Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Augusta, Georgia

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Executive Summary

Introduction

During the week of February 10-14, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs Medical Center (VAMC), Augusta, Georgia, which is part of the Veterans Integrated Service Network (VISN) 7. 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 4 fraud and integrity awareness training sessions to 289 employees.

Results of Review

The VAMC implemented an effective Performance Improvement/Quality Management (PI/QM) Program to monitor the quality of care. The Home Care Committee actively monitored the provision of home care to veterans and reported its findings to the Performance Improvement Board (PIB). Surgical Service managers schedule pre-operative conferences the week before scheduled cases to review surgical evaluations, monitor for appropriateness of procedures, thoroughly identify operative risk, and formulate a post-operative plan. The VAMC's credentialing and privileging (C&P) program adequately monitored physicians and dentists. In addition, VAMC PI employees trended all inpatient deaths by wards, providers, and diagnoses, and planned to begin trending according to times of patients' deaths. To improve operations, the VISN and VAMC Directors needed to:

- Strengthen monitoring of the Government Purchase Card Program.
- Enhance automated information systems (AIS) security.
- Increase physical security in pharmacy areas.
- Improve controlled substances inspection procedures.
- Accurately monitor patient waiting times in the Eye Clinic, including fee-basis patient appointments.
- Address minor physical plant issues.
- Improve physical security in clinical laboratories.
- Complete background investigations.

- Improve the timeliness of completing histories and physical examinations (H&P) for patients admitted to Mental Health Service.

- Validate transcription services.

- Designate a coordinator for the management of the Violent Patient Behavior Program, and address employee concerns.

VISN 7 and VAMC Directors' Comments

The VISN and VAMC Directors comments met the intent of all recommendations and suggestions, and they provided acceptable implementation plans (See Appendices A and B, pages 13-26, for the full text of the Directors' comments). We will follow up on planned actions until they are completed.

Michael G. Sullivan

for RICHARD J. GRIFFIN
Inspector General

Introduction

VA Medical Center Profile

Organization & Programs. The Augusta VAMC is a two-division, tertiary care clinical referral facility. As a teaching hospital, the VAMC provides a full range of patient care services using state-of-the-art technology, and provides medical education and research. Comprehensive health care is provided through primary and secondary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics and extended care. Special emphasis programs include a 15-bed Blind Rehabilitation Center and a 60-bed Spinal Cord Injury Unit. The VAMC is a part of VISN 7.

Affiliations. The VAMC is affiliated with the Medical College of Georgia (MCG). More than 500 MCG residents, interns, and students are trained at the VAMC each year. The VAMC also has teaching agreements with 21 other colleges and universities to provide clinical training in numerous allied health disciplines.

Research. The VAMC had 49 principal investigators working on 97 active research projects. The estimated annual research budget was $2.4 million. Additional resources come from numerous outside sources and agencies including the National Institutes of Health. Areas of major research interest included stroke, neuroscience studies, molecular biology, schizophrenia, and gastroenterological disorders. In 2002, the VAMC entered into a leasing agreement with the MCG allowing the MCG sole occupancy of approximately 5,200 square feet of space in the Research Wing at the Downtown Division. This lease will generate approximately $97,000 a year in revenue to the VAMC.

Sharing Agreement. The VAMC and the Department of Defense Dwight David Eisenhower Army Medical Center (EAMC) at Fort Gordon, have a long-standing and mutually beneficial relationship. In 1993 both facilities entered into a Joint Venture Shared Services Agreement (JVSS). This agreement allowed both facilities to enter into shared services without having to address many of the technical requirements of traditional sharing agreements. The VAMC and the EAMC share services in neurosurgery, cardio-thoracic surgery, laboratory studies, laboratory testing, physical therapy, imaging services and many others. Opportunities for joint venturing are continually monitored through a JVSS Executive Steering Committee consisting of senior managers representing both facilities.

Resources. In Fiscal Year (FY) 2002, the VAMC had medical care expenditures totaling $159,195,718, which included $9,368,967 from Medical Care Collections Fund (MCCF) collections and did not include capital funds. The FY 2003 appropriated budget is about $154,471,380 with an estimated $12,337,148 in MCCF collections for a total available budget of $166,808,528. The FY 2003 budget represents about a 4.8-percent increase over the FY 2002 spending level. As of December 31, 2002, the VAMC had 1695 full-time equivalent employees (FTEE), including 86.5 FTEE physicians and 693.3 FTEE nursing personnel.

