAMC employees from accepting free meals or refreshments of any kind from vendor representatives. Clinical service chiefs stated that vendors have not provided free luncheons since the VAMC policy was implemented. Vendor representatives do provide promotional items of inconsequential value, such as pens, note pads, and coffee mugs. The value of these items was de minimis, and therefore permitted by regulation.

CBOC Management Controls and Procedures Were Effective. The VAMC had effective management controls to ensure the achievement of operational and patient care goals at the Charleston CBOC. The Charleston CBOC had direct access to VA computerized records allowing the VAMC oversight that included monitoring for quality control issues and performance measures, maintaining IT security, and performing coding and billing functions. The CBOC Coordinator also monitors for patient care quality control issues. IT security was effective and means tests were completed as required.

The Performance Improvement/Quality Management (PI/QM) Program Was Comprehensive and Effective. The VAMC implemented and maintained an effective PI/QM program to monitor the quality of care provided using national and local performance measures, patient safety management, and utilization review. Comprehensive PI/QM monitors were in place to improve patient care. PI/QM findings were properly analyzed to detect trends, and actions were taken to address individual issues. Administrative investigations, PI/QM focused reviews, root cause analyses, and peer reviews were conducted properly, and corrective actions were implemented. Clinical managers also implemented a structured and comprehensive PI/QM program for monitoring attending physicians' supervision of medical residents.

In addition to meeting Veterans Health Administration (VHA) requirements, the Credentialing and Privileging (C&P) office's physician files also contained results of checks with the Department of Health and Human Services Medicare exclusionary list. The C&P staff utilizes a VA Central Office (VACO) developed web site that allows appropriate staff to access information at the main campus. This information includes CBOC clinician-specific clinical privileges; scopes of practice for health professionals such as clinical nurses, physician assistants, and pharmacists; and graduated levels of responsibility for physician residents. The Medical Staff Council is active, and they routinely review the results of PI/QM monitors from health care disciplines and services.

The VAMC Peer Review Committee Uses An Innovative Process Involving Computerized Medical Records to Facilitate Peer Reviews. A multi-specialty physician group, chaired by the Chief, Medical Service, conducts the VAMC's peer review process. During peer review meetings, pertinent aspects of patients' medical records in the facility's database, including images from procedures and diagnostic studies, are projected on a screen for viewing. According to peer review committee members, the method of review has significantly improved the timeliness, accuracy, and the dynamics of the group peer review process.

The H/HHA Program Was Cost-Effective. The VAMC provided H/HHA services for 42 patients during FY 2001 and 50 patients during FY 2002. All of the patients were eligible for VA nursing home care, but because of the H/HHA Program, they were able to remain and receive needed care in their homes. At the time of our visit, the facility was contracting with 27 Community Health Agencies (CHA) in West Virginia, Ohio, and Kentucky. In FY 2002 the CHAs provided the facility H/HHA services at an annual cost of $277,175. We compared this to the reported cost of keeping these patients in VA nursing homes. According to VHA, in FY 1999 (the latest data available) the average annual cost of keeping a patient in a VA nursing home was $78,767. Using this per-patient cost for comparison purposes, the total annual cost to provide VA nursing home care would have been $3,938,350 (50 patients x $78,767) in FY 2002. This reflects a cost savings of $3,661,175 ($3,938,350 less $277,175) in FY 2002.

Opportunities for Improvement

Information Technology Security – Management Controls and Security Measures Needed to be Strengthened

Conditions Needing Improvement. VAMC management needed to strengthen controls and security measures in the following areas in order to fully comply with VHA policy.

Information Security Officer (ISO) Collateral Duties. The VAMC ISO had many collateral duties and dedicated only 30 percent of her time to the duties of the ISO position. The assigned collateral duties prevented her from performing all the responsibilities required of an ISO. For example, she did not review computer access profiles for all VAMC employees to ensure that access to applications was based on legitimate need as required by VHA policy.

Computer Room Access. The computer room had two entrances, controlled by key/lock entry, and there was an access log book at each entrance. Seventeen Information Resource Management (IRM) employees requiring access to the computer room were provided keys. However, VAMC policy did not require IRM employees that had keys to the computer room to log in upon entry. Further, the log books were not reviewed by the ISO to ensure that only individuals with a need for access were permitted entry to the computer room.

