Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

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VA Office of Inspector General
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Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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Contents

Executive Summary

Introduction

During the week of January 13–17, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Roseburg Healthcare System (VARHS), which is part of Veterans Integrated Service Network (VISN) 20. The purpose of the review was to evaluate selected healthcare system 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 138 VARHS employees.

Results of Review

VARHS patient care, QM, financial, and administrative controls reviewed were generally operating satisfactorily. To improve operations, the VARHS needed to:

- Reduce excess engineering, medical, and prosthetic supply inventories and strengthen inventory management controls.
- Improve procedures for identifying veterans with insurance and pursue insurance receivables more aggressively.
- Strengthen administrative oversight of the Government Purchase Card program.
- Enhance QM by improving analysis of data, documentation of corrective actions, and use of evaluation criteria.
- Perform annual inventories of nonexpendable equipment and update equipment inventory lists.
- Strengthen controls and correct security deficiencies for information technology (IT) resources.
- Correct deficiencies in controlled substances inspection procedures.
- Improve the management of violent patients by documenting analyses of violent incidents and posting alerts about potentially violent patients in the hospital computer system.
- Correct safety deficiencies in the Canteen Service and the Nutrition and Food Service.

VISN 20 Director and VARHS Director Comments

The VISN 20 Director and the VARHS Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix B, pages 15–25, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by
Deputy Inspector General)
RICHARD J. GRIFFIN
Inspector General

Introduction

Healthcare System Profile

Organization. The VARHS provides inpatient and outpatient care at the medical center in Roseburg, OR and also provides outpatient care at community based outpatient clinics (CBOCs) in Eugene, Brookings, and Bandon, OR. The VARHS is part of VISN 20 and serves a population of about 62,320 veterans in a primary service area that includes 4 counties in southern Oregon and 1 county in northern California.

Workload. In Fiscal Year (FY) 2002, the VARHS treated 21,501 unique veterans, an 8.5 percent increase from FY 2001. The FY 2002 inpatient average daily census (ADC), including nursing home patients, was 112. For FY 2003 through December 2002, the ADC was 120. Outpatient workload totaled 228,730 patient visits in FY 2002 (a 0.5 percent decrease from FY 2001) and 56,605 visits in FY 2003 through December 2002.

Resources. The FY 2003 medical care budget is $67.4 million, about a 1 percent increase over the FY 2002 budget of $66.6 million. FY 2003 staffing through January 2003 was 678.7 full-time equivalent employees (FTEE), including 27 physician and 230.8 nursing FTEE. FY 2002 staffing was 676.8 FTEE, including 26 physician and 229.7 nursing FTEE.

Programs. The VARHS provides acute medical, surgical, and psychiatric inpatient services and has a total of 68 acute care beds. Programs include primary and specialty care, ambulatory surgery, and psychiatry. The VARHS also has a 40-bed nursing home and a 15-bed Alzheimer's Unit. Specialty services include cardiology, ophthalmology, endocrinology, gerontology, dermatology, and vocational rehabilitation.

Affiliations. For nursing programs, the VARHS has affiliations with Umpqua and Mt. Hood Community Colleges, Graceland College, Gonzaga University, the University of Portland, and the Oregon Health Sciences University (OHSU). For physician assistant rotations, the VARHS has affiliations with OHSU and the University of Washington. As of January 2002, an elective rotation for Family Medicine was also made available to medical residents from OHSU.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected health care system operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered VARHS operations for FY 2002 and FY 2003 through December 2002 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

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 23 activities:

- Accounts Receivable
- Acute Medical-Surgical Units
- Agent Cashier
- Behavioral Health
- Community Based Outpatient Clinics
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Employee Quarters
- Enrollment and Resource Utilization
- Environment of Care
- Equipment Accountability
- Government Purchase Card Program
- Information Technology Security
- Laboratory Security
- Long-Term Care
- Management of Violent Patients
- Medical Care Collections Fund
- Pharmacy Security
- Primary Care Clinics
- Quality Management
- Service Contracts
- Supply Inventory Management
- Unliquidated Obligations

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–13). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective action is implemented. Suggestions pertain to issues that should be monitored by VISN and VARHS management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

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. Questionnaires were sent to all employees, 53 of whom responded. We also interviewed 32 patients during the review. The survey indicated high levels of patient and employee satisfaction and did not disclose any significant issues.

During the review, we also presented 3 fraud and integrity awareness briefings that were attended by 138 VARHS employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Organizational Strengths

Group Medical Visits Provided Efficient, Satisfying Care. As part of the primary care program, the VARHS had begun group clinics for diabetic patients. The goals of the clinics included improving quality of care and clinical outcomes, controlling costs, and increasing patient satisfaction. About 10 patients and their caregivers attended the monthly diabetic clinics. During the visits, the clinical team provided patient education, discussed expectations, and provided care such as foot exams. The interaction among the patients in the group setting was rewarding to both patients and providers.

Vendor and Employee Accounts Receivable Were Aggressively Pursued. Fiscal Service had effective controls for identifying and pursuing delinquent vendor and employee accounts receivable. We reviewed accounts receivable records for the 4-month period August–November 2002 and found that Fiscal Service staff had verified the accuracy of billed, collected, and delinquent receivables by reconciling the General Ledger to subsidiary accounting records. We also evaluated Fiscal Service collection efforts for all 40 receivables (value = $39,414) owed as of November 30, 2002, and found no deficiencies. Receivables with recovery potential were aggressively pursued, and receivables that did not have recovery potential were promptly written off as uncollectible.

Unliquidated Obligations Were Reviewed Monthly and Canceled when Not Needed. As of November 30, 2002, the VARHS had 799 unliquidated obligations valued at $13.7 million. We reviewed a judgment sample of 10 obligations (5 undelivered orders valued at $1.1 million and 5 accrued services payable valued at $217,011). Fiscal Service was reviewing unliquidated obligations every month, contacting VARHS services to determine whether the obligations were still needed, and promptly canceling obligations that were no longer needed.

CBOCs Were Well Managed and Controls Were Effective. The three CBOCs had effective programs to monitor financial and administrative activities and had sound management controls in place. Means test certifications were obtained from veteran-patients, and notices for annual updates were sent out when required. Patient wait times for follow-up appointments were satisfactory. Employees who held Government Purchase Cards had been properly trained and were using the cards appropriately. CBOC lease and service contract prices were reasonable, and contract files included all required documentation.

Agent Cashier Operations Were Sound. All agent cashier funds were properly accounted for. Physical security was adequate, alarm systems worked, and the VARHS Police Service quickly responded to an OIG-initiated test alarm. Unannounced audits were properly conducted, and the amount of the cash advance was appropriate.

Opportunities for Improvement

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Conditions Needing Improvement. The VARHS needed to reduce excess inventories of engineering, medical, and prosthetic supplies and make better use of automated controls to more effectively manage supply inventories. In FY 2002, the VARHS spent $2.2 million on engineering, medical, and prosthetic supplies. The Veterans Health Administration (VHA) Inventory Management Handbook establishes a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Engineering Supplies. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgment sample of 10 supply items. Because the Facilities Support Services did not use GIP, we asked service staff to estimate usage rates for the 10 items. For five of the items, the stock on hand exceeded the 30-day standard, with inventory levels ranging from 60 days to 4 years of supply. The estimated value of these excess items was $7,200. We inspected various locations across the VARHS campus and found engineering supplies in at least 30 different locations including basements, attics, and interstitial spaces between floors. Substantial amounts of excess supplies were stored in many of these locations. For example, in the basement of one building there were several spools of electrical wire, more than 40 pieces of metal shelving, a new air conditioner, and various other items.

Excess engineering supply inventory occurred primarily because Facilities Support Services staff did not use GIP or any other formal inventory controls, including periodic physical inventories. They did not maintain any written inventory records or establish normal stock level standards or reorder points. In addition, supplies were stored in too many locations to adequately control the entire inventory. Without inventory records, we could not estimate the value of all engineering supplies or the total amount of inventory that exceeded current needs. To correct these deficiencies and improve the control of engineering supplies, Facilities Support Services staff should conduct a wall-to-wall supply inventory and begin using GIP to manage the inventory.

Medical Supplies. Materiel Management Section staff used GIP to manage inventory and applied some good inventory management practices, such as performing physical inventories and ordering supplies frequently. However, we found excess medical supplies. In addition, the values of some supply items were overstated in GIP. The VARHS used a "super primary" inventory model, which means there is only one main warehouse inventory that supports the entire medical center. This inventory included medical, miscellaneous, laundry, and housekeeping supplies. As of January 2003, the GIP warehouse inventory consisted of 2,711 items with a stated value of $104,103.

To test the reasonableness of inventory levels, we reviewed a sample of 10 high-cost medical supply items. GIP showed a value of about $8,905 for the stock of the 10 items. We determined

that the actual value of this stock was about $5,126, which meant that the GIP value was overstated by about 74 percent. In addition, 7 of the 10 items had stock on hand that exceeded a 30-day supply (estimated value = $3,225).

The excess stock and inaccuracies in GIP occurred because staff were not properly recording transactions, monitoring supply usage rates, and adjusting stock levels in GIP to meet the 30-day standard. Because the GIP data was inaccurate, we could not determine the value of stock on hand or the value of excess stock for the entire inventory. However, the Chief of the Materiel Management Section agreed that inventory should be reduced and that staff should monitor supply usage and adjust stock levels accordingly.

Prosthetic Supplies. The Prosthetics and Sensory Aids (P&SA) Service used VA's Prosthetics Inventory Package (PIP) automated system to control inventory. However, prosthetic inventory exceeded the 30-day standard, and P&SA Service staff did not know exactly what items they had on hand. The P&SA Service maintained a supply inventory of 104 line items valued at $46,502. To evaluate inventory levels, we reviewed a judgment sample of five items (PIP value = $6,274). The stock levels of all five items exceeded a 30-day supply, with inventory levels ranging from 225 days to 8 years of supply. For the five items, the estimated value of stock exceeding 30 days was $4,320, or 69 percent of the total value.