Workload. In FY 2002, the VAMC treated 30,500 unique patients, an 8.3 percent increase over FY 2001. In FY 2002, inpatient care bed sections at the Downtown Division had 5,525 patient discharges, and the Uptown Division had 2,068 discharges. The VAMC outpatient workload during FY 2002 totaled 283,159 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 employees 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, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

QM	Patient waiting times
Government Purchase Card Program	Environment of care
AIS	Mental health and behavioral sciences
Pharmacy security	Contracts
Controlled substances accountability	Management of violent patient behavior

As part of the review, we used questionnaires and interviews to survey patients' and employees' satisfaction with the timeliness of services and the quality of care. We sent an electronic survey questionnaire to all VAMC employees, 268 of whom responded. With the exception of responses to questions concerning the management of violent patient behavior, the survey results generally indicated high levels of patient and employee satisfaction. We informed senior managers of the employee and patient survey results.

During the review, we also presented four fraud and integrity awareness briefings for VAMC employees. About 289 employees attended these briefings, which 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 VAMC operations for FYs 2002 and 2003 through January 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VAMC and VISN 7 managers until corrective actions are completed.

Results of Review

Organizational Strengths

The Performance Improvement/Quality Management Program Was Comprehensive and Effective. The VAMC had implemented an effective PI/QM program to monitor the quality of care using national VA, VISN, and local performance measures as well as patient safety improvement and utilization management indicators. Clinical and QM managers analyzed PI/QM results to detect patterns and trends and took actions to address identified issues. The Home Care Committee actively monitored the provision of home care to veterans and reported its findings to the Geriatrics/Mental Health Service Line Committee and the PIB. Administrative investigations, tort claim reviews, focused reviews, root-cause analyses (RCA), and peer reviews were properly conducted, and corrective actions were implemented.

VAMC Surgery Service managers improved surgical morbidity and mortality rates by implementing a pre-operative conference the week before scheduled surgical cases to review surgical evaluations, monitor for appropriateness of procedures, thoroughly identify operative risk, and formulate a post-operative plan. The medical center's C&P program monitored physicians and dentists. Clinical Service Line Executive Directors' physician-specific profiling, used in reprivileging, included evaluation of peer review and patient satisfaction results.

In response to outpatients reporting significantly high numbers of incidents of perceived rudeness and uncaring attitudes by clerical and other front-line employees, the VAMC Education/Staff Development Department and the Medical Center Customer Service Team implemented a veterans/customer service training program called "Give Them A (an extra) Pickle." The training encourages employees to make an extra effort when providing services for patients. Front-line employees were among the first group attending the sessions, and the program is scheduled for employees throughout the VAMC.

In response to a VHA directive, presently in draft, entitled Responses to Suspicious Events, VAMC performance improvement employees trended all inpatient deaths by bed service units, providers, and diagnoses. They planned to expand the review to include trending according to times of death.

Opportunities for Improvement

Government Purchase Card Program – Monitoring of the Program Needed to be Improved

Conditions Needing Improvement. During the 15-month period ending December 31, 2002, cardholders completed about 30,000 transactions valued at about $17 million. The following conditions required managers' attention:

Cardholders Split Purchases to Stay Within Their Spending Limit. Four cardholders split 22 purchases valued at about $96,000 to stay within their single purchase limits of $2,500. Split purchases are multiple transactions by the same cardholder to the same vendor on the same date.

Quarterly Audits of Cardholder Accounts Needed to be Conducted. Fiscal Service and Acquisition and Materiel Management Service employees did not conduct quarterly audits of cardholders' accounts. VA policy requires quarterly audits of cardholder accounts not reviewed during monthly VA Financial Service Center statistical sampling audits.

The Citibank System had Incorrect Spending Limits. Citibank had incorrect spending limits for two cardholders:

- The Purchase Card Coordinator did not register a cardholder's $2,500 spending limit with Citibank. As a result, Citibank did not detect four transactions exceeding the cardholder's spending limit. The cardholder detected the unauthorized purchases while reconciling her account.

- A cardholder's spending limit was set at $50,000. However, the cardholder was only "warranted" to make purchases up to $25,000.

Cardholders Needed to Reconcile Transactions Timely. VA policy requires that cardholders reconcile 95 percent of their purchase card transactions within 17 days and 100 percent of the transactions within 30 days. Cardholders only reconciled about 87 percent of the transactions within 17 days and about 93 percent of the transactions within 30 days. During the 15-month period ending December 31, 2002, cardholders had not timely reconciled 1,883 transactions valued at about $1.2 million within the 30-day period. The cardholders averaged 69 days to reconcile these transactions.

Approving Officials Needed to Approve Reconciled Transactions Timely. VA policy requires approving officials to approve 100 percent of the reconciled transactions within 14 days. Approving officials approved 91 percent of the reconciled transactions within 14 days. During the 15-month period ending December 31, 2002, approving officials had not timely approved 2,018 reconciled transactions valued at about $1.6 million. The approving officials averaged 71 days to approve these reconciled transactions.