Management Level Account Access. Six IRM employees had access to a management level user account, with authority to perform various administrative actions. All six employees used the same password. By having more than one user with the same password, there is no way to determine which employee accessed the account, thus eliminating individual accountability.

Alternate Site Selection. One key element of a successful contingency plan is the identification of an alternate site where business can be continued in the event of a catastrophe. The VAMC did not designate an alternate site as part of its contingency plan. The Systems Manager and ISO took corrective action when we brought this issue to their attention. VAMC Lexington was selected as the alternate site.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director: (a) assigns information security as the primary responsibility of the ISO; (b) requires that access to critical and sensitive areas be logged and reviewed by the ISO on a monthly basis; (c) implements password controls to track employees accessing the management level user account; and (d) identifies VAMC Lexington as the alternate site in the facility contingency plan.

The VISN Director and VAMC Director agreed with our recommendations and reported that a full-time ISO position has been advertised and should be filled by March 17, 2003. The list of IRM employees authorized a key to the computer room will be reviewed by the ISO on a monthly basis, as will the log books that have all entries logged by visitors. Access to the management level user account has been edited to require IRM staff to log in using their access codes so that entry to this account can be tracked. The contingency plan was amended to

identify VAMC Lexington as the alternate site. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Contract Administration – Compliance With VA Policies Needed To Be Strengthened

Conditions Needing Improvement. VISN and VAMC management needed to ensure contracts were negotiated and administered in accordance with VA policy.

Contract Administration Requirements. VA policy requires contracting officials to initiate background investigations of contractor personnel granted access to VA computer systems. Additionally, VA policy requires that copies of all scarce medical specialists services and scarce medical resource contracts executed locally be submitted to VACO's Director, Medical Sharing Office to facilitate quality assurance and oversight of locally awarded contracts. VA policy requires VAMCs to maintain documentation supporting the exercising of contract options, contractor signature acknowledgement of the VA-delegated Contracting Officer Technical Representative (COTR), and amendments to delete non-relevant contract clauses.

VAMC Contracts. We reviewed six current clinical service contracts (total estimated value $2.8 million) negotiated, awarded, and administered by VAMC Huntington. The following table identifies the contract administration deficiencies found in the six contracts:

Contract Number	V581P-2642	V581P-2706	V581P-2652	V797P-2657	V581P-2591	V581P-2593
Contract Value	$224,000	$929,000	$110,000	$975,000	$430,000	$151,000
Contract Deficiencies						
Required background investigation process was not initiated.	X			X		
Mandatory contract reporting to VACO was not accomplished.	X			X	X	X
No documentation of contractor signature acknowledgement of VA-delegated COTR.	X	X	X	X	X	X
Amendment to delete non-relevant clauses was not issued.			X			

The contract administration deficiencies are briefly described below:

- A diagnostic radiology contract (V581P-2642) effective July 1, 2001, (estimated value $224,000) allows two contractor personnel access to VA computer systems. VA policy seeks to maintain information security controls to protect sensitive data from destruction, manipulation, and inappropriate disclosure. The policy states: "contract performance shall not commence prior to the contracting officer initiating the process that requests appropriate

background investigations." As of June 30, 2002, 12 months after the contract became effective and access to VA computer systems was granted, the required background investigation process had not been initiated.

- A radiation therapy services contract (V797P-2657) effective October 1, 2001, (estimated value of $975,000) allows three contractor personnel access to VA computer systems. The required background investigation process had not begun as of June 30, 2002, 9 months after the contract became effective and access to VA computer systems was granted.
- Mandatory submission of contracts to VACO was not accomplished for four clinical services contracts (V581P-2642, V581P-2657, V581P-2591, and V581P-2593) with a total estimated value of $1.8 million.
- None of the six contract files contained documentation that the contractors acknowledged by signature the VA-delegated COTR for each contract.
- A contract for home intravenous therapy services (V581P-2652) with an estimated value of $110,000 needed to be amended to delete non-relevant clauses pertaining to IT security. The contract stated that contractor personnel would have access to VA computer systems. We were informed that contractor personnel would not have this access and that the clause should be deleted from the contract.

