
# Department of Veterans Affairs
# Office of Inspector General

# Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts

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**VA Office of Inspector General**
**Washington, DC 20420**

# Office of Inspector General
# Combined Assessment Program Reviews

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

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

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

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# Executive Summary

## Introduction

During the period of January 27–February 7, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Edith Nourse Rogers Memorial Veterans Hospital (hospital). The purpose of the review was to evaluate selected hospital 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 60 employees.

## Results of Review

Hospital management used multidisciplinary performance improvement councils for each service line to improve the quality of services and care. Patient surveys indicated generally high levels of patient satisfaction. To improve operations, hospital management needed to:

- Improve access to specialty clinics and the accuracy of the Enrolled Wait List.
- Provide greater management oversight of contracting practices.
- Strengthen accountability over controlled substances.
- Improve controls over engineering supplies.
- Monitor the electronic work order system.
- Deobligate unnecessary accrued services payable and undelivered orders in a timely manner.
- Improve controls over delinquent accounts receivable.
- Strengthen controls over the Government Purchase Card Program.
- Strengthen controls over information technology (IT) security.
- Enhance the Violence Prevention Program.
- Improve security over the research laboratory.
- Enhance security at the Haverhill Community-Based Outpatient Clinic (CBOC).
- Enhance facility cleanliness and correct minor maintenance problems.
- Issue bills to health insurance carriers in a timely manner.

## VISN 1 Director and Hospital Director Comments

The Veterans Integrated Service Network (VISN) 1 Director and the hospital Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 23-37, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

*(original signed by*
*Deputy Inspector General*
*Michael G. Sullivan)*
RICHARD J. GRIFFIN
Inspector General

# Introduction

## Hospital Profile

**Organization.** Located in Bedford, MA, the Edith Nourse Rogers Memorial Veterans Hospital is a psychiatric and long term care facility with a state of the art Primary Care Center that provides a broad range of inpatient and outpatient health care services. Primary care is also provided at four CBOCs located in Fitchburg, Gloucester, Haverhill, and Lynn, MA. In addition, the hospital provides outpatient mental health care at the Veterans Community Care Center located in Lowell, MA, and at a Day Activities Center located in Winchendon, MA. The hospital is part of VISN 1 and serves a veteran population of about 245,000 in a primary service area that includes the counties of Middlesex, Essex, and Worcester, MA.

**Workload.** In fiscal year (FY) 2002, the inpatient care workload totaled 1,845 discharges; and the average daily census, including nursing home patients, was 428. The outpatient workload was 196,121 visits. Additionally the hospital treated 16,471 unique patients, a 19 percent increase from FY 2001. The hospital Director attributed this substantial increase in the delivery of care during FY 2002 to hiring more clinical staff, increasing or more closely monitoring patient panels in primary care clinics, and expanding the number of CBOCs.

**Resources.** In FY 2002, medical care expenditures totaled $88.3 million. The FY 2003 medical care budget is $90.1 million, 2 percent more than FY 2002 expenditures. FY 2002 staffing was 882.6 full-time equivalent employees (FTEE), including 36.6 physician FTEE and 298.6 nursing FTEE. The hospital has 65 medical beds, 52 Psychiatric Residential Rehabilitation Treatment Program beds, 40 domiciliary beds, and 304 nursing home beds.

**Programs.** The hospital provides primary care, medical, mental health, geriatric, and Geriatric Research Education Clinical Center services. The hospital also has enhanced use leases with the following entities: The Burdenko Institute, the Town of Lexington, MA, and Nextel Communications.

**Affiliations and Research.** The hospital is affiliated with the Boston University School of Medicine and supports 10.4 medical resident positions in the Geriatric Medicine, Physical Medicine and Rehabilitation, Preventive Medicine, and Psychiatry training programs. In FY 2002, the hospital research program had 59 funded projects and a budget of $8.3 million. Areas of research include Parkinson's disease, Huntington's disease, Alzheimer's disease and other dementia, rheumatology, Hepatitis C, alcoholism, and drug dependence projects.

## Objectives and Scope of CAP Review

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

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

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

**Scope.** We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered hospital operations for FY 2002 and FY 2003 through February 7, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Accrued Services Payable and Undelivered Orders
Clinic Appointment Scheduling
CBOCs
Contract Administration
Controlled Substances Accountability
Delinquent Accounts Receivable
Electronic Work Order System
Environment of Care Inspections
Engineering Supplies Management
Government Purchase Card Program
IT Security
Medical Care Collections Fund Billing
Pharmacy Security
Prompt Payment and Interest Payments
QM
Research Laboratory Security
Violence Prevention Program

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–22). For these activities, we make recommendations or suggestions. 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 VISN and hospital management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. We sent electronic survey questionnaires to hospital employees and interviewed patients during our review. The full survey results were provided to hospital management.

During the review, we presented three fraud and integrity awareness briefings for hospital employees. Sixty 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.

# Results of Review

## Organizational Strengths

**The QM Program Was Comprehensive.** The QM program monitored quality of care using national and local performance measures, patient safety management reviews, and utilization studies. Hospital managers used multi-disciplinary performance improvement councils for each service line to improve the quality of services and care. There were representatives from each service line and from hospital management on the QM Board that monitored QM activity. QM program employees provided training to hospital employees on process action team concepts used to address health care and other issues.

**Patients Were Satisfied with the Quality of Care.** We interviewed 30 patients during our review to survey patient satisfaction with the timeliness of services and the quality of care. These surveys indicated generally high levels of patient satisfaction.