Some Cardholders and Approving Officials Needed Training. VA policy requires that Purchase Card Coordinators ensure that cardholders receive required training prior to issuing purchase cards. No documentation was found to confirm that 5 cardholders and 18 approving officials had received the required training.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director take action to ensure that:

a. Cardholders do not split purchases.
b. Quarterly audits of all cardholder accounts are conducted.
c. Medical center and Citibank spending limits are in agreement.
d. Transactions are reconciled timely.
e. Reconciled transactions are approved timely.
f. Required training for cardholders and approving officials is conducted and properly documented.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needed Improvement

Conditions Needing Improvement. The following AIS security conditions required managers' attention:

Contingency Plans Could be Strengthened. AIS contingency plans had not been sufficiently developed and implemented to reduce the impact of disruptions in services, provide critical interim processing support, and provide the ability to resume normal operations. AIS contingency plans generally did not identify:

- Completion dates for the contingency plans.
- A disaster recovery team or roles of key personnel in the process.
- An off-site storage location for the contingency plans and back-up tapes.
- AIS equipment and software configurations.
- Mission-critical functions and the resources needed to support those functions.
- Priority of specific tasks to be performed and computer applications to be installed in a disaster recovery situation.

Additionally, the contingency plan for the Informatics Service Line (ISL) had not been tested.

Quarterly Computer Access Needs Assessments Needed to be Performed. The Information Security Officer (ISO) did not perform quarterly reviews of the continued need for Veterans Health Information System and Technology Architecture (VISTA) access and remote access. As of January 31, 2003, the medical center had 940 non-medical center employees[1] with VISTA access and 213 individuals with remote access, including 32 contractor employees. Of the 940 individuals with VISTA access, we found that all but 18 individuals had accessed VISTA within 90 days prior to our review. The most recent access for the remaining 18 individuals ranged from 127 to 996 days prior to our review.

Remote access for 13 of the 32 contractor employees was terminated by the ISO as a result of our review.

An Independent Gateway Needed Approval. The medical center had not requested or received approval from VHA's Internet Management Review Board for an independent outbound gateway as required by VHA policy.

AIS Generic Accounts were in Use. ISL employees established two generic VISTA accounts which are prohibited by VHA policy. Such accounts prevent identification of individuals making system changes.

Background Investigations Needed to be Performed. VA policy requires that personnel working in sensitive positions have background checks performed appropriate to their positions. The telephone switch manager, the New Technology Administrator, and a telephone switch maintenance contractor employee did not have required background investigations completed.

The ISO Needed Technical Training. The ISO was unfamiliar with the auditing tools available in the VISTA system. VA policy requires the ISO to possess the requisite knowledge and skills to effectively monitor the system.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director require that:

a. Contingency plans are comprehensive.
b. Quarterly reviews of VISTA and remote access users are performed.
c. The independent outbound gateway is approved.
d. AIS generic accounts are terminated.
e. Background investigations are completed for all sensitive positions.
f. The ISO is trained in the VISTA audit features.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

[1] Represents VA employees of other VA entities and non-VA employees, including volunteers, contractors, students, and residents.

Pharmacy Security – The Physical Security of Pharmacy Areas Needed to be Improved

Conditions Needing Improvement. Pharmacy security needed to be improved at both divisions. The Downtown Division outpatient dispensing counter did not have bulletproof glass to provide proper security for dispensing personnel. VA policy (VHA Program Guide 18-3, May 2003, Chapter 14.6) requires that dispensing counters must meet the Class III Ballistic Level.

A refrigerator unit containing controlled substances in the Uptown Division inpatient area did not have a lock to provide security against theft. VHA policy requires that refrigerators must be equipped with a built-in lock mechanism or a hasp with a padlock when used to store controlled substances outside of the vault.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director require that:

a. Pharmacy dispensing areas meet VHA physical security requirements.
b. Refrigerated controlled substances are stored in lockable refrigerators.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Inspection Procedures Needed to be Improved

Conditions Needing Improvement. VAMC inspectors did not review receiving reports and 72-hour inventories of controlled substances during monthly unannounced inspections. VHA policy requires that inspectors review receiving reports and 72-hour inventories to properly account for all controlled substances. Additionally, the inspectors did not return supporting documentation of the inspections to the Pharmacy Service. VHA policy requires that pharmacies maintain these records for 2 years.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director require inspectors to complete reviews of receiving reports and 72-hour inventories during monthly unannounced inspections and return the supporting documentation to Pharmacy Service.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Patient Waiting Times – The Eye Care Clinic (ECC) Needed to Include Fee-Basis Patient Appointments in Waiting Time Reports

Conditions Needing Improvement. ECC employees did not report fee-basis patients' waiting times, as required. The ECC employees did not enter fee-basis patient appointments into the VISTA Appointment Manager Menu. As a result, they reported that the average waiting time for the ECC was 28 days. Had fee-basis patient appointments been included in reports, the average waiting time for patients to be seen by ECC clinicians would have been about 80 days. VHA is striving to reduce patient clinic waiting times to 30 days.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the VAMC Director require ECC employees to include fee-basis patient appointments in determining and monitoring average waiting times.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Environment of Care – Safety Measures Needed to be Improved

Conditions Needing Improvement. The following safety conditions needed to be strengthened:

Minor Physical Plant Issues. We inspected all clinical and administrative areas of the facility and found the environment of care to be generally acceptable.[2] In those areas where we found problems, managers were responsive and took immediate actions to correct the deficiencies.