PIP showed inaccurate inventory levels for all five sample items. For three of the items, the PIP stock levels did not match shelf counts because staff did not consistently update PIP when items were received or issued. The shelf stock of the other two items was inappropriately mixed with similar types of items, which resulted in incorrect item counts in PIP. For example, two different types of filters (a disposable filter and a reusable filter) from different manufacturers were reported in PIP as one item. The excess prosthetic inventory and other inventory control problems occurred because P&SA Service staff were not properly using PIP features and were not accurately inputting supply data into PIP. In addition, they were not retaining documentation of physical inventories. Because of the inaccuracy in PIP data and the mixing of items, we could not determine the value of stock on hand or the value of excess stock for the entire inventory.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VARHS Director requires: (a) the Facilities Support Services to implement GIP to manage the engineering supply inventory, (b) the Materiel Management Section to monitor supply usage rates and reduce excess medical supplies, and (c) the P&SA Service to reduce excess inventory and improve the accuracy of PIP data. The VISN Director and VAMC Director agreed and reported that plans had been developed to use GIP for managing engineering supply inventory, improve the accuracy of medical and prosthetic supply inventories, and reduce prosthetics inventory. The target date for full implementation of these plans is June 30, 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medical Care Collection Fund – Better Identification of Insured Veterans and Stronger Follow-Up Would Increase Collections

Conditions Needing Improvement. VARHS staff needed to improve procedures for identifying patients with insurance coverage and to more aggressively pursue accounts receivable from insurers. Under the Medical Care Collection Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain veterans who have insurance.

Insurance Identification. VARHS policy requires that veteran insurance information be obtained at the time of treatment. Clinic staff should ask veterans if they have insurance or if their coverage has changed and obtain copies of the veterans' insurance cards. To determine if clinic staff obtained the necessary insurance information, we observed check-in and check-out procedures in five VARHS medical clinics. None of the staff we observed inquired about veteran insurance coverage. Clinic staff and managers stated that they were aware of the requirement to obtain insurance information. However, they could not explain why clinic staff did not comply with the requirement.

Insurance Receivables. As of November 2002, the VARHS had 10,393 insurance accounts receivable with a total value of about $1.9 million. Of these receivables, 8,679 with a value of about $1.3 million (68 percent of the total value) were more than 90 days old.

To evaluate collection potential, we reviewed a judgment sample of 10 receivables (value = $266,606). Based on our review and discussions with the Health Administration Section supervisor, we determined that all 10 receivables required more aggressive collection. MCCF staff had sent original bills to insurers but had not routinely made follow-up telephone calls to determine why they had not paid. Based on discussions with the supervisor, we estimated that if MCCF staff pursued receivables more aggressively they could increase the collection rate by about 5 percent, which would provide the VARHS with additional revenue of about $65,000. (The $65,000 estimate was calculated by applying the 5 percent collection rate increase to the $1.3 million value of receivables older than 90 days.)

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements procedures to: (a) obtain and update veteran insurance information at the time of treatment and (b) pursue MCCF receivables more aggressively. The VISN Director and VAMC Director agreed and reported that clinic staff were being trained on procedures for updating insurance information. In addition, as of March 2003, VARHS management was recruiting for two MCCF staff. VARHS management believed that hiring the additional staff would allow more aggressive pursuit of receivables and elimination of the backlog by August 2003. The improvement actions are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Administrative Oversight Should Be Strengthened

Conditions Needing Improvement. VARHS management and the Purchase Card Coordinator (PCC) needed to ensure that the Government Purchase Card program was administered effectively. We reviewed purchase card use for the 14-month period October 2001–November 2002. During this review period, VARHS staff authorized approximately 10,000 transactions totaling $2.8 million. As of November 2002, the VARHS had 71 cardholders and 18 approving officials. VARHS management needed to correct control weaknesses in three areas.

Card Sharing. A contract employee was allowed to use a purchase card assigned to a Facilities Support Services employee. VHA policy states that purchase cards should not be distributed to contract employees and that cardholders must not allow others to use their cards. The contract employee used the card and signed his name on invoices. We could not readily determine the number and dollar value of his purchases because there was no record of the dates that he held the card. The Facilities Support Services employee to whom the card was assigned prepared transaction reconciliations without knowing the reasons for purchases and without verifying that the VARHS had received the purchased items. The employee and the contract employee stated that a Facilities Support Services supervisor had authorized the contract employee's use of the card, but the supervisor denied this. The contract employee had the card in his possession at the time of our review. We reported this problem to VARHS management who immediately retrieved the card and formally counseled the Facilities Support Services supervisor.

Timeliness of Transaction Reconciliations. Purchase card reconciliations were not always completed within the required time limits. VHA policy requires that 75 percent of purchase card reconciliations be completed within 10 days, 95 percent be completed within 17 days, and 100 percent be completed within 30 days. For the 6-month period June–November 2002, 81 percent of the purchases were reconciled within 10 days, which met the 75 percent standard. However, only 88.3 percent of the transactions were reconciled within 17 days, which did not meet the 95 percent standard, and only 94.7 percent of charges were reconciled within 30 days, which fell short of the 100 percent standard. Delinquent reconciliations ranged from 1 to 293 days.

Separation of Duties. The PCC served as an alternate approving official for 19 cardholders. Proper separation of duties requires that the PCC not act as an approving official or cardholder. We brought this issue to the PCC's attention, and he immediately removed himself as an alternate approving official.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director requires the PCC to: (a) provide training to all cardholders and approving officials on the policy that prohibits the sharing of cards and (b) enforce reconciliation timeliness standards. The VISN Director and VAMC Director agreed and reported that as of March 2003 annual refresher training had been implemented for all purchase cardholders. By June 2003 Fiscal Service will conduct purchase card audits that will evaluate compliance with policies and procedures. In addition, VARHS management had implemented procedures to review and follow up on delinquent reconciliations. The improvement plans are acceptable, and we consider the issues resolved.

Quality Management – Better Data Analysis, Action Identification, and Use of Evaluation Criteria Would Strengthen the QM Program

Conditions Needing Improvement. To evaluate the QM program, we reviewed 16 monitoring functions and identified 3 conditions that needed corrective action — service chiefs and program coordinators did not consistently analyze data critically, identify actions needed to meet goals, or use criteria to evaluate the effectiveness of corrective actions.

Data Analysis. Analyses of several QM areas consisted of data tabulations based on one variable, such as a topic (for example, coordination of care or patient waiting times). Managers and program coordinators did not consistently complete more detailed analyses of multiple variables, such as unit, shift, and variation over time. For example, patient complaints were hand tallied by type of complaint, and the top five complaint types were reported. The data were not fully analyzed to identify trends in the specific types of complaints, nor were the data compared with other sources of patient feedback. VHA policies and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require critical analysis of patient complaints. The Patient Advocate agreed that her method of data tabulation and analysis could be improved.

Action Identification. When data indicated that goals were not met, managers did not always identify corrective actions. For example, several months of Utilization Management reports showed that the percentage of acute care admissions meeting admission criteria was below the stated goal, but no corrective actions were identified or taken.

Evaluation Criteria. For some areas, including performance measures and root cause analyses, managers had identified criteria for determining whether corrective actions were effective. However, they needed to identify criteria to evaluate effectiveness for all areas of quality review, as required by JCAHO. Evaluation criteria were not consistently defined for corrective actions identified by performance improvement teams, such as the consult tracking team. The QM Coordinator agreed that team activities should be adapted to incorporate evaluation criteria.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements procedures to: (a) thoroughly tabulate and analyze quality review data using multiple variables, (b) document clear corrective actions when data indicate that goals are not met, and (c) define and use evaluation criteria consistently for identified corrective actions. The VISN Director and VAMC Director agreed and reported that procedures had been developed to analyze quality review data using multiple variables, document clear corrective actions when data indicates that established performance goals are not met, and define and use evaluation criteria consistently for identified corrective actions. The target date for full implementation of the planned actions is June 30, 2003. The improvement plans are acceptable, and we consider the issues resolved.

Equipment Accountability – Inventories Should Be Done and Equipment Inventory Lists Updated

Conditions Needing Improvement. The VARHS needed to improve procedures for performing inventories of nonexpendable equipment (equipment costing more than $5,000 with an expected useful life of more than 2 years). VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). VARHS policy requires that EIL inventories be done annually. Materiel Management Section staff are responsible for coordinating the annual EIL inventories, which includes notifying all services when inventories are due and following up on delinquent inventories. Each VARHS service is required to perform an inventory of equipment assigned to it and to update the EIL when equipment is transferred or excessed.

As of January 2003, the VARHS had 74 EILs (equipment value = $13.8 million). To determine if inventories had been done annually, we reviewed records for all 74 EILs. VARHS staff had done timely inventories for 43 (58 percent) of the 74 EILs. However, inventories for 31 (42 percent) EILs were overdue (range = 6 months to 11 years). Five of the 31 overdue EILs had never been inventoried, and the Facilities Support Services EIL had not been inventoried for 11 years.

To determine if equipment was properly accounted for, we reviewed a judgment sample of 15 items assigned to 12 EILs (5 with completed inventories and 7 with overdue inventories). For 5 of the 15 items (33 percent), the EIL entries were inaccurate or incomplete. For two of the five items, the EILs did not show locations of the equipment. A third item had been excessed but had not been removed from the EIL. For the fourth item, the serial number was not correct. The fifth item, a data card embossing machine (value = $9,000), could not be located at all during our review.

Delinquent inventories occurred because Materiel Management Section staff did not consistently ask services to perform annual inventories, services did not submit completed inventories, and Materiel Management Section staff did not follow up on delinquent inventories. When physical inventories are not regularly performed and EIL information is inaccurate or incomplete, it is difficult to properly account for and safeguard equipment.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements controls to: (a) inventory equipment annually and (b) correct and update incomplete and inaccurate EILs. The VISN Director and VAMC Director agreed and reported that with an additional staff person, the inventory schedule had been reinstituted and all inventories should be completed by December 31, 2003. In addition, Materiel Management Section staff were following up on delinquent inventories by sending memos to responsible officials. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Security Deficiencies Should Be Corrected and Controls Strengthened

Conditions Needing Improvement. We reviewed VARHS IT security to determine if controls were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that Information Resource Management (IRM) staff had implemented virus detection procedures and established effective controls for assigning passwords. However, we identified four IT security issues that required corrective action.