## Opportunities for Improvement

### Clinic Appointment Scheduling — Clinic Access and the Accuracy of the Enrolled Wait List Needed Improvement

**Conditions Needing Improvement.** Hospital management can improve access to primary and specialty clinics by taking action to reduce the number of no-shows for specialty clinics and increase the size of provider panels of medical practitioners. In addition, the usefulness of the Enrolled Wait List as a management tool for scheduling appointments could be enhanced if it more accurately identified patients who were seeking care.

Clinic Appointment Waiting Periods Could Be Shortened. VHA's goal is to achieve a waiting period of not more than 30 days for veterans to receive an appointment in primary care and specialty clinics. We reviewed 22 medical clinics, including 5 primary care and 17 specialty clinics. Eight of the specialty clinics did not meet VHA's goal.

Appointment waiting times for these eight clinics ranged from 33 days to 132.7 days. For example, the Diabetes Education Clinic had a waiting period of 132.7 days for the next available appointment, and the Neurology Clinic had a waiting period of 59.9 days. We noted that steps were taken such as making necessary scheduling changes and/or supplementing health care providers to help these specialty clinics improve their performance. Additional actions can be taken to further reduce clinic access wait time.

Excessive No-shows. The annualized no-show rates for all 17 specialty clinics in our sample exceeded VHA's established threshold of 10 percent. For example, at the close of FY 2002,

annualized no-show rates were reported as 20 percent in the Diabetes Education Clinic, 31 percent in the Gastrointestinal Clinic, and 15 percent in the Ophthalmology Clinic. Patients who are chronic no-shows impact clinic utilization, causing delays in providing care to other veterans requiring care. Patients should be encouraged to cancel appointments when they are unable to keep them. The hospital has a no-show policy that provides for preventive actions such as appointment reminders and remedial actions such as refusing to renew prescriptions at the provider's discretion until appointments are rescheduled. This policy is not publicized or enforced. A publicized and enforced no-show policy will help to achieve appointment wait time performance goals.

Undersized Provider Panels. Based on the number of assigned clinicians and VHA's informal guidance on panel size, the hospital's primary care panels had a capacity of 15,132 patients but had only 14,257 patients assigned. Provider panels are the number of unique patients assigned to medical practitioners. Provider panel sizes should be equitably increased based on clinical staff FTEE, optimizing the use of all health care providers. According to VHA informal guidance on panel sizes, a full-time physician should have an optimum number of 1,200 unique patients assigned, and a registered nurse practitioner 800 unique patients. Expanding provider panel sizes to 100 percent of capacity will improve clinic access for 875 veterans on the Enrolled Wait List who are in need of care.

Inaccurate Enrolled Wait List. The number of veterans on the Enrolled Wait List did not accurately identify the number of veterans in need of medical care. All veterans enrolling for medical care are placed on the hospital's Enrolled Wait List. As of January 24, 2003, the Enrolled Wait List showed 1,491 new enrollees were awaiting their first appointments at the hospital. When veterans were initially enrolled, hospital staff did not attempt to identify enrollees who did not intend to seek care, inflating the number of veterans on the Enrolled Wait List actually waiting for their first appointments. Identifying the need for care (e.g., primary care, mental health, enrollment only) at the time of enrollment will facilitate access to primary care providers for those veterans who actually want or need care.

**Recommended Improvement Action 1.** We recommended that the VISN Director ensures that the hospital Director improves clinic access by:

(a) publicizing and enforcing the no-show policy;
(b) increasing provider panel sizes to 100 percent of capacity; and
(c) reviewing and correcting the Enrolled Wait List by establishing enrollment process procedures to identify the veteran's purpose for enrollment and medical need.

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

## Contract Administration — Greater Management Oversight Is Needed To Improve Contract Practices and Ensure Compliance with VA Policies and the Federal Acquisition Regulations

**Conditions Needing Improvement.** Hospital management needed to ensure that contracts were awarded and administered in accordance with VA Office of Acquisition policies and the Federal Acquisition Regulations (FAR). Contract files reviewed were disorganized, the contract award process was not adequately documented, and contract administration and management oversight needed improvement.

Contract Files Were Disorganized. We made a judgmental sample of 23 contract files (valued at $8.7 million) with individual values exceeding $50,000 from the universe of 53 contracts. The individual contract files were not well organized, there was no systematic or uniform filing system for important contract documents, many contract files contained loose papers, and often, important documents were missing; preventing reconstruction of actions taken. VA policy states that contract files are to be complete, uniform, and neatly organized. The contract files should be adequately documented to permit reconstruction of actions taken without having to obtain additional information from other sources.

Contract Award Process Was Not Adequately Documented. We made a second judgmental sample of 18 contract files with individual values exceeding $50,000 from the universe of 53 contracts to evaluate contract award documentation. Documentation was deficient in each of the 18 contract files (total value $8.6 million). The FAR requires officials to establish files containing records of significant contractual actions. Listed below are documentation deficiencies identified.

- No documentation was found in the files indicating that the required searches of the Government's Excluded Parties Listing System (EPLS) were performed for the 18 contracts. Contracting officers are required to conduct searches of the Government's EPLS to determine if prospective contractors are ineligible for Federal contracts. The Head of the Contracting Activity (HCA) stated that the EPLS was "visually" referenced, but that no screen print was made to document the results.

- Nine of the 18 contracts reviewed required Price Negotiation Memorandums (PNMs). PNMs had not been prepared for six of these contracts valued at $2.5 million. The FAR requires contracting officers to prepare PNMs in order to provide documentation including the purpose of the negotiations, a description of the services being procured, and an explanation of how contract prices were determined.

- Three contracts valued at $600,000 were not signed by either a contracting officer or the contractor. The FAR requires contracts to be signed by both Government and contractor officials. Not having a signed contract increases the potential for disputes regarding terms, performance, or payments.

- One contract for solid waste removal services valued at $438,000 did not contain the documentation required to justify exercising the option year. The contracting officