Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through March 2003

Report No. 03-01091-87 **April 28, 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) effort to ensure that high quality health care is provided to our nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

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

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

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2002 through March 2003

1. This report summarizes recommendations and suggestions made in reports of Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews at Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities published during the period October 2002 through March 2003. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls.

2. During the period covered by this summary report, the OIG published 11 reports for CAP reviews conducted at VHA medical facilities. Each of the conditions discussed in this summary report was found at two or more medical facilities. We also provided fraud and integrity awareness training for about 3,200 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. VHA management should ensure that the directors of the Veterans Integrated Services Networks (VISN) and medical centers are advised of the issues identified in this summary report. We may follow up on the issues reported here in future CAP reviews and include new areas of inquiry.

(originial signed by Michael G. Sullivan for)
RICHARD J. GRIFFIN
Inspector General

Introduction

Background

During the period October 2002 through March 2003, the OIG published 11 reports for CAP reviews conducted at VHA medical facilities. The OIG issued its first report of CAP findings at a VHA medical facility in March of 1999.

Scope of CAP Reviews

The scope of our CAP reviews is tailored to address both national and facility specific issues. Because the scope of review has been modified through time, the areas of inquiry described below were not necessarily reviewed at each medical facility included in this report. This report summarizes issues, reported in two or more CAP reports, for which recommendations or suggestions were made.

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

Fraud and integrity awareness briefings were also conducted during each of the 11 CAP reviews and about 3,200 VHA employees attended the briefings. The briefings included a film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and question and answer sessions.

CAP Reports Issued

The following 11 VHA medical facility CAP reports were issued during the period of October 2002 through March 2003.

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Lexington, KY	9	02-01933-3	10/16/2002
Combined Assessment Program Review, VA Medical Center Bronx, NY	3	02-01760-06	10/18/2002
Combined Assessment Program Review, VA Medical Center San Juan, PR	8	02-00868-15	11/13/2002
Combined Assessment Program Review, VA Medical Center Boise, ID	20	02-02582-36	12/20/2002
Combined Assessment Program Review, VA Medical Center Birmingham, AL	7	02-01432-39	12/24/2002
Combined Assessment Program Review, Northern Arizona VA Health Care System, Prescott, AZ	18	01-02641-40	12/26/2002
Combined Assessment Program Review, Chalmers P. Wylie VA Outpatient Clinic, Columbus, OH	10	02-01430-50	1/23/2003
Combined Assessment Program Review, VA Medical Center West Palm Beach, FL	8	02-01273-55	2/3/2003
Combined Assessment Program Review, VA Medical Center Atlanta, GA	7	02-02757-63	2/25/2003
Combined Assessment Program Review, VA Salt Lake City Health Care System	19	02-03263-68	3/7/2003
Combined Assessment Program Review, VA Medical Center Alexandria, LA	16	02-01985-77	3/26/2003

CAP Findings by VISN and by Medical Facility

CAP Findings	VISN 3	VISN 7		VISN 8		VISN 9	VISN 10	VISN 16	VISN 18	VISN 19	VISN 20
	VA Medical Center Bronx, NY	VA Medical Center Birmingham, AL	VA Medical Center Atlanta, GA	VA Medical Center West Palm Beach, FL	VA Medical Center San Juan, PR	VA Medical Center Lexington, KY	Chalmers P. Wylie VA Outpatient Clinic, Columbus, OH	VA Medical Center Alexandria, LA	Northern Arizona VA Health Care System, Prescott, AZ	VA Salt Lake City Health Care System	VA Medical Center Boise, ID
Community Residential Care			●								
Contracting for Clinical Services and Sharing Agreements	●	●	●	●	●	●	●		●		
Contracting for Non-Clinical Services	●	●	●	●	●						
Controlled Substances Accountability	●	●	●	●	●	●	●	●	●		●
Environment of Care	●		●				●				
General Post Funds						●					
Government Purchase Cards	●	●		●	●	●	●		●		
Homemaker/Home Health Aide Program		●		●	●	●	●	●	●		●
Information Management Security	●	●	●	●	●	●	●	●	●	●	●
Management of Equipment Inventories						●					●
Management of Supply Inventories		●				●	●	●	●	●	●
Patient Care and Quality Management	●	●	●		●		●	●	●	●	●
Pharmacy Waiting Times, Security, and Prescription Refills			●		●		●		●		
Prosthetics		●	●		●			●			
Time and Attendance of Part-Time Physicians	●	●	●	●	●	●					
Vendor Visits/Gratuities	●										●