Laboratory Security. VHA Directive 2002-075, requires that access to laboratories be limited and controlled. We found that non-VA personnel had direct access to the Clinical Laboratory that operated a BioSafety Level-II (BSL-II) laboratory. Local funeral homes were given keys to access the morgue refrigerator, which also open the doors in the laboratory area including the BSL-II laboratory. During the day the doors to the laboratory were propped open. In addition, the door to the incubator that contains mycobacterium tuberculosis was not locked.

Background Investigations. VA Directive 5005, Part II, Chapter 2, Section A, 5(2)b requires that all employees be subject to background investigations and finger printing appropriate to their positions prior to appointment. VAMC managers acknowledged that they could not certify that all employees, who have been employed for more than a year, had valid and up-to-date background investigation clearances in their Official Personnel Files. Furthermore, they had not completed background investigations on without compensation (WOC) employees, including WOC employees of the affiliated universities.

[2] Criteria used from the Centers for Disease Control and Prevention – Healthcare Infection Control Practices Advisory Committee's Guideline for Environmental Infection Control for Healthcare Facilities.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the VAMC Director:

a. Limit access to the clinical laboratory.
b. Complete background investigations.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Mental Health and Behavioral Sciences – Timelines for Completion of Histories and Physical Examinations Needed Improvement

Conditions Needing Improvement. Providers in Mental Health and Behavioral Sciences needed to complete H&Ps within 24 hours of patients' admissions.

VAMC Bylaws and Rules of the Medical Staff require that "...histories and physical examinations, including all pertinent findings with provisional diagnosis, must be written by a qualified practitioner or resident within 24 hours of the patient's admission." We reviewed H&P reports for patients admitted to the VAMC's Mental Health Unit in December 2002 and January 2003. We found that timely H&P reports were not performed for 19 (13 percent) of 147 patients admitted in December 2002, and 24 (15 percent) of 159 patients admitted in January 2003. Failure to complete H&P reports in a timely manner prevents clinicians from having the appropriate medical information on patients upon admissions and risks delaying or postponing necessary treatments.

The QM Coordinator and the Chief of Mental Health were aware of this issue and said that they will better monitor the problem, and instruct non-compliant employees to complete H&Ps within 24 hours of admission.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the VAMC Director assure:

a. Providers complete H&Ps on all mental health patients within 24 hours of admission.
b. Responsible employees monitor the timeliness of completing H&Ps in mental health.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Contracts – Invoices for the Transcription Contract Needed to be Validated

Conditions Needing Improvement. A Contracting Officer Technical Representative (COTR) certified transcription contract invoices based on the vendor's log without validating the accuracy of the number of lines billed for the individual transcriptions. The contractor billed the medical center about $121,600 for transcription services during the period March 2001 through December 2002, under a $6.4 million VISN contract. The contract payment terms ranged from 13.75 to 15.6 cents per line (containing 75 characters) during the life of the contract.

A sample of 10 transcripts showed that the medical center paid for 1,053 lines that contained 72 characters. Based on the contract terms, the medical center should have been billed for 991 lines. VISN 7 is reviewing the VISN-wide contract to determine what changes are required and the monetary impact that the difference in characters per line creates for reimbursement purposes.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the VAMC Director require that COTRs verify transcription services received prior to certifying invoices. Our suggestion only addresses the COTR's certification of the invoices.

The VISN and VAMC Directors comments and planned actions met the intent of the suggested improvement action, and they provided acceptable improvement plans.

Management of Violent Patient Behavior – Coordination, Training, and Management Support Needed to be Improved

Conditions Needing Improvement. VISN 7 and the VAMC needed to improve the following aspects for preventing and managing violent patient behavior:

There was no Coordinator Designated for VISN 7. VISN 7 did not have a coordinator assigned for the Prevention and Management of Violent Patients Program as recommended by VHA. In an August 2001 "VHA Task Force on Violence Prevention Report" and the "Veterans Health Administration Network Directors' Performance Monitor: Violence Prevention for 2002," it is recommended that each VISN establish a coordinator of violence prevention. The responsibilities of the coordinator, which could be a collateral duty, would include coordination of training initiatives and reporting and tracking of violent incidents for the VISN.

