



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the San Francisco VA Medical Center

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.

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Executive Summary

Introduction

From July 29 through August 2, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (the medical center). 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 310 employees.

Results of Review

Medical center patient care administration, QM, and financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. To improve operations, the medical center needed to:

- Implement pharmacy inventory requirements and ensure controlled substances inspections comply with Veterans Health Administration (VHA) policy.
- Correct physical security deficiencies in the pharmacy.
- Improve QM by documenting providers' QM data when renewing clinical privileges and analyzing mortality data to develop trends and patterns.
- Enhance service contract administration by thoroughly screening contractor invoices and monitoring contractor patient rolls.
- Improve controls over community-based outpatient clinic (CBOC) patient enrollment data.
- Correct deficiencies in information technology (IT) security.
- Improve controls over the Homemaker/Home Health Aide (H/HHA) Program.
- Strengthen Government purchase card program controls.

Veterans Integrated Service Network 21 Director Comments

The Veterans Integrated Services Network (VISN) 21 Director agreed with the CAP review findings and provided acceptable implementation plans. (See Appendix A, pages 12-17, for the full text of the VISN Director's comments.) We may follow up on implementation of our suggested improvement actions.



RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in San Francisco, California, the medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is provided at the medical center and at four CBOCs located in San Francisco, Santa Rosa, Eureka, and Ukiah, California. The medical center is part of VISN 21 and serves a veteran population of about 162,000 in a primary service area covering over 11,000 square miles of Northern California.

Programs. The medical center provides tertiary, primary, and long-term care in the areas of medicine, surgery, mental health, dental, geriatric, oncology, neurology, and rehabilitation services. The medical center has 124 acute care hospital beds, a 120-bed nursing home care unit that provides skilled nursing and hospice care, and 11 psychiatric inpatient beds.

Affiliations and Research. The medical center is affiliated with the University of California, San Francisco (UCSF) and supports 127 medical resident positions in medicine, surgery, psychiatry, and geriatrics. The medical center also supports training programs in nursing, social work, laboratory technology, pharmacy, dental, neurology, nutrition, optometry, radiology, podiatry, and occupational therapy. In Fiscal Year (FY) 2001, the medical center's research program had 688 projects and direct funding of about \$51 million.

Resources. In FY 2001, the medical center's medical care expenditures totaled \$221.9 million. The FY 2002 medical care budget was \$237.7 million, 7.1 percent more than FY 2001 expenditures. FY 2001 staffing was 1,750 full-time employee equivalents (FTEE), including 146.4 physician and dentist FTEE and 471.8 nursing FTEE.

Workload. In FY 2001, the medical center treated 35,086 unique patients, a 10 percent increase over FY 2000. The inpatient care workload totaled 5,104 discharges, and the average daily census was 93. The outpatient care workload was 336,037 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected 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 the need to refer suspected fraud to the OIG.

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

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, and financial and administrative records. The review covered the following 14 activities:

Controlled Substances Accountability	Government Purchase Card Program
Pharmacy Security	Safety Program
Quality Management	Primary Care Clinics
Service Contracts	Long-Term Care
Community-Based Outpatient Clinics	Behavioral Health
Information Technology Security	Acute Medical-Surgical Units
Homemaker/Home Health Aide Program	Part-Time Physician Time and Attendance

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction on timeliness of service and quality of care. The survey indicated high levels of patient and employee satisfaction, and did not disclose any significant issues. The full survey results were provided to medical center management.

During the review, we also presented 8 fraud and integrity awareness briefings attended by 310 medical center employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered medical center operations for FYs 2001 and 2002 through July 2002, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make suggestions for improvement. Suggestions pertain to issues that should be monitored by medical center and VISN management until corrective actions are completed.