VISN Contracts. We reviewed two community nursing home daily rate contracts negotiated and administered by the VISN, on behalf of VAMC Huntington. We found exceptions with one of the contracts. According to VA policy, contract files must contain price negotiation memoranda (PNM) and supporting documentation to justify exercising option years. The PNM generally describes the services being procured, the purpose of the negotiations, and an explanation of how prices were determined. Supporting documentation for the exercising of an option year certifies: (a) the option was evaluated by VA contracting officials to determine continued need for the contract, and that the exercising of the option is the most advantageous method of fulfilling the Government's needs; and (b) required funds are available. Additionally, VHA policy requires that: "Each patient admitted to a community nursing home will be visited no less frequently than every 30 days by a VA staff member. A nurse will make follow-up visits at least once every 60 days, and more often if necessary, to ensure that adequate and safe care is being provided." The following deficiencies were found:

- Required documentation was missing from the contract file (V249P-0109) for a VISN administered community nursing home contract. With the base year and 2 option years, this contract has a period of performance of April 19, 2000 through April 18, 2003. Although the rates stated in the agreement were within VA guidelines, there was no PNM in the contract file describing the important elements of the contract negotiation process, nor was there supporting documentation to justify the exercise of option year 2 on March 19, 2002.
- Visits to contract community nursing homes by VA staff members and nurses were not conducted as frequently as required by VHA policy. Four veterans placed in a contract nursing home under contract V249P-0109 during the period October 1, 2000 to June 30, 2002 did not receive the required number of visits by VA staff members. We suggest that management ensures that visits by VA staff members and nurses to contract community nursing homes are at the frequency required by VHA policy.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that: (a) the VAMC Director implements controls to improve contract administration and compliance with VA procurement policies and procedures, and (b) VISN contracts for community nursing homes contain the required PNM and supporting documentation to justify the exercising of option years.

The VISN Director and VAMC Director agreed and stated that all current contracts have been reviewed and the appropriate documentation/memoranda/security requirements have been completed. All current and future contracts will have the Business Review Program checklist incorporated into the contract file to improve contract administration and compliance with VA policies. The nursing home agreements have been reviewed and PNMs are now on file in each contract folder. Supporting documentation to justify the exercising of renewal options has been improved. The improvement actions adequately respond to our recommendation and we consider the issues to be closed.

Controlled Substances Accountability – Inspection Procedures Needed To Be Improved.

Conditions Needing Improvement. Medical center management needed to ensure that required training was provided to controlled substances inspectors and documentation of the training was maintained by the VAMC Director or an appointed Controlled Substances Inspection Coordinator. In addition, proper procedures needed to be followed in reporting the loss of controlled substances. VHA policy requires an adequate and comprehensive system to include safety and control of stocks for all Schedule II-V controlled substances. The following deficiencies were identified:

- There was no documentation of training for 9 (36 percent) of 25 controlled substances inspectors.
- Controlled substances inspectors were not reconciling receiving reports against all entries of quantities on the pharmacy electronic inventory sheets.
- Controlled substances inspectors were not properly inspecting all outdated and unusable controlled substances returned to the pharmacy to await destruction.
- A loss of 60 Oxycodone tablets in March 2002 was reported to the Drug Enforcement Agency. However, the loss was not reported to the OIG Office of Investigations or the VAMC Police and Security Service as required by VHA policy. Local policy did not include this requirement and did not reference VHA policy.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director: (a) provides and documents training for controlled substances inspectors, (b) properly reports the loss of controlled substances, and (c) updates VAMC policies to include reporting requirements regarding loss of controlled substances and reference to current VHA policies.

The VISN Director and VAMC Director agreed and a controlled substances security officer/ISO position has been posted. One of the responsibilities of this position will be to establish a more thorough training program for the inspecting officials. Checklists have been developed for each inspection area to ensure all duties are accomplished for the individual area. The training will be completed by April 30, 2003. Appropriate staff has been advised on the proper reporting of the loss of any controlled substance and the applicable Medical Center Memorandum will be updated to include this process by April 1, 2003. The improvement plans are acceptable and we will follow up on the completion of planned actions.

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

Conditions Needing Improvement. Clinicians should improve the H/HHA Program's patient assessment procedures and oversight practices. We found that patient assessments needed to be adequately documented. The H/HHA Program coordinator needed to ensure treatment plans were completed and CHA supervisory activities were monitored. In addition, managers needed to complete contracts for H/HHA services.

Patient Assessments. We found that nurses and social workers had not completed and documented initial needs assessments for 2 of the 10 patients in our sample prior to their referrals to CHAs for H/HHA services.

VAMC teams are required by VHA policy to perform follow-up needs assessments on patients. We found that only the social worker performed follow-up needs assessments for the 10 patients we reviewed. VHA requires nurses and social workers to follow up with their patients every 90 days to determine if they continue to need H/HHA services, and to monitor the quality of care provided to the patients by homemakers and home health aides. To ensure compliance with VHA policies and ensure that veterans receive the highest quality of care, the interdisciplinary team should participate in the follow-up needs assessment process. The H/HHA Program coordinator needed to strengthen H/HHA procedures by requiring clinicians to adequately document and justify patient placements, and monitor their patients' continuing need for the services.

Treatment Plans and PI Data. We found that the medical records of the 10 patients included in our review did not contain documentation of treatment plans. Treatment plans are necessary to enable VA clinicians to monitor whether patients are improving and continue to benefit from this service. In addition, we found no evidence that VAMC managers required the CHAs to submit patient care PI data, such as records of medication errors, complaints, untoward incidents, and patient falls. This patient care PI data would enable clinicians to better monitor the quality of services provided to patients, and it would assist them in identifying areas warranting performance improvement initiatives.

CHA Contracts. H/HHA Program managers did not have formal contracts with CHA's, only agreements with them to provide H/HHA services. The agreements did not require CHAs to

certify that they had valid state licenses, nor did they include full descriptions of the services provided, rates for services, or instructions for billing. Moreover, the agreements did not require CHAs to itemize the services provided to VAMC patients for billing purposes.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director: (a) completes and documents interdisciplinary initial and follow-up assessments for all patients referred to the H/HHA Program; (b) H/HHA Program managers obtain and review quarterly CHA PI data and patient follow-up needs assessments reports to monitor the quality of care provided to VAMC patients; and (c) contracts with CHAs are completed for each patient.

The VISN and VAMC Directors agreed with our recommendations and reported that a new interdisciplinary template for the initial referral and the 90-day reevaluations has been implemented to provide information necessary to screen the veterans for program eligibility. CHAs will be required to submit an initial care plan and follow-up assessments every 90 days. A new form has been designed to be used on a monthly basis by the CHAs to document services and time spent in the home. This documentation must be submitted with the agency's monthly invoice for the agency to receive payment. The Directors also agreed to initiate contracts with the CHAs. The Directors stated that establishing contracts with the CHAs would result in higher costs due to higher CHA labor rates. However, they provided no evidence that CHA labor rates would be higher if formal contracts are utilized. We believe that the present level of costs can be maintained within the framework of formal contracts and, in our opinion, contracting for these services would not adversely impact the quality of care provided patients. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Parking Garage – Signage Needed To Be Improved

Condition Needing Improvement. VAMC management needed to improve signage in the facility parking garage. The VAMC has a 5-level covered parking garage for patients, employees, and visitors. We found that the garage did not have adequate signage to direct drivers where to park, describe how to access the medical center, or how to exit the garage. The patients and employees we interviewed told us that signage was a problem and that they often got confused and lost. The Chief, Engineering Service agreed that signage needed improvement. Improving signage in the parking garage should enhance the service to and customer satisfaction of patients, employees, and visitors.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the VAMC Director take action to improve the signage for patients, employees, and visitors parking in the facility parking garage.

The VISN and VAMC Directors agreed and stated that directional signage will be designed and installed pending the decision of re-designating parking spaces. It is estimated that this project will be completed in April 2003. The improvement plans are acceptable and we will follow up on the completion of planned actions.