Employees Perceptions for Training and Management Support Needed Improvement. We received 268 responses to our employee survey. The employee survey included questions on the prevention and management of violent patient behavior. Not everyone responded to all of the violent patient behavior questions. Fifty-four (25 percent) of 219 employees, who responded to the question, did not feel that the facility supported "zero tolerance" for patient violence, and 59 (22 percent) of 265 responding employees said they did not receive training in the prior year in the prevention of violence in the workplace. Forty-four (49 percent) of 90 responding employees indicated not receiving feedback on reports of violence, and 23 (24 percent) of 94 employees did

not feel they were supported by their supervisor to report these incidents. Forty-six (25 percent) of 181 employees believed incidents were not followed-up appropriately, and 69 (26 percent) of 264 employees did not feel safe from potential incidents in their work environment. Of 141 responses, 106 (75 percent) denied knowing how to respond when seeing a violent patient warning flag in the computer.

Suggested Improvement Action 2. We suggested that the VISN Director:

a. Designate a coordinator for the Preventative Management of Violent Patient Behavior Program.
b. Direct the VAMC Director to assess and improve any deficiencies perceived by employees related to training and workplace safety.

The VISN and VAMC Directors comments and planned actions met the intent of the suggested improvement action, and they provided acceptable improvement plans.

VISN 7 Director Comments

Appendix A
VISN Director Comments
OIG Combined Assessment Program Review of the
VA Medical Center Augusta, GA
Project Number 2003-00752-HI-0100

Recommended Improvement Action 1.

Government Purchase Card Program – Monitoring of the Program Needed to be Improved.

The VISN Director should ensure that the AVAMC Director takes action to ensure that:

a. Cardholders do not split purchases.
b. Quarterly audits of all cardholder accounts are conducted.
c. Medical Center and Citibank spending limits are in agreement.
d. Transactions are reconciled timely.
e. Reconciled transactions are approved timely.
f. Required training for cardholders and approving officials is conducted and properly documented.

VISN Director's Comments: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Recommended Improvement Action 2.

Automated Information Systems – Security Needed Improvement.
The VISN Director should ensure that the AVAMC Director requires that:

a. Contingency plans are comprehensive.
b. Quarterly reviews of VISTA and remote access users are performed.
c. The independent outbound gateway is approved.
d. AIS generic accounts are terminated.
e. Background investigations are completed for all sensitive ISL positions.
f. The ISO is trained in the VISTA audit features.

VISN 7 Director Comments

VISN Director's Comments: (a. through f.) The issue of whether the contract employees have access to sensitive information is being determined, and will be addressed appropriately in the modification of the contract if warranted. The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Recommended Improvement Action 3.

Pharmacy Security – The Physical Security of Pharmacy Areas Needed to be Improved.

The VISN Director should ensure that the AVAMC Director requires that:

a. Pharmacy dispensing areas meet VHA physical security requirements.
b. Refrigerated controlled substances are stored in lockable refrigerators.

VISN Director's Comments: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Recommended Improvement Action 4.

Controlled Substances Accountability – Inspection Procedures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director requires inspectors to complete reviews of receiving reports and 72-hour inventories during monthly unannounced inspections and return the supporting documentation to Pharmacy Service.

VISN Director's Comments: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

VISN 7 Director Comments

Recommended Improvement Action 5.

Patient Waiting Time – The Eye Care Clinic (ECC) Needed to Include Fee-Basis Patient Appointments in Waiting Time Reports.

The VISN Director should ensure that the AVAMC Director requires ECC employees to include fee-basis patient appointments in determining and monitoring average waiting times.

VISN Director's Comments: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Recommended Improvement Action 6a.

Environment of Care – Safety Measures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director:

a. Limit access to the clinical laboratory.

VISN Director's Comments: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Recommended Improvement Action 6b.

Environment of Care – Safety Measures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director:

b. Complete background investigations.

VISN 7 Director Comments

VISN Director's Comments: Concur. However, there was some discussion as to whether residents were required to undergo a background check. VA Directive 0710, PERSONNEL AND NATIONAL INFORMATION SECURITY suggested that residents were exempt provided that their appointments did not exceed a year of continuous service at the VA facility, regardless of the duration of the residency program.

> *d. Exemptions. By agreement with the Office of Personnel Management, investigative requirements as set forth in E.O. 10450, Security Requirements for Government Employment, as amended, will not apply to:*
>
> *1) Consultants and experts in nonsensitive positions who are appointed for 1 year or less and not reappointed or those appointed for more than 1 year after the initial 1 year appointment period.*
>
> *(2) VA appointees in nonsensitive positions whose period of employment is specifically limited to 6 months or less in the following categories: per diem, temporary, seasonal, and intermittent.*
>
> *(3) Medical and dental residents appointed by VA to temporary, nonsensitive, noncareer positions, whose appointments do not exceed a year of continuous service at a VA facility, regardless of the duration of the residency program.*

We have since received clarification for VACO ISO that background investigations will likely be required in the future. In advance of a national policy change, VISN Director has undertaken steps to implement the requirement for background investigations. To accomplish this, all residents were sent the required SF-85. The residents are currently being scheduled by the Augusta Education Service Line to have their prints taken by Human Resources. The prints will be taken as the residents rotate to the medical center.