Results of Review

Organizational Strengths

The medical center's patient care administration, QM, and financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

Cardiothoracic Surgery Program Honored. The medical center was designated by VHA as a Clinical Program of Excellence in Cardiothoracic Surgery for the fourth time in FY 2002. According to VHA, these awards are given to clinical programs that are among the best in American healthcare. As one of the first cardiothoracic programs in VA, the medical center's program has provided the highest standards of clinical care, patient satisfaction, and resource utilization. Procedures performed included coronary bypass graft surgery, heart valve repair and replacement, and lung resections. The program's risk mortality adjusted to include all types of surgery, has consistently been better than the VA average. The program is affiliated with UCSF and is involved in blood vessel constriction and minimally invasive coronary bypass surgery research.

Effective Safety Program Significantly Reduced Lost Time Claims Rate. Employee time lost due to occupational accidents is an important measurement of the effectiveness of the facility's safety program. In the late 1990s, management identified problems with lost time due to occupational accidents and implemented improvements with the goal of reducing the lost time claims rate (LTCR). (The LTCR is determined by multiplying the medical center's number of lost time claims by 100 and dividing that total by the number of medical center employees.) By implementing aggressive measures to track the LTCR, management reduced their LTCR from 4.82 in FY 1996 to 1.27 in FY 2001. Management accomplished this reduction by implementing a variety of proactive interventions, including vigorous follow-up of light duty program participants, expansion of the Back Injury Prevention and Ergonomics Awareness Training Program, and on-site physical therapy services.

Other Results. Aspects of primary care clinic operations, long-term care, behavioral health, acute medical-surgical units, and part time-physician time and attendance that we reviewed were generally operating satisfactorily.

Opportunities for Improvement

Controlled Substances Inventory Management and Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. The medical center needed to improve its management of controlled substances inventories and its controlled substances inspection program. VHA has established a 10-day supply goal for controlled substances inventories to lower holding costs and reduce outdated items. Inspectors are required to conduct monthly unannounced inspections of controlled substances to ensure accountability for all controlled substances.

To assess controlled substances inventory management and accountability, we interviewed pharmacy staff, tested stock inventory levels, and inspected drug storage areas. We also interviewed inspectors, observed an unannounced inspection in the pharmacy and one ward, and reviewed inspection reports for the 9-month period ended June 30, 2002. We identified five weaknesses in inventory and inspection procedures.

- A review of all 150 line items of controlled substances in pharmacy stock found that 135 (90 percent) line items exceeded VHA's 10-day supply goal. The value of those line items exceeding the 10-day supply goal was approximately \$82,000.
- Inspection procedures did not ensure that all controlled substances were included in the inspection process. We found excess, expired, and unusable controlled substances pending destruction stored in the pharmacy vault and controlled substances stored in the operating room's automated dispensing machine that were not included in the inspection process.
- Inspectors did not independently verify controlled substances counts in the inpatient, outpatient, and the Santa Rosa CBOC pharmacies. Instead, the inspectors relied on the inventory counts provided by pharmacy staff for these areas.
- Inspectors did not review the 72-hour pharmacy inventory verification reports.
- Inspector training was not documented.

The controlled substances inventory and inspection deficiencies occurred because medical center pharmacy and inspection procedures did not comply with VHA policy. During the CAP review, medical center management began to revise controlled substances policies and procedures to comply with VHA policy.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) controlled substances inventory levels are reduced to a 10-day supply and (b) the controlled substances inspection program complies with VHA policy. The VISN Director agreed and indicated that the medical center was in the process of reducing

its controlled substances inventory levels to a 10-day supply. The Director further reported that controlled substances inspections policies and procedures were modified to ensure compliance with VHA requirements. The improvement actions are acceptable, and we consider the issues resolved.

Pharmacy Security – Physical Security Should Be Improved

Conditions Needing Improvement. The medical center needed to improve physical security in the pharmacy. VA requires facilities to maintain effective security controls to prevent unauthorized access to controlled substances storage areas and ensure all controlled substances are physically secure. To evaluate pharmacy security controls, we inspected pharmacy dispensing and storage areas, reviewed security policies and procedures, and interviewed pharmacy and security personnel. We identified three security weaknesses that needed to be addressed.