Patient Waiting Times and Clinic Seating Availability – Patient Waiting Times and Clinic Seating Availability in Pathology and Laboratory Medicine Service Needed Improvement

Condition Needing Improvement. VAMC management needed to improve PLMS patient waiting times and increase the availability of seating for patients waiting to have their blood drawn. We interviewed PLMS managers and reviewed internal studies conducted from April through June 2002. We found that patients were waiting up to 68 minutes in the PLMS clinic to have their blood drawn. We observed clinic patients standing in long lines waiting to have their blood drawn. We also noted that patients had to stand in the clinic waiting area because it only had 13 seats. The Chief, PLMS told us that when lines are excessive patients are often transferred to another floor to have their blood drawn. Transferring patients to a different location is inconvenient, can be confusing to patients, and can create further delays. The Chief, PLMS acknowledged that the present clinic waiting area was not adequate.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director improve service to patients by reducing waiting times and providing additional seating in the clinic waiting area. The VISN and VAMC Directors agreed and an additional phlebotomist position was filled. Two phlebotomy students are also assisting with the drawing of blood. The phlebotomy room was remodeled to increase the number of workstations and improve patient access. Additional seating has been provided in a contiguous area and patients are given a number upon signing in. Patients are notified by number when it is their turn to have their blood drawn. The improvement actions adequately respond to our suggestion and we consider the issue to be closed.

Charleston Community-Based Outpatient Clinic – Security Over Medical Supplies Should Be Enhanced

Condition Needing Improvement. VAMC management needed to improve security over medical supplies at the Charleston CBOC. The supply closet at the Charleston CBOC has a standard interior door with a basic handle lock. It is used to store medical supplies including scalpels, needles, and syringes. The door is left open for the convenience of employees, but could easily be accessed by any person at the CBOC, creating an inherent security threat to patients, employees, and visitors.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director takes action to install an electronic combination lock on the supply closet at the Charleston CBOC. The VISN and VAMC Directors agreed in part and a manual lock, rather than an electronic combination lock, has been installed on the supply closet. Personnel have been instructed to keep the door closed at all times. The improvement actions adequately respond to our suggestion and we consider the issue to be closed.

Appendix A

VISN 9 and VAMC Huntington Director Comments

DEPARTMENT OF VETERANS AFFAIRS **MEMORANDUM**

Date: February 4, 2003

From: Network Director (10N9) MidSouth Healthcare Network, Nashville, TN

Subj: Status Request – DRAFT Combined Assessment Program Review Huntington VAMC (2002-02939-R1-0149)

To: Assistant Inspector General for Auditing (52)
THRU: Director, Management Review and Administration Service (105E)

1. Attached for your review are comments from the Huntington VAMC relating to the DRAFT Combined Assessment Review.

2. If you have any questions or require additional information, please contact Vivieca Wright, Health Systems Specialist/Compliance Officer, 615) 340-2393.

John Dandridge, Jr.
Network Director
/s/

Attachment – DRAFT Huntington VAMC CAP Response

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the VAMC Director: (a) assigns information security as the primary responsibility of the ISO, (b) requires that access to critical and sensitive areas be logged and reviewed by the ISO on a monthly basis, (c) implements controls to track employees accessing the management level account, and (d) identifies VAMC Lexington as the alternate site in the facility contingency plan.

VAMC Comments January 24, 2003:

a) A full-time position has been advertised and the position should be filled by March 17, 2003.

b) There is a published list of officially authorized IRM employees that have access to the computer room. This list is reviewed by the ISO. The server room contains multiple systems to which staff must have access. These employees have all completed required background investigations and are trusted employees and must access the room on a routine basis to do their daily assigned duties. Action: The list of IRM employees authorized a key to the computer room will be reviewed by the ISO on a monthly basis, as will the two log books that have all entries logged by visitors. The Facility is in the process of purchasing a monitored "card/key" system that will be monitored by the ISO. The system will also be used for Pharmacy area security.

c) The following recommendation was provided to the Auditor while on site and implemented based on that discussion. Access to the management account was edited to require the person accessing the account to enter his/her access code, which would have to match the Vista Access code. This provides a means to track the account user. Action is complete.

d) The contingency plan was amended to identify VAMC Lexington as the alternate site. Action is complete.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that: (a) the VAMC Director implements controls to improve contract administration and compliance with VA procurement policies and procedures and (b) VISN contracts for community nursing homes contain the required price negotiation memorandum and supporting documentation to justify the exercise of the option years.