Physical Security. The computer room did not have adequate entry controls to restrict and track access. Although the room had an access logbook, it was not readily available and was intended only for visitor use. Entries in the logbook indicated that it was used infrequently. The Chief of IRM agreed that all access to the computer room should be logged and reviewed and that for controlling access a magnetic card reader would be a better option than the logbook. VARHS management also had not taken actions on physical security recommendations made by the VARHS Police Service. These recommendations included installing motion sensors, door access alarms, and keyed deadbolt locks in numerous locations that contain IT resources.

System Access. VHA policy requires that facilities review Veterans Health Information Systems and Technology Architecture (VISTA) user access and privileges at least every 90 days for appropriate levels of access or continued need. As of December 2002, VISTA records showed more than 200 user accounts that required review by the Information Security Officer (ISO) to determine continued need (for users who never logged on, had not logged on in the past 90 days, or who did not appear on VA payroll records). Working with the ISO, we reviewed a judgment sample of 15 of the 200 accounts and concluded that all 15 needed to have user access revoked. The ISO should review the remaining 185 user accounts to determine continued need.

Contingency Plan. The IT contingency plan did not designate an alternate processing facility to provide backup services in the event that primary facilities were severely damaged or could not be accessed. The Chief of IRM stated that by August 2003 he would develop a new contingency plan that will include an alternate processing facility.

IT Security Training. Numerous system users had not received VHA-required computer security and awareness training in FY 2002. For example, at least 25 intermittent employees and at least 10 CBOC employees had not received the training.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) correct the physical security deficiencies in the computer room and other IT locations, (b) revoke VISTA access for the 15 accounts identified by our review and review the remaining 185 accounts and revoke access as appropriate, (c) include an alternate processing facility in the IT contingency plan, and (d) enforce the requirement that all VARHS employees receive annual computer security and awareness training. The VISN Director and VAMC Director agreed and reported that by August 31, 2003, a magnetic card device will be installed on the computer room and security deficiencies cited by the VARHS Police Service will be corrected. In addition, IRM staff would regularly review VISTA

accounts, establish a policy that addresses terminated employee VISTA access, include an alternate processing facility in the IT contingency plan, and ensure that all employees, including contract physicians, receive IT security training. The improvement plans are acceptable, and we consider the issues resolved.

Controlled Substances Accountability – Inspection Deficiencies Should Be Corrected

Conditions Needing Improvement. VARHS management needed to correct weaknesses in controlled substances inspection procedures. VA medical facilities are required to conduct monthly unannounced inspections of all drug storage locations to ensure that controlled substances are properly accounted for. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period January–December 2002, observed unannounced inspections of selected areas where controlled substances were stored and dispensed, and assessed the physical security of drug storage areas. Pharmacy access controls were effective, and physical security was adequate. However, three inspection deficiencies needed corrective action.

Location of Inspections. Inspection procedures did not ensure that all controlled substances storage locations were inspected every month. During the review period, there should have been 108 inspections (9 storage locations x 12 months). However, 39 inspections (36 percent) were not done. Additionally, no inspections were performed in May, and only one location, the main pharmacy vault, was inspected in June and October.

Timing of Inspections. Although the inspections were unannounced, they were performed at predictable times. Of the 69 inspections performed, 33 were conducted on the third Thursday of the month, and 19 were conducted on the fourth Wednesday of the month. The other 17 inspections were performed on other days during the last 2 weeks of the month.

Rotation of Inspection Assignments. Inspection assignments were not rotated as required. Two of six inspectors conducted inspections of the same areas 2 months consecutively, and four of six inspectors conducted more than six inspections during a 12-month period.

As a result of our review, VARHS management immediately began correcting the deficiencies. As of January 2003, the Controlled Substances Inspection Coordinator had implemented new training procedures, and the Director had appointed seven new inspectors.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements controls to: (a) include all controlled substances storage locations in monthly inspections, (b) conduct unannounced inspections at unpredictable times, and (c) rotate inspector assignments. The VISN Director and VAMC Director agreed and reported that as of March 2003 several new controlled substances inspectors had been appointed, trained, and assigned monthly inspection locations. In addition, the Controlled Substances Inspection Coordinator and Patient Safety Coordinator had developed procedures to ensure that inspections

are random and inspector assignments are rotated. The improvement actions are acceptable, and we consider the issues resolved.

Management of Violent Patients – Incident Analysis Documentation and Violent Patient Alerts Should Be Improved

Conditions Needing Improvement. VARHS management had developed an effective program for preventing and managing patient violence. However, the program could be strengthened by documenting the analyses of violent patient incidents and by posting VISTA alerts about potentially violent patients.

Incident Analysis Documentation. VARHS management had implemented effective procedures for managing violent patient incidents by establishing an emergency response system. To determine if the procedures were properly followed, we reviewed three incidents. Although the patients' medical records contained adequate descriptions and follow-up analyses of the incidents, the meeting minutes of the responsible committee did not contain documentation of follow-up analyses. For managers to evaluate the effectiveness of the response system, it is important to document follow-up analyses in the meeting minutes to identify lessons learned and opportunities for employee training and process improvement.

Violent Patient Alerts. VARHS management had implemented an electronic process to alert clinical employees about potentially violent patients. We reviewed records for seven potentially violent patients and found appropriate Computerized Patient Record System (CPRS) alerts in all cases. However, we did not find similar alerts in VISTA. It is critical that alerts about potentially violent patients be available to all employees who have a need to know. Since all administrative employees do not have access to CPRS, the alerts should also be posted in VISTA.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) document analyses of violent patient incidents in committee minutes and (b) ensure that alerts about potentially violent patients are posted in VISTA. The VISN Director and VAMC Director agreed and reported that as of March 2003 the VARHS had implemented a data management process making the Environment of Care Committee responsible for reviewing, tracking, and documenting analyses of violent patient incidents. In addition, the VISN designated the VARHS as a pilot site for the VISTA-Based Behavioral Emergency Flag system to notify employees about potentially violent patients. The improvement actions are acceptable, and we consider the issues resolved.

Environment of Care – Safety Deficiencies in the Canteen Service and Nutrition and Food Service Should Be Corrected

Conditions Needing Improvement. VARHS staff maintained a generally clean and safe environment of care. To ensure employee and patient safety, managers needed to make several improvements in the Canteen Service and Nutrition and Food Service. To evaluate the

environment of care, we inspected selected clinical and nonclinical areas for general cleanliness, safety, infection control, and facility and equipment maintenance. We also inspected food preparation, service, dining, delivery, storage, and disposal areas in the Canteen Service and in the Nutrition and Food Service.

Canteen Service. The Canteen Service food preparation area did not have a separate employee hand washing sink, dishwashing chemicals were improperly stored with food items, and personal protective equipment and an emergency eyewash were not available for employees. In addition, a storeroom had boxes of food stacked from the floor to the ceiling, which did not meet fire and safety requirements for a 6-inch clearance above the floor and an 18-inch clearance below the ceiling. The dry food storeroom was converted space that had no ventilation and that contained a dirty restroom. The Canteen Service Manager agreed that the lack of ventilation could lead to mold growth and that a restroom should not be located in a food storage area.

Nutrition and Food Service. The Nutrition and Food Service patient dining room did not have a locking door. Equipment and food in this area were accessible at all times and open to possible pilferage and contamination.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) install a hand washing sink, separate chemicals from food, and provide protective equipment and an emergency eyewash for staff in the Canteen food preparation area; (b) ensure that food is stored with required floor and ceiling clearances in the Canteen Service storeroom; (c) install a ventilation system in the Canteen Service dry food storeroom and thoroughly clean and then seal the restroom; and (d) install a locking door at the entrance of the Nutrition and Food Service patient dining room. The VISN Director and VAMC Director agreed and reported that all of the deficiencies had been corrected in the Canteen Service and that a work order had been submitted to install a locking door for the Nutrition and Food Service patient dining room. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

Report Number: 03-00699-83

Recommendation	Explanation of Benefit	Better Use of Funds
N/A	Better use of funds by collecting delinquent insurance receivables.	$65,000

Appendix B

VA Roseburg Healthcare System Director and VISN 20 Director Comments

Department of Veterans Affairs

Memorandum

Date: March 21, 2003

From: Director, VA Roseburg Healthcare System (653/00)

Subj: OIG/CAP Follow-up Report

To: Claire McDonald, VA Office of Inspector General

1. Attached is the response to the OIG CAP Site Review and comments from the Network Director, VISN 20.

2. I appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

(Original signed by:)
GEORGE MARNELL

Attachment

Appendix B

VA ROSEBURG HEALTH CARE SYSTEM
Response to the OIG/CAP Site Review

Comment and Implementation Plan

1. Supply Inventory Management – Excess Inventories and Controls

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VARHS Director requires: (a) the Facilities Support Services to implement GIP to manage the engineering supply inventory, (b) the Materiel Management Section to monitor supply usage rates and reduce excess medical supplies, and (c) the P&SA Service to reduce excess inventory and improve the accuracy of PIP data.

a. Engineering Supplies:

Concur with recommended improvement actions

We plan to implement the GIP Program for the following items by May 2003. A joint FSS and GIP Implementation and Operational Task Force, consisting of supervisors and front line employees, will be created to guide this process.

1. Light Bulbs, Fluorescent, seven tube types.
2. Paint, Latex for interior work, three finishes
3. Air Filters for Air Handlers (types and sizes of filters)

Start date: May 2003

b. Medical Supplies:

Concur with recommended improvement actions

A wall to wall physical inventory of all items in warehouse supplies using an automated barcode trakker scanners will be conducted. Double counts will be performed to verify accuracy. All discrepancies will be researched and corrected accordingly. Upon completion, we should have 100% accuracy between shelf counts and computer and dollar accounts. This inventory will then be maintained on a regular basis.

Target date: April 30, 2003

c. Prosthetic Supplies:

Concur with recommended improvement actions

An educational and training refresher highlighting the benefits of the PIP was provided the staff. A complete physical inventory of all prosthetics supplies will be conducted to adjust PIP balances to match the inventory. Thorough usage data, stock and reorder levels will be established for each item in the PIP. An inventory will be conducted to define what specific supplies are required for stock in the PIP, all appliances on hand for more than 30 days, or items identified as no longer required for stock will be excess.

Target Date: June 30, 2003

2. Medical Care Collection Fund – Better Identification of Insured Veterans and Stronger Follow-Up

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements procedures to: (a) obtain and update veteran insurance information at the time of treatment and (b) pursue MCCF receivables more aggressively.

a. Insurance Identification:

Concur with suggested improvement actions

Additional emphasis has been placed on updating insurance information at every visit. Training is being conducted and we are reviewing current processes for check in and check out to improve collect information regarding insurance identification.