- The ground-level windows of the outpatient pharmacy did not have the required steel security mesh to prevent unauthorized entry.
- The door leading to the outpatient pharmacy vault was protected with an electronic locking system. However, the electronic locking system keypad did not have a shield to prevent passersby from observing access codes entered by pharmacy personnel.
- A glass panel in a door located between the outpatient pharmacy and a public corridor could be easily broken allowing unauthorized entry to the outpatient pharmacy. VA requires a steel or solid core door.

During the CAP review, medical center management initiated actions to correct pharmacy security deficiencies.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) steel security mesh is installed for the outpatient pharmacy ground-level windows; (b) a shield is installed on the electronic locking system keypad of the outpatient pharmacy vault door to prevent observation of access codes by passersby; and (c) a steel or solid core outpatient pharmacy door is installed. The VISN Director agreed and reported security steel mesh had been installed on all ground-level windows to prevent unauthorized entry and a shield was installed onto the keypad outside of the outpatient pharmacy vault to prevent observation of access codes by passersby. The Director further reported the outpatient pharmacy door had been replaced with a solid core door. The improvement actions are acceptable, and we consider the issues resolved.

Quality Management – Facility Managers Needed to Improve Clinical Privileging Documentation and Mortality Data Analyses

Conditions Needing Improvement. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files. The QM program was comprehensive and provided appropriate oversight of patient care. However, clinical service chiefs did not consistently document their consideration of QM results for renewing clinical privileges. In addition, clinical service chiefs did not fully analyze mortality data to identify specific trends or patterns.

QM Results Were Not Consistently Reviewed and Documented for Reprivileging Providers. To improve quality, safety, and cost effectiveness, clinical service chiefs should include the review of providers' QM results as a factor in determining whether providers' clinical privileges should be renewed. The provider profile form used by the medical center for renewing clinical privileges includes a statement that the clinical service chiefs must document the review of providers' QM data. However, we found that the clinical service chiefs had not consistently complied with this review and documentation requirement. The Quality Manager was aware of this deficiency and had established a task force to improve this process and foster compliance.

Mortality Data Were Not Completely Analyzed and Reported. Facility deaths should be analyzed to determine if patterns or trends exist (location, provider, and/or the time of day). Although the Quality Manager collected information related to the location and provider associated with each death, the data had not been completely analyzed and reported to the medical center's Executive Quality Review Board. The Quality Manager was not aware of this requirement but agreed to implement measures to comply with the guidance.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) clinical service chiefs consider and consistently review and document providers' QM results for renewal of providers' clinical privileges and (b) the Quality Manager implements measures to ensure complete analysis and reporting of mortality data. The VISN Director agreed and reported the modified provider profile form now requires the service chiefs to consider QM findings when renewing providers' clinical privileges. The Director further indicated the medical center's analysis of mortality data now includes the bed location, provider, time of death, and day of week and will be periodically reported to the Executive Quality Review Board. The improvement actions are acceptable, and we consider the issues resolved.

Service Contracts – Contract Monitoring Should Be Improved

Conditions Needing Improvement. The medical center needed to improve its contract monitoring practices. The VISN 21 Network Business Center contracting officers are responsible for awarding the medical center's contracts. Medical center contracting officer's technical representatives (COTRs) assist contracting officers by monitoring and reviewing administrative, financial, and technical activities for compliance with contract terms. To determine the effectiveness of the service contracts program, we reviewed policies and

procedures, interviewed contracting personnel, and reviewed 14 service contracts valued at about \$5.2 million. We identified three contracts where monitoring should be improved.