VAMC Comments January 24, 2003:

a) All current contracts have been reviewed and the appropriate documentation/memorandums/security requirements have been completed. All current and future contracts will have the Business Review Program checklist incorporated into

the contract file. The process will improve contract administration and compliance with VA procurement policies and procedures. Action is complete

b1) V249P-0109 was missing a price negotiation memorandum. The initial agreement was prepared by a previous Contracting Officer who no longer works for the VA. The contract file for this agreement did contain a divider named "Price Negotiation Memorandum", however there was no official memorandum filed, just the back up material. We have reviewed other nursing home agreement files accomplished by this employee and they have all of the appropriate official memorandums filed behind the designated divider. We are unsure why this particular one was not present. It is standard practice to have price negotiation memorandums in our nursing home files. The contracting officers currently assigned to Nursing Home contracts have gone through each nursing home agreement and have assured that there are now price negotiation memorandums on file in each contract folder.

b2) Supporting documentation to justify the exercising of renewal options has been improved. As discussed with the OIG team in August, prior to their visit, we changed the process of exercising renewal options to include a memorandum, which is signed by the Chief, Social Work Service and Medical Staff indicating their approval to continue an agreement with the nursing home. It should be noted that while these nursing homes are referred to as "contract" nursing homes, they are in fact only "Basic Ordering Agreements", better known as BOA's. In accordance with FAR 16.703, a basic ordering agreement is not a contract. Basic ordering agreements do not obligate funds nor are the options evaluated prior to award. While we are in agreement that these files do not contain the memorandum signed by the Chief, Social Work Service and Medical Staff indicating their approval to continue with the BOA, it is only because their agreements had not come up for renewal since we had implemented the change in our process to cover this requirement. The process we now have in place will cover the supporting documentation required for exercising the renewal options.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the VAMC Director: (a) provides and documents training for controlled substances inspectors; (b) properly reports the loss of controlled substances; and (c) updates VAMC policies to include reporting requirements regarding loss of controlled substances and reference to current VHA policies.

VAMC Comments January 24, 2003:

a) A controlled substance security officer (CSSO)/ISO position has been posted and the announcement closed on January 10, 2003. One of the responsibilities of this position will be to establish a more thorough training program for the inspecting officials. Best practices have been gathered from other facilities by the Chief, Pharmacy Service to share with the CSSO. Checklists have been developed for each inspection area to ensure

all duties are accomplished for the individual area. The training will be completed by April 30, 2003.

b) It has been noted that any loss that is reported to the DEA should also be reported to the OIG Criminal Investigations Division and Police and Security at the Huntington VA. All appropriate staff has been advised.

c) Medical Center Memorandum QA/IC-5 has been updated to include the appropriate reporting of any controlled substance loss. This includes reporting to the DEA, OIG Criminal Investigations Division, and the local Police and Security. This memorandum will also be revised to include any changes that will occur with the new controlled substance security officer and the final approval by the Medical Center Director will occur by April 1, 2003.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the VAMC Director: (a) completes and documents interdisciplinary initial and follow-up assessments for all patients referred to the H&HHA program; (b) H&HHA Program managers obtain and review quarterly CHA PI data and patient reassessment reports to monitor the quality of care provided to VA patients; and (c) contracts with CHAs are completed for each patient.