Target date: June 30, 2003

b. Insurance Receivables:

Concur with suggested improvement actions

The number of Accounts Receivable (AR) positions has increased from three to four. Currently two AR positions are vacant and have been advertised. Once fully staffed, we are certain that we will be able to maintain an acceptable level of performance with our aging receivable plus clear the backlog in a timely manner.

Target Completion Date: August 1, 2003

3. Government Purchase Care Program – Administrative Oversight

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director requires the PCC to: (a) provide training to all cardholders and approving officials on the policy that prohibits the sharing of cards and (b) enforce reconciliation timeliness standards.

a. Card Sharing:

Concur with suggested improvement actions

1) Mandatory training required for all cardholders:
   a) Initial orientation for new cardholders
   b) Annual refresher training
   c) Tracking documentation to identify training requirements met.

2) Purchase Card Audits by Fiscal Service are planned to ensure that cards are kept secure, accurate records are maintained and supporting documentation is kept, timeliness of reconciled orders, and appropriate fund control points are utilized for purchases.

Target date: May 30, 2003

b. Timeliness of Transaction Reconciliation's:

Concur with suggested improvement actions

The following actions have already been implemented:

1) Priority message sent on March 3, 2003 to all approving officials with reconciliation over 30 days with instructions for reconciliation of delinquent orders be completed by March 7, 2003.
2) Currently 75% of delinquent list has been reconciled. The remaining 25% will be completed by March 21,2003.
3) Procedures have been implemented to review outstanding orders and reconciliation on a weekly basis with contact made with approving officials.

Target date: March 21, 2003

4. Quality Management – Better Data Analysis, Action Identification, and Use of Evaluation Criteria

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements procedures to: (a) thoroughly tabulate and analyze quality review data using multiple variables, (b) document clear corrective actions when data indicate that goals are not met, and (c) define and use evaluation criteria consistently for identified corrective actions.

a. Data Analysis:

Concur with the suggested improvement actions

The following actions have been implemented:

1) We have implemented procedures to analyze quality review data using multiple variables, such as unit, shift, subtopic, and variation over time. These procedures are in place for analysis of data related to falls, medication errors, nosocomial infections, and many of the performance measures. Patient complaint data for FY02 has been tabulated and stratified for analysis by the Customer Relations Lead Committee and for comparison to SHEP survey results. This analysis of data will continue.

Target Date: June 30, 2003

b. Action Identification:

Concur with suggested improvement actions

Since the IG visit the following actions have occurred:

1) We are documenting clear corrective actions when data indicates that established performance goals are not met. These actions are documented in minutes of Lead Committees that oversee continuous monitoring and improvement activities. Future UM reports will be stratified by separating the admission and continued stay days not meeting criteria for reasons we have no control over.

Target Date: May 8, 2003

c. Evaluation Criteria:

Concur with suggested improvement actions

Since the IG visit the following actions have occurred:

Evaluation criteria for most corrective actions is identified through progress toward meeting established performance targets. Evaluation criteria for actions based on root cause analyses is recurrence of the sentinel event. For those critical actions for which these criteria do not constitute adequate evaluation, minutes or tracking logs have been developed to document evaluation criteria.

Completed

5. Equipment Accountability – Inventories and Equipment Inventory Lists

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements controls to: (a) inventory equipment annually and (b) correct and update incomplete and inaccurate EILs.

Concur with suggested improvement actions

The inventory schedule has been re-instituted and we are on schedule to complete all inventory CMR/EILs by end of calendar year. Delinquent CMR inventories have been followed up by submitting memos to the responsible official. All copies of follow up memos are located in the inventory schedule file.

Target Date: December 31, 2003

6. Information Technology Security – Security Deficiencies and Controls

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) correct the physical security deficiencies in the computer room and other AIS locations, (b) revoke VISTA access for the 15 accounts identified by our review and review the remaining 185 accounts and revoke access as appropriate, (c) include an alternate processing facility in the IT contingency plan, and (d) enforce the requirement that all VARHS employees receive annual computer security and awareness training.

a. Physical Security:

Concur with suggested improvement actions

Since the IG visit the following actions have been taken:

1) Resource Committee has approved the resources to install magnetic card devices on all rooms identified by the OIG.
2) A monthly review of the log books for compliance with sign- in requirements is implemented.
3) The recommendations made by the facilities Police Service, i.e. motion sensors, door access alarms, and keyed deadbolt locks has been approved by the Resource Committee.

Target date: Aug. 31, 2003

b. System Access:

Concur with the suggested improvement actions

Since the IG visit the following actions have been taken:

1) VISTA user accounts that have never been activated with a verify code and password are not active accounts. All other terminated or disused accounts will be reviewed for deletion of primary menus, security keys, and options. Non-activated accounts will have primary menus and security keys removed.

2) A new policy is being formulated to address the issue of terminated employees access.
3) All terminated disused active accounts will be reviewed every 30 days to insure that no primary menus or options remain.