Processes are in place to ensure that all individuals who are given access to IT sensitive systems will receive a background investigation. This required a change to our WOC process whereby WOC letters now include the required SF-85 be sent to the individual and for fingerprints to be taken upon the appointment of the individual.

VISN 7 Director Comments

Recommended Improvement Action 7.

Mental Health Behavioral Sciences – Timelines for Completing Histories and Physicals Needed Improvement.

The VISN Director should ensure that the AVAMC Director assure:

a. Providers complete H&Ps on all Mental Health patients within 24 hours of admission.
b. Responsible employees monitor timeliness of H&P in Mental Health, and their compliance with approved Bylaws and Rules.

Response: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

Suggested Improvement Action 1.

Contracts – Invoices for the Transcription Contract Needed to be Validated.

The VISN Director should ensure that the AVAMC Director requires that COTRs verify transcription services received prior to certifying invoices. Our suggestion only addresses the COTR's certification of the invoices.

VISN Director's Comments: Concur. On February 20, 2001 at the Birmingham VA Medical Center, Contracting Officer Technical Representative (COTR) training was provided to all individuals who were to be designated as COTRs for the VISN transcription contract. The four-hour training session consisted of review and discussion of the contents of the VISN COTR handbook, standards of conduct for employees/COTRs including conflict of interest and how to write a statement of work. The training discussed the roles and responsibilities of the COTR, acquisition basics and processes, and post award administration to include the process of certifying invoices.

A modification to the VISN contract has been issued to correct the overpayment of lines. The modification provides for a 3% credit of the total paid amounts from the inception of the contract in 2001 through March 2003. The credit for the AVAMC of $3,679.03 (through December 2002 as invoices were not certified after this date until the modification was resolved) will be credited against future invoices. The modification also provides a 3% discounted price per line effective April 2003 and forward through any option year renewals.

VISN 7 Director Comments

Suggested Improvement Action 2a.

Management of Violent Patient Behavior – Coordination, Training, and Management Support Needed to be Improved.

We suggested that the VISN Director:

a. Designate a coordinator for the management of violent patient behavior program.

VISN Director's Comments: Do not concur with the finding however concur with the suggested improvement. There is no requirement for the VISN to appoint a coordinator for the management of violent patient behavior, as page 4 of the OIG CAP manual section on Violence prevention would suggest. The citation in the CAP manual directs surveyors to identify "someone responsible for providing support to the facilities for the management of violent patients" and identifies this assumption as a performance measure.

VHA set a performance monitor for FY 2002 to develop a local violence policy, participate in a national stand-down for violence prevention training, and at the end of the year review incidents of violence. The Network Directors were to appoint a VISN coordinator who would ensure employees in the VISN received this training. The VHA's Violent Behavior Prevention Program addresses violent behavior of patients, beneficiaries, visitors, volunteers, and/or employees.

Although the establishment of a coordinator is not a VHA requirement, VISN Director took the initiative of establishing the Network's Mental Health Service Line as the responsible oversight office for the Network's management of its violent patient behavior program. The Mental Health Service Line's Clinical Manager was charged with ensuring that the Network's violent patient behavior program is administered adequately and that the program meets the Network Directors' FY2003 performance monitor for violence prevention in the work place. This complies with the Undersecretary for Health's Information Letter, IL 10-97-006 and with VISN Director Memorandum 10N7-086, Network Occupational Safety and Health Program.

VISN 7 Director Comments

Each facility's violent patient behavior program is designed to enhance the care and services provided by allowing staff to safely interact with patients, beneficiaries, visitors, volunteers, and other employees and to reduce costs associated with work-related injuries. To accomplish this each Network facility has identified and provided instruction to at least two trainers. These individuals have in turn provided instruction to all other facility employees. Additionally, annual refresher training is provided. The Mental Health Service Line's Clinical Manager is charged with tracking the progress and success of each facility's program and reporting annually to the Network Director.

In addition, the VISN has a designated Patient Safety Officer and a VISN Safety Officer.

Suggested Improvement Action 2b.

Management of Violent Patient Behavior – Coordination, Training, and Management Support Needed to be Improved.

We suggested that the VISN Director:

b. Direct the AVAMC Director to assess and improve any deficiencies perceived by employees related to training and workplace safety.

Response: The VISN Director concurs with the recommended improvement actions and the corrective action plan submitted by the AVAMC Director (Appendix B).

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(Original signed by)

LARRY R. DEAL

VAMC Director Comments

Appendix B
Augusta VAMC Director Comments
OIG Combined Assessment Program Review of the
VA Medical Center Augusta, GA
Project Number 2003-00752-HI-0100

Recommended Improvement Action 1.

Government Purchase Card Program – Monitoring of the Program Needed to be Improved.