VAMC Comments January 24, 2003:

a) A new template for the initial referral and for the 90-day reevaluations has been developed and implemented to incorporate information necessary to screen the veteran to determine eligibility for the program. This is a multidisciplinary note involving the Social Worker, Community Health Nurse, Physician, H/HHA Coordinator, referring clinician, and other involved disciplines as needed.

b) The VAMC will require the community agencies to submit the initial care plan and follow-up assessments every 90 days. Since the implementation of the H/HHA Program at the Huntington VAMC, each community agency has been required to submit monthly documentation that outlines the services provided to the veterans at each visit. A new form has been designed to be used by the community agencies that will document the services and time spent in the home. The veteran and/or their caregiver must sign this document verifying the accuracy of the information documented by the aid. The documentation is submitted by the community agency with their monthly invoice for payment. The VA will not process the bill unless this documentation is present and completely filled out including the appropriate signatures by the veteran, caregiver, and the aid providing the services.

c) The current system in place establishes clear expectations between the VA and the agencies, and proper reimbursements are made for services rendered. As verified by the site surveyor, cost effective services, providing quality care are in place for the patients we service. As noted in the draft report under Organizational Strengths – "The Homemaker and Home Health Aide (H&HHA) Program was cost-effective. The VAMC provided H&HHA services for 42 patients during FY 2001 and 50 patients during FY 2002. All of the patients were eligible for VA nursing home care, but because of the H&HHA program, they were able to remain and receive all needed care in their homes." The recommendation to establish formalized contracts will result in higher cost of the program without added benefit to the patient. The average hourly cost for the H/HHA is currently in the $12 - $15 per hour range. Formalized contracts will be sought but an expected outcome is that agencies will be required to pay their staff at a much higher hourly rate than their normal pay scale.

The collaborative approach at the VAMC with the agencies serving patients in the rural and remote settings has resulted in positive impact for the patient without increasing costs. The VA is conducting formal inspections of the community agencies. An MSW or the Community Health Nurse carries out the inspections that include:

- External licensing or certification boards
- Internal audit of services
- Patient satisfaction surveys conducted by the agency
- Type of services that can be provided
- Limitation of services
- Agency chart

Agencies' policies are reviewed to determine:

- Recruitment procedures
- Hiring procedures
- Orientation/training procedures
- Health screening requirements
- Criminal background investigation procedures

The agency receives a written review of the inspection outlining any necessary recommendations with a request for a written plan of correction. The above practices are based on VHA DIRECTIVE 96-031 April 16, 1996 and VHA DIRECTIVE 96-045 July 12, 1996.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the VAMC Director takes actions to improve the signage for patients, employees, and visitors parking in the facility-parking garage.

VAMC Comments January 24, 2003:

Directional signage and adequate patient parking is currently being reviewed. An increased number of patient parking spaces in the garage is anticipated based on the increased number of veterans receiving care at the Medical Center. Pending the final decision of re-designating parking spaces, appropriate directional signage will be designed and installed. Completion date is estimated April 2003.

SUGGESTED IMPROVEMENTS

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the VAMC Director improve service to patients by reducing waiting times and providing additional seating in the clinic waiting area.

VAMC Comments January 24, 2003:

a) Recruitment of one additional phlebotomist was requested and approved in October. The position has been filled. Two phlebotomy students are also assisting with staffing. The phlebotomy room was remodeled in October 2002 to increase the number of workstations from 5 to 7 (including 1 wheelchair position), and improve patient access. Action is complete.

b) Additional seating was provided in the lobby contiguous to the phlebotomy room in mid-October, increasing seating capacity to 27. Patients are given a number upon signing in, and there is an intercom to notify patients by number when it is their turn to be drawn. Action is complete.

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the VAMC Director takes action to install an electronic combination lock on the supply closet.

VAMC Comments January 24, 2003:

a) Personnel have been instructed to keep the door closed at all times. On-site inspections by CBOC manager have ascertained that this is current practice.

b) A manual lock is consistent with locking mechanisms on supply closets throughout the Medical Center and has been installed. Action is complete.

Appendix B

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (105E)
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 Operations (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Management and Financial Reports Service (047GB2)
Medical Inspector (10MI)
VHA Chief Information Officer (19)
Director, National Center for Patient Safety (10X)
Veterans Integrated Service Network Director (10N9)
Director, VAMC Huntington (581/00)

Non-VA Distribution

Office of Management and Budget
General Accounting Office
Senator Robert C. Byrd
Senator John Rockefeller IV
Congressman Nick J. Rahall II
Congresswoman Shelley Moore Capito
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, 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
- 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

Appendix B

Subcommittee on National Security, Veterans, Affairs and International Relations, Committee on Government Reform and Oversight, 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 Audit 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.