Target date: August 31, 2003

c. Contingency Plan:

Concur with suggested improvement actions

Certification and accreditation process currently under way addresses the entire computer system and contingency plan, and also addresses off-site storage and alternate Processing Centers or sites. This process was started prior to the OIG visit and when completed will be submitted for Office of Cyber Security (OCS) certification and approval. In the interim, alternative storage has been arranged.

Target date: September 30, 2003

d. IT Security Training:

Concur with suggested improvement actions

Since the IG visit, the following actions have occurred:

Presently, 90% of employees, contractors, work studies, interns, etc. have completed the annual Cyber Security Awareness training. It has been noted that many contract MODs and locum tenens have not completed the training. We will include the Cyber Security training in their initial orientation.

Target date: May 31, 2003

7. Controlled Substances Accountability – Inspection Deficiencies

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director implements controls to: (a) include all controlled substances storage locations in monthly inspections, (b) conduct unannounced inspections at unpredictable times, and (c) rotate inspector assignments.

a. Location of Inspections:

Concur with suggested improvement actions

Since the IG visit, the following actions have occurred:

New inspectors have been appointed and trained in the completion of controlled substance inspections. Each inspector has been provided an area assignment schedule, which indicates the area they will be inspecting each month.

Completed

b. Timing of Inspections:

Concur with suggested improvement actions

Since the IG visit, the following actions have occurred:

A random schedule known only to the Controlled Substance Inspections Coordinator and the Patient Safety Coordinator has been developed. Inspectors are notified of the dates on the first day of the week inspections will be held. A concentrated effort has been made to randomize the inspections.

Completed

c. Rotation of Inspection Assignments:

Concur with the suggested improvement actions

Since the IG visit, the following actions have occurred:

1) New inspectors have been appointed and trained in the completion of controlled substance inspections. Each inspector has been provided an area assignment schedule, which indicates the area they will be inspecting each month.
2) The Controlled Substance Inspections Coordinator will submit a monthly report the Patient Safety Coordinator with the results of the inspections.
3) The Patient Safety Coordinator will include this information in quarterly report to the Leadership Performance Board.

8. Management of Violent Patients – Incident Analysis Documentation and Violent Patient Alerts

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) document analyses of violent patient incidents in committee minutes and (b) ensure that alerts about potentially violent patients are posted in VISTA.

a. Incident Analysis Documentation:

Concur with the suggested improvement actions

Since the IG visit, the following actions have occurred:

1) Environment of Care Committee (EOC) is the committee responsible for oversight and analysis/documentation of reported cases of violent patient incidents. The EOC has implemented a process that will monthly review the data on such incidents and will track the number of disturbances, code greens that required police response & police takeover management.

2) Managers will ensure that their staff are educated on the process and will monitor to assure procedure is followed. Immediately after a Code Green or "show of force", a debriefing of the incident with staff involved including staff member in charge of the area at the time of the incident, will occur.

b. Violent Patient Alerts:

Concur with the suggested improvement actions

Since the IG visit, the following actions have occurred:

1) Thursday, March 6, 2003 the VISTA Based Behavioral Emergency Flag system was initiated. VARHS is the targeted pilot site for all VISN 20 sites who currently do not have VISTA Based Behavioral Emergency flagging in place.
2) A report must be submitted to the VISN Coordinated Care Review Board within one month s to how the implementation evolved, with the intent the remaining facilities will come aboard at that time.

Target Date: April 30, 2003

9. Environment of Care – Safety Deficiencies in the Canteen Service and Nutrition and Food Service.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the VARHS Director takes action to: (a) install a hand washing sink, separate chemicals from food, and provide protective equipment and an emergency eyewash for staff in the Canteen food preparation area; (b) ensure that food is stored with required floor and ceiling clearances in the Canteen Service storeroom; (c) install a ventilation system in the Canteen Service dry food storeroom and thoroughly clean and then seal the attached restroom; and (d) install a locking door at the entrance of the Nutrition and Food Service patient dining room.

a. Canteen Service:

Concur with the suggested improvement actions

Since the IG visit, the following actions have occurred:

1) Hand wash sink has been designated.
2) Dishwashing chemicals are now stored in a locked cabinet.
3) Personal Protective Equipment (eye goggles) is now provided.
4) Eye wash station has been installed.
5) Stockroom items have been restacked meeting the Fire and Safety Requirements.
6) Deficiencies in the dry food storeroom have been corrected to meet the Fire and Safety Requirements.
7) The rest room has been locked prohibiting access.

Completed

b. Nutrition and Food Service:

Concur with suggested improvement actions

Since the IG visit the following actions have occurred:

A work order request has been submitted and a locking type door will be installed.

Target Date: August 31, 2003

Appendix B

VISN 20 Director Comments

We appreciated the opportunity to participate in the Combined Assessment Program (CAP) review process. It is our expectation that the recommendations and suggestions generated by your visit will further help the facility and the VISN improve our healthcare delivery process. Attached is the response from the VA Roseburg Healthcare System. I understand from the facility, that your team provided helpful suggestions during their visit and did so in a very professional and courteous manner, and that Mr. Bellah's presence was both helpful and supportive of the process. His presence was most definitely helpful to us, as he not only fostered extensive sharing of information among our facilities, but will incorporate what he learned into our network's continuous readiness program.

(Original signed by:)
Leslie M. Burger, MD, FACP
Network Director, VISN 20

Appendix C

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