- Beginning with the February 2002 invoice and continuing through the June 2002 invoice, a contractor had overcharged the medical center's Pathology Service \$35 per unit for autologous blood. The contractor charged \$250 per unit of blood, while the contract called for \$215 per unit. Pathology Service had certified payments of the incorrect rate, resulting in a total overpayment of \$1,575. When we brought the overpayment to the attention of Pathology Service staff, they contacted the contractor who refunded the \$1,575. The overpayment occurred because the COTR responsible for reviewing invoices had left the medical center in February 2002, and the new COTR had not reviewed the contract's terms before certifying invoices for payment.
- The medical center contracts for pharmacy support for its Ukiah CBOC. The support involves retail pharmacy services for patients awaiting their prescriptions from the VA Consolidated Mail Out Pharmacy. We found that the COTR certifying Ukiah CBOC pharmacy invoices for payment had not compared the contractor's charges to the contract terms. The COTR informed us that since the inception of the contract in February 2002, invoices were reviewed to determine whether there was a written prescription for the charge and that the prescription did not exceed more than a 14-day supply. Verifying that prescriptions exist is important, however, the COTR also needed to monitor the contract by carefully screening the contractor's invoices for compliance with the contract terms.
- The medical center contracts for the delivery and management of primary care at its Eureka CBOC. The contractor is reimbursed monthly at a fixed rate of \$30.78 per enrolled patient, but the contract terms allow the medical center to remove patients from the contractor's rolls who no longer meet enrollment criteria, such as deceased patients. However, we found the COTR did not remove patients from the contractor's rolls until the end of each contract year. Under this practice, the contractor would receive monthly payments for a patient that died in January, through the end of the year. The COTR should monitor the CBOC rolls and remove ineligible patients as soon as possible.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) COTRs certifying invoices for payment closely monitor contractor compliance with the contract terms and (b) COTRs remove patients no longer meeting enrollment criteria from the contractor patient rolls monthly. The VISN Director agreed and reported contractor payments were reviewed to ensure the proper amounts were paid. The COTRs had received mandatory training and will receive annual refresher training to remind them of their duties. Contracts will be reviewed in the future to ensure the COTRs are performing their assigned duties. Patients no longer meeting enrollment criteria will be removed from the contractor's rolls at the end of each month. The improvement actions are acceptable, and we consider the issues resolved.

Community-Based Outpatient Clinics – Patient Enrollment Reporting Data Needed Improvement

Condition Needing Improvement. The medical center needed to improve the validation of CBOC patient enrollment reporting data. To ensure the accuracy of patient enrollment data, VHA requires that facilities periodically review the Primary Care Management Module (PCMM) database and remove inactive patients, such as those patients who have not been seen in 2 years and who do not have a future appointment.

We found that prior to June 2002, Ambulatory Care staff had not periodically removed patients from the PCMM database to ensure the accuracy of the CBOC patient enrollment data. The removal of inactive patients is especially critical at the medical center's CBOCs, because some CBOCs have capped enrollments and stopped accepting new patients. For example, the Ukiah CBOC had stopped accepting new patients because of workload and space constraints. We identified 79 patients residing in the Ukiah area who had to travel about 60 miles each way to the Santa Rosa CBOC to receive primary care. One of VHA's objectives in establishing CBOCs was to reduce the need for patients to travel long distances to receive their primary care. If the PCMM database is periodically reviewed and inactive patients removed, the Ukiah CBOC might be able to accommodate additional Ukiah area patients. We believe it is reasonable to review the PCMM monthly and remove inactive patients. Medical center management agreed that Ambulatory Care staff needed to periodically remove inactive patients from the PCMM database and also informed us that they intended to seek additional space and hire an additional provider for the Ukiah CBOC.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director requires that Ambulatory Care staff review the PCMM database monthly and remove inactive patients. The VISN Director agreed and reported monthly reports listing inactive patients are now reviewed and appropriate actions, such as removing deceased patients, are taken. The Director further indicated a person will be hired to manage the PCMM database and that this person's primary duty will be to ensure the database is accurate and ensure inactive patients are removed monthly. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Policies, Procedures, and Physical Security Need To Be Improved