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

Summary of CAP Findings

1. Community Residential Care (findings at 2 of 3 medical facilities)

- Ensure VA clinicians visit patients every 30 days as required.
- Document informed consent when patients are placed in homes that are not approved by VA.
- Provide employees with annual ethics training, including the subject of conflict of interest.

2. Contracting for Clinical Services and Sharing Agreements (findings at 8 of 11 medical facilities)

- Pursue a more cost effective contract arrangement with the university to provide compensation and pension examinations.
- Ensure contracting officers obtain cost data and document price negotiation memorandums in contract files.
- Ensure officials developing, soliciting, awarding, and administering contracts comply with conflict of interest statutes.
- Ensure contracting officer technical representatives (COTRs) effectively monitor contractor performance.
- Ensure clinical services contracts include required clauses that facilitate performance monitoring.
- Verify time and attendance and services provided by a service chief prior to paying for those services.
- Pursue recovery of overcharges.
- Assess the appropriateness of using existing VISN or national contracts before awarding a local contract.

3. Contracting for Non-Clinical Services (findings at 5 of 9 medical facilities)

- Improve documentation of price determination and contract award decisions.

- Ensure that COTRs verify work performed to prevent over billing.
- Monitor contractor performance.
- Negotiate prices for noncompetitive contracts as required by Federal Acquisition Regulations and prepare price negotiation memorandums.

4. Controlled Substances Accountability (findings at 10 of 11 medical facilities)

- Properly schedule and conduct controlled substances inspections in all areas where these substances are stored.
- Ensure physical security weaknesses are corrected.
- Maintain complete accountability records for all Schedule II-V controlled substances.
- Store unusable and expired controlled substances in sealed containers in the pharmacy vault, and properly witness and document custody and destruction of these substances.
- Include unusable and expired controlled substances in monthly inspections.
- Develop and document a training program for controlled substances inspectors.
- Complete monthly inspections within 1 day.
- Reduce excessive inventories of controlled substances.
- Report missing controlled substances to the OIG.

5. Environment of Care (findings at 5 of 6 medical facilities)

- Improve pest control.
- Ensure that work orders are initiated timely and that work is completed satisfactorily.
- Provide clean and odor-free patient care areas and public areas, including public restrooms.
- Conduct frequent random environmental rounds.
- Improve patient safety by storing potentially dangerous objects and substances out of reach of patients.

- Keep patient care and food preparation areas clean and establish deep-cleaning schedules.
- Thoroughly clean and maintain all Canteen areas.
- Include the Canteen in environmental rounds.

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

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

7. Government Purchase Cards (findings at 7 of 11 medical facilities)

- Ensure acquisition personnel, including purchase cardholders, use the designated Federal Supply Schedule before making open market purchases.
- Ensure purchase cardholders do not engage in "purchase splitting."[1]
- Ensure purchase cardholders and approving officials reconcile and certify invoices timely.
- Provide purchase cardholders and approving officials adequate, documented training.
- Ensure adequate separation of duties.
- Conduct monthly and/or quarterly audits of purchase card transactions, as required.
- Ensure telecommunications services are not procured with purchase cards.
- Ensure interim warrants are properly granted and used.
- Provide appropriate warrants to purchase cardholders with purchase limits in excess of $2,500.
- Cancel purchase cards for employees routinely failing to comply with purchase card policies and procedures.

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

8. Homemaker/Home Health Aide Program (findings at 8 of 9 medical facilities)

- Consider the prevailing state Medicaid rates when contracting for services.
- Ensure interdisciplinary assessments are completed and documented for all patients referred to the program.
- Ensure that the program coordinator and billing staff coordinate when a patient is hospitalized or otherwise no longer receiving services.
- Obtain and review quarterly performance improvement and patient assessment reports to evaluate the quality of care and need for continued service.
- Ensure clinicians reassess the need for services at 90-day intervals.
- Conduct visits or make telephone contacts with veterans to assess their satisfaction with services.
- Reconcile all bills and notify the program coordinator of discrepancies between services authorized and services actually provided.
- Ensure patients receiving services meet clinical eligibility requirements.