The VISN Director should ensure that the AVAMC Director takes action to ensure that:

a. Cardholders do not split purchases.
b. Quarterly audits of all cardholder accounts are conducted.
c. Medical Center and Citibank spending limits are in agreement.
d. Transactions are reconciled timely.
e. Reconciled transactions are approved timely.
f. Required training for cardholders and approving officials is conducted and properly documented.

AVAMC Director's Comments:

a. Additional training has been provided to all Medical Center cardholders and approving officials to include review of transactions that are considered split orders as well as orders exceeding the cardholder's authority. In addition, those cardholder's who were responsible for the split orders were individually counseled regarding the inappropriateness of their actions.

b. Per guidance provided by Stanley Wallace, VACO Purchase Card POC, audits on all individual cardholders are to be conducted quarterly. All individual cardholder audits were most recently completed March 10-13, 2003. Audits will be conducted quarterly.

c. Corrections to both accounts with discrepancy between Medical Center and Citibank spending limits were corrected immediately during the CAP review. This area is monitored to ensure compliance.

VAMC Director Comments

d. & e. The full-time Purchase Card Coordinator position has been filled. This will enable monthly follow-ups on all unreconciled cardholder charges and unapproved reconciliations. Outstanding charges over 30 days old have been decreased significantly and work continues to eliminate any over 30 day charges.

f. Training was conducted for all cardholders and approving officials on March 11, 12, 2003. New VAF 0242 forms (Government-wide Purchase Card Certification) were signed and completed at the training sessions. A process is in place to ensure any new cardholder or approving official is trained and this training is documented.

Recommended Improvement Action 2.

Automated Information Systems – Security Needed Improvement.

The VISN Director should ensure that the AVAMC Director requires that:

a. Contingency plans are comprehensive.
b. Quarterly reviews of VISTA and remote access users are performed.
c. The independent outbound gateway is approved.
d. AIS generic accounts are terminated.
e. Background investigations are completed for all sensitive ISL positions.
f. The ISO is trained in the VISTA audit features.

AVAMC Director's Comments:

a. Contingency plans are comprehensive. The most recent contingency plan templates have been received from the Office of Cyber Security. Contingency plans are currently being updated to these templates. Target date for completion is July 18, 2003.

b. Quarterly reviews of VistA and remote access users are performed. The VISN 7 Security Council has appointed a task group to develop procedures to control and manage new and existing staff access. Until such time as a VISN policy/procedure is in place, the ISO will devise a local monitor for review. Target date is July 1, 2003.

c. The independent outbound gateway is approved. A waiver for this gateway was and still is in place. A request was submitted to the VHA Internet Management Review Board within a month of the inspection. To date, no response has been received from the Board.

VAMC Director Comments

d. The two AIS generic accounts referenced in the report have been terminated.

e. The background investigation for one of the three employees referenced in the report (the New Technology Administrator) has been accomplished. The other two employees referenced are contract employees, and this issue is being handled by the Logistics Office for VISN 7. The contract that covers these positions (telephone switch manager and telephone switch maintenance contractor employee) is due for renewal in October 2003 and will be modified to include the required background investigations.

f. The ISO is trained in the VistA audit features and has been assigned auditing features in VistA.

Recommended Improvement Action 3.

Pharmacy Security – The Physical Security of Pharmacy Areas Needed to be Improved.

The VISN Director should ensure that the AVAMC Director requires that:

a. Pharmacy dispensing areas meet VHA physical security requirements.
b. Refrigerated controlled substances are stored in lockable refrigerators.

AVAMC Director's Comments: The AVAMC concurs with the OIG relative to the recommendations related to the Pharmacy.

a. Security issues must be balanced with patient needs to allow patient consultation and access to the pharmacist, while limiting access to controlled substances. We will develop an NRM project to remodel the pharmacy dispensing area based on the VA Design Guide, Pharmacy Service, revised March 1997. This design guide recommends that the pharmacist consultation and receiving area is separate from the dispensing and medication assembly area. To achieve this, the plan will be to create a wall behind two of the existing "windows". This wall will be consistent with the security requirements of the other perimeter walls in the pharmacy. One of the other two windows will be closed off and will meet the requirements of a perimeter wall. The fourth window will be modified to meet the security requirements of a pharmacy dispensing counter, with windows and walls that meet the U.L. Standard 752 for Class III Ballistic Level. It is anticipated that the project will be completed approximately three months after the contract is awarded. The target completion date will be dependent on available funds, but no later than 4th Quarter FY04.

VAMC Director Comments

b. Corrective actions were taken during the OIG inspection to place a lock on the refrigerator in the Uptown controlled substance dispensing area. This has been completed.

Recommended Improvement Action 4.

Controlled Substances Accountability – Inspection Procedures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director requires inspectors to complete reviews of receiving reports and 72-hour inventories during monthly unannounced inspections and return the supporting documentation to Pharmacy Service.