Conditions Needing Improvement. The medical center needed to improve controls over the Information Resources Management (IRM) computer equipment building's physical security, the process of terminating system access for former employees, the Contingency/Disaster Plan, and security of data backups. VHA requires each facility to protect both electronic and physical access to VA resources. The Contingency/Disaster Plan should include a prioritized list of equipment and systems to be restored in case of disaster. Daily data backups should be maintained outside the IRM computer building in a secure fire-safe location. We identified four weaknesses in IT security that needed to be addressed.

- The IRM computer building containing computer equipment for both the medical center and VISN 21 did not have an intrusion alarm system. This building also had plain glass, rather than security glass, windows on the sides and on the two doors leading into the building. These deficiencies leave the building vulnerable to unauthorized intrusion and forcible entry. The Chief, IRM, agreed with the need for an intrusion alarm system and requested one be installed. During our CAP review, medical center management replaced the glass on the two doors with security glass. Further, medical center management stated a contract would be awarded to install the required security mesh over the windows on the sides of the building.
- Access to sensitive VA resources should be limited to only those individuals who need access to perform their duties. To further restrict access to sensitive data, access should be timely removed when an employee separates from the medical center. Our review identified 17 individuals who had current access to the Veterans Health Information Systems and Technology Architecture (VistA), even though they appeared on a list of separated employees. The Information Security Officer (ISO) determined that 14 of the 17 individuals had legitimate access because they remained employed in unpaid positions. The ISO planned to follow up on whether the remaining three individuals had legitimate access. The ISO stated access questions occurred because IRM was not always notified when an employee separated or converted to an unpaid position.
- The Contingency/Disaster Plan did not contain a list of equipment and systems prioritized by their critical need and the order in which they should be restored in the event of a disaster. As a result, should a disaster occur there may be a delay in restoring the most critical functions. During our CAP review, the IRM staff and the ISO began prioritizing their equipment and systems by critical need.
- We found that although weekly computer system backup data were properly stored off-site, the daily backup data were improperly stored in a room in the computer equipment building. In the event of a disaster, backup data could be destroyed, resulting in the loss of critical data. During our CAP review, IRM staff began storing tapes in a secure fire-safe container in another building.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) construction materials in the IRM computer equipment building be strengthened and an intrusion alarm system installed; (b) IRM be notified of the separation or conversion to unpaid positions of all employees to prevent unauthorized access to VistA; (c) IRM updates the Contingency/Disaster Plan to include a prioritized list of equipment and systems to be restored in case of a disaster; and (d) the daily computer system backup tapes be stored outside the IRM computer equipment building in a secure fire-safe container. The VISN Director agreed and reported a contractor would install security mesh over the windows on the sides of the IRM computer equipment building and an intrusion alarm. Human Resources now provides the ISO a listing of all employees who have separated or converted to unpaid positions every pay period and the IRM has incorporated into the Contingency/Disaster Plan a prioritized list of equipment and systems to be restored in case of a disaster. In addition, IRM now stores the daily system backup tapes in a secure fire-safe

container outside the IRM computer equipment building. The improvement actions are acceptable, and we consider the issues resolved.

Homemaker/Home Health Aide Program – Patient Assessment Procedures and Oversight Practices Should Be Improved

Conditions Needing Improvement. The medical center needed to improve its H/HHA Program's patient assessment procedures and oversight practices. The H/HHA Program is designed to provide functionally impaired veterans with in-home support such as bathing, dressing, and mobility. The underlying goal of the program is to keep patients in their homes rather than in nursing homes.

To assess H/HHA Program procedures and practices, we reviewed the medical records of 10 patients participating in the program, reviewed a draft of the new facility policy, and interviewed program officials and 5 patients enrolled in the program. We identified the following issues that needed to be addressed:

Patient Assessments Were Not Properly Documented. An initial interdisciplinary assessment that reflects the clinical need and administrative eligibility for H/HHA services should be documented in the patient's medical record. The 10 medical records we reviewed lacked this documentation.

Evaluations of H/HHA Services Were Not Properly Documented. There was no evidence that Community Health Agency (CHA) performance improvement data and quarterly patient assessments were used to evaluate the quality of care and the need for continued care. Program officials stated that CHAs submitted patient assessments and performance improvement data every 60 days. However, the 10 medical records we reviewed lacked this documentation.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) interdisciplinary assessments are performed and documented for every patient in the H/HHA Program and (b) CHA performance improvement data and patient assessment reports are reviewed quarterly to evaluate the quality of care and the need for continued care, and are filed in the medical records. The VISN Director agreed and reported a social worker, physician, and nurse would complete a current referral for each H/HHA patient that reflects the clinical need and administrative eligibility for H/HHA services. All plans of care will be reviewed and updated every 60 days and the plans will reflect the patient's current level of care needs. The improvement actions are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Controls Need To Be Strengthened

Condition Needing Improvement. The medical center needed to improve controls over the Government purchase card program. VHA requires the duties and responsibilities of the cardholders, Government Purchase Card Program Coordinator, and approving officials to be

properly segregated. To evaluate Government purchase card program controls, we interviewed the Program Coordinator and reviewed Government purchase card transactions and records. We identified a weakness in Government purchase card program controls that needed to be addressed.

We found that the Program Coordinator was an active cardholder for four Government purchase cards and an approving official for one other cardholder's Government purchase card. VHA policy prohibits the Program Coordinator from being a cardholder or an approving official. Key positions must be properly segregated to prevent a single individual from having too much control and the ability to initiate, record, reconcile, review, and approve purchase card transactions.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director removes the Program Coordinator's approving official and cardholder duties in accordance with VHA policy. The VISN Director agreed and reported the Program Coordinator had relinquished approving official duties and all purchase cards. The improvement actions are acceptable, and we consider the issues resolved.

VISN 21 Director Comments

Department of Veterans Affairs

Memorandum

Date: April 8, 2003

From: Network Director, VA Sierra Pacific Network (10N21)

Subj: Response to OIG CAP Review of the VA Medical Center San Francisco

To: Assistant Inspector General for Auditing (52)

Thru: Deputy Under Secretary for Health for Operations & Management (10N)

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the VA Medical Center (VAMC) in San Francisco. I carefully reviewed the report, as well as my notes from the exit briefing on August 2, 2002. In addition, I discussed the findings and recommendations with senior leadership at VAMC San Francisco and the VISN 21 office.

2. In brief, I concur with all of the findings and suggested improvement actions. The implementation plan showing specific corrective actions and target implementation dates is provided in an attachment. As you will note, the vast majority of the actions have already been completed. The remaining proposed remedies will be completed in the next few months.

3. I am pleased that there are no suggested improvement actions and no "negative" findings related to environment of care, part-time physicians and inventory management (other than the specific issue related to controlled substances). I was also pleased that the questionnaires and patient interviews indicated a high level of patient and employee satisfaction.

4. In closing, I would like to express my thanks to the CAP review team. The team members were professional, comprehensive and focused. I appreciated that the survey team discussed issues. The educational sessions regarding fraud and abuse awareness were also helpful and well received. The collective interest and efforts of the CAP review team have helped improve our clinical and business practices at VAMC San Francisco.

Robert L. Wiebe, M. D.
Network Director
Attachment

Controlled Substances Inventory Management & Accountability**Suggested Improvement Action 1: Controlled Substances Inventory levels are reduced to a 10-day supply**

Concur. A review of all controlled substance items and the identification of a 10-day supply level are in process. Once completed, the inventory will be reduced downward towards the VHA's 10-day supply goal by June 1, 2003. Additionally, Pharmacy will conduct follow-up quarterly reviews of the inventory to ensure we maintain this level.

Target Completion Date: Completion by June 1, 2003.

Savings: The "savings" of \$82,000 based on the reduction of the inventory cannot be verified because of the inventory fluctuation; however, it appears to be reasonable and it is only a one-time shift.

Suggested Improvement Action 2: Controlled Substances Inspection Program complies with VHA policy

Concur. Inspection process has been modified to be in full compliance with VHA policy. The monthly-unannounced inspection process includes items ready for destruction; the Pyxis machine in the OR; inventory at the Outpatient, Inpatient and the Santa Rosa Pharmacies; as well as reviewing the 72-hour pharmacy inventory verification reports. In addition, inspector training has been conducted and documentation (sign-in sheets) was maintained; however, it is now included in the TEMPO electronic training package.

Target Completion Date: Completed as of August 15, 2002.

Pharmacy Security**Suggested Improvement Action 1: Steel security mesh is installed for the outpatient pharmacy ground-level windows**

Concur: Security steel mesh has been installed on all ground-level pharmacy windows to prevent unauthorized entry.

Target Completion Date: Completed as of March 7, 2003

Suggested Improvement Action 2: A shield is installed on the electronic locking system keypad of the outpatient pharmacy vault door to prevent observation of access codes by passersby

Concur: Prior to the CAP inspectors leaving, a shield was installed onto the keypad outside the Outpatient Pharmacy vault to prevent observation of access codes by passersby.

Target Completion Date: Completed as of August 1, 2002.

Suggested Improvement Action 3: A steel or solid core outpatient pharmacy door is installed

Concur: The glass in the door of the Outpatient Pharmacy is architectural wired mesh, which is not breakable; however, we have replaced the door with a solid core door based on your recommendation.

Target Completion Date: Completed as of March 11, 2003.

Quality Management

Suggested Improvement Action 1: Clinical Service Chiefs consider and consistently review and document providers' QM results for renewal of providers' clinical privileges

Concur: The Professional Standards Board has reviewed and modified the Service/Section Chief renewal forms for providers' clinical privileges. Modifications require the Service Chief to document a review of a number of QI findings, e.g. morbidity and mortality rates and service /section monitor findings, as a part of the renewal package for a provider's clinical privileges.

Target Completion Date: Completed September 3, 2002.

Suggested Improvement Action 2: Quality Manager implements measures to ensure complete analysis and reporting of mortality data

Concur: QM reviews all facility deaths. Analysis of this data now includes bed location, provider, time of death and day of the week and will be periodically reported to the Executive Quality Review Board.

Target Completion Date: Completed September 3, 2002.

Service Contracts

Suggested Improvement Action 1: COTRs certifying invoices for payment closely monitor contractor compliance with the contract terms

Concur: (a) Laboratory Medicine is reviewing all payments, including those made to the blood contractor, to ensure the proper amounts are paid to the provider based on the contracts.

Target Completion Date: Completed as of August 1, 2002.

Savings: One time savings of \$1,575 savings from the blood contractor is correct.

Concur: (b) Mandatory training for all COTRs will be conducted by the Consolidated Contracting Activity at the San Francisco VAMC on March 14, and 21st, 2003. During this training the COTRs will be reminded of ALL their duties including closely monitoring contractor compliance with contract terms. Annual refresher training for the COTRs will be required; beginning in 2004 the Contracting Officer and the COTR will survey a sample of the contracts to ensure the COTR is fulfilling all their duties appropriately.

Target Completion Date: Completed as of March 21, 2003.

Suggested Improvement Action 2: COTRs remove patients no longer meeting enrollment criteria from the contractor patient rolls monthly

Concur: The Eureka CBOC contractor is reimbursed monthly based on a fixed rate for patients enrolled. When we are notified a patient is deceased or no longer meets enrollment criteria we removed them from the contractor's rolls. This purging occurs at the end of each month.