9. Information Management Security (findings at 11 of 11 medical facilities)

- Develop a consolidated and comprehensive information technology contingency plan that contains all required elements.
- Monitor access to the computer room.
- Perform background checks on Information Resources Management (IRM) Service staff.
- Ensure major information systems are certified and accredited.
- Ensure that the Information Security Officer is qualified, trained, and reports to the Director or Associate Director.
- Monitor access to computer-based employee-patient records.
- Periodically review authorized users to determine if they still have a legitimate need for access.

- Store computer back-up tapes in a secure off-site location.
- Remind all employees to log off computers when leaving their workstations.
- Require IRM Service employees to back-up server configurations on a computer at the back-up facility.
- Issue policy on, and monitor, remote Local Area Network usage.
- Terminate system access when employment ends.
- Certify that sensitive data has been removed from equipment with storage media before disposing of the equipment.

10. Management of Equipment Inventories (findings at 2 of 4 medical facilities)

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

11. Management of Supply Inventories (findings at 8 of 8 medical facilities)

- Fully implement the Generic Inventory Package (GIP) for all inventory points.
- Improve accuracy and update the GIP data.
- Provide GIP training to all inventory managers.
- Eliminate stock in excess of a 30-day supply.

12. Patient Care and Quality Management (findings at 9 of 11 medical facilities)

- Ensure employees consistently follow procedures to positively identify patients.
- Monitor all significant Quality Management (QM) action items until resolved.
- Consider peer review data in re-privileging decisions.
- Monitor safety and quality control.
- Develop and document appropriate corrective actions for Level 2 and Level 3 peer review findings.

- Ensure patient complaints go to service chiefs or QM program staff.
- Develop procedures for the implementation and tracking of Root Cause Analysis corrective actions until issues are resolved.
- Perform better follow-up on recommendations from boards of investigations and improve documentation of resolution and follow-up of QM reviews.
- Aggregate and trend peer review outcomes.
- Appropriately analyze and use QM data to improve the quality of patient care.
- Ensure that the Professional Standards Board reviews and documents Level 3 peer review findings.
- Improve reviews of responses to cardio-pulmonary episodes.
- Collect and trend performance improvement data, and use the data to make patient care decisions.
- Document and analyze patient complaints.
- Analyze mortality data to identify patterns or trends.

13. Pharmacy Waiting Times, Security, and Prescription Refills (findings at 4 of 6 medical facilities)

- Verify that the patient receives all medications before he/she leaves the dispensing window.
- Reduce waiting times for prescriptions.
- Improve the physical security of the dispensing area.
- Provide privacy hoods for access keypads.
- Provide a unique alarm for the pharmacy.

14. Prosthetics (findings at 5 of 6 medical facilities)

- Obtain physicians' prescriptions before issuing equipment, supplies, and accessories.
- Inventory durable medical equipment stored in a contractor's warehouses and reconcile with VA records.

- Determine veteran eligibility for eyeglasses before ordering eyeglasses from vendors.
- Properly enter data into the national prosthetics database.

15. Time and Attendance of Part-Time Physicians (findings at 6 of 10 medical facilities)

- Ensure physicians are present at the medical center during their tours of duty.
- Cease improper payments to part-time physicians for on-call status.
- Ensure timekeepers verify physicians' attendance, and conduct semi-annual audits of timekeepers' records.
- Ensure part-time physicians designate their core hours.
- Provide required training to all timekeepers.
- Adjust surgeons' hours of work consistent with their workload levels.
- Train all physicians and their supervisors on VA time and attendance policies.

16. Vendor Visits/Gratuities (findings at 2 of 6 medical facilities)

- Prohibit vendor representatives from visiting the medical facility without appointments.
- Discontinue allowing vendors to provide employees with meals that exceed annual dollar limitations on such gifts.

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