AVAMC Director's Comments: Mandatory training for all narcotics inspectors was held March 6, 2003. These concerns were shared with the inspectors and they were informed that when the vaults were being counted they would inspect the receiving reports and the 72-hour inventories. Also, all inspectors were told that they would forward a hard copy of their monthly inspections and all backup paperwork to the Chairperson, Narcotics Committee who would then forward them to the Pharmacy where they would be maintained for at least two years. The MCPM 509-03-00/07, "Controlled Substances Inspection Program," has been updated to reflect these changes.

Additionally, files were assembled for the last year of all inventories and were sent to the Pharmacy for safekeeping.

Recommended Improvement Action 5.

Patient Waiting Time – The Eye Care Clinic (ECC) Needed to Include Fee-Basis Patient Appointments in Waiting Time Reports.

The VISN Director should ensure that the AVAMC Director requires ECC employees to include fee-basis patient appointments in determining and monitoring average waiting times.

AVAMC Director's Comments: Fee-basis appointments for eye care (provided by two contractors) are now scheduled into the VA VistA Appointment Management system rather than scheduled by the individual contractor. This allows the inclusion of these visits in the determination of average waiting times for appointments.

VAMC Director Comments

Recommended Improvement Action 6a.

Environment of Care – Safety Measures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director:

a. Limit access to the clinical laboratory.

AVAMC Director's Comments: The following actions were taken to ensure limited access to the clinical laboratory:

1) All laboratory doors opening onto public corridors are closed and locked at 4:30 pm. Certain doors that cannot be monitored on a frequent basis are locked at all times.
2) Keyed access to the Microbiology Section (BioSafety level-II) is limited to the employees assigned to that section, the evening lead medical technologist, and the night lead medical technologist.
3) An additional lock has been installed to allow the Mycobacterium Tuberculosis incubator to be locked when the section is unoccupied.
4) Funeral home representatives are accompanied to the morgue area in the P&LM Department AT ALL TIMES by the Details Clerk (Decedent Affairs) or AOD who maintains control of the keys to this area. These newly issued keys will open only the double doors to the back of the Autopsy Suite (that enable access to the Cold Room) and the Cold Room and will not allow access to any other area in P&LM Department.

Recommended Improvement Action 6b.

Environment of Care – Safety Measures Needed to be Improved.

The VISN Director should ensure that the AVAMC Director:

b. Complete background investigations.

AVAMC Director's Comments: This requires a VISN response (Appendix A).

VAMC Director Comments

Recommended Improvement Action 7.

Mental Health Behavioral Sciences – Timelines for Completing of Histories and Physicals Needed Improvement.

The VISN Director should ensure that the AVAMC Director assure:

a. Providers complete H&P on all Mental Health patients within 24 hours of admission.
b. Responsible employees monitor timeliness of H&P in Mental Health, and their compliance with approved Bylaws and Rules.

AVAMC Director's Comments: At the time of review it was noted that 13% of December 2002, and 15% of January 2003, history and physical examinations were not performed within 24 hours of patient's admission. Staffing adjustments and reassignments have been made and the most recent report for May 2003 demonstrated a decrease in deficiency rate to 5.6%. The Mental Health & Geriatrics Service Line will continue to monitor completion of history and physical examinations with the goal of 0% deficiencies.

Suggested Improvement Action 1.

Contracts – Invoices for the Transcription Contract Needed to be Validated.

The VISN Director should ensure that the AVAMC Director requires that COTRs verify transcription services received prior to certifying invoices. Our suggestion only addresses the COTR's certification of the invoices.

AVAMC Director's Comments: This requires a VISN response (Appendix A).

Suggested Improvement Action 2a.

Management of Violent Patient Behavior – Coordination, Training, and Management Support Needed to be Improved.

We suggested that the VISN Director:

a. Designate a coordinator for the management of violent patient behavior program.

VAMC Director Comments

AVAMC Director's Comments: This requires a VISN response (Appendix A).

Suggested Improvement Action 2b.

Management of Violent Patient Behavior – Coordination, Training, and Management Support Needed to be Improved.

We suggested that the VISN Director:

b. Direct the AVAMC Director to assess and improve any deficiencies perceived by employees related to training and workplace safety.

AVAMC Director's Comments: In FY 2002, 101 classes on Workplace Violence were offered at various times during the day, evening and weekend tours. Approximately 98% of the employees at this facility received this training. Employees that did not receive the training were on military leave, sick leave or were on intermittent appointments. The support of leadership and management for "zero tolerance" for violence is evidenced in Medical Center Policy Memorandum 509-02-00/37 and 509-98-132C/1. Instructions on when and how to report incidents of violence are delineated in these policies. Follow-up to reports of violent behavior are conducted by the identified service and appropriate actions taken.

Additionally, the AVAMC is a test site for the computer "violent patient warning flags" program. A local committee has been established to meet the requirements of this program.

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(Original signed by)

JAMES F. TRUSLEY, III

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