Target Completion Date: Completed as of August 30, 2002.

Community-Based Outpatient Clinics

Suggested Improvement Action 1: Ambulatory Care staff review the PCMM database monthly and remove inactive patients

Concur: (a) The review of the PCMM database is an ongoing process for the Ambulatory Care staff. When patients die they are removed as soon as we are notified. KLF provides a monthly report listing inactive patients by provider panel. Those are reviewed and appropriate action taken.

Target Completion Date: Process implemented August 30, 2002.

Concur: (b) we are recruiting for a new position to manage the PCMM database. This person's primary duty will be to ensure the accuracy of this database and ensure inactive patients are removed on a monthly basis.

Target Completion Date: Completion by June 1, 2003.

Information Technology Security

Suggested Improvement Action 1: Construction materials in the IRM computer equipment building be strengthened and an intrusion alarm system installed

Concur: (a) A contractor will be installing security mesh over the windows on the sides of the IRMS building.

Target Completion Date: Completion by July 1, 2003.

Concur: (b) contractor will install the intrusion alarm system for the IRMS building.

Target Completion Date: Completion by June 15, 2003.

Suggested Improvement Action 2: IRM be notified of the separation or conversion to unpaid positions of all employees to prevent unauthorized access to Vista

Concur: HRMS provides the ISO a listing of employees who have separated or converted to unpaid positions every pay period. The ISO reviews the report, identifying any inconsistencies with current computer access and takes appropriate action.

Target Completion Date: Completed as of August 30, 2002.

Suggested Improvement Action 3: IRM update the Contingency/Disaster Plan to include a prioritized list of equipment and systems to be restored in case of a disaster

Concur: A prioritized list of equipment and systems to be restored in case of a disaster has been finalized. The list has been incorporated into the IRMS Contingency/Disaster Plan, as well as the station Disaster Plan.

Target Completion Date: Completed as of February 25, 2003.

Suggested Improvement Action 4: Daily computer system backup tapes be stored outside the IRM computer equipment building in a secure fire-safe container

Concur: During the CAP survey the daily computer system backup tapes were moved outside the IRMS building into a secure fire-safe container as recommended. Since that time IRMS has acquired their own fire-safe container and the backup tapes are now located in building #200 which is in a separate fire zone.

Target Completion Date: Completed as of August 1, 2002.

Homemaker/Home Health Aide Program

Suggested Improvement Action 1: Interdisciplinary assessments are performed and documented for every patient in the H/HHA Program

Concur: The current referral for each H/HHA patient is completed by a Social Worker and reflects clinical need and administrative eligibility for these services. To comply with the Homemaker and Home Health Aide Directive, a MD and RN will complete an additional note reflecting clinical need for these services.

Target Completion Date: Completion by March 21, 2003.

Suggested Improvement Action 2: CHA Performance improvement data and patient assessment reports are reviewed quarterly to evaluate the quality of care and the need for continued care and are filed in the medical records

Concur: The Plans of Care currently received on all patients from outside agencies will be reviewed and transferred onto a new CPRS template, which will reflect the Medicare 485 (Plan of Care) style. All plans of care will be reviewed and updated every 60 days. Plans will reflect patient's current level of care needs.

Target Completion Date: Completion by May 9, 2003.

Government Purchase Card Program

Suggested Improvement Action 1: Remove the Program Coordinator's approving official and cardholder duties in accordance with VHA policy

Concur: The Program Coordinator has relinquished her approving official duties and all her purchase cards.

Target Completion Date: Completed as of February 26, 2003.

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the San Francisco VA Medical Center

Report Number: 02-00987-96

<u>Suggestion</u>	<u>Explanation of Benefits</u>	<u>Better Use of Funds</u>
Pg 6	Better use of funds by screening invoices for unallowable costs.	\$1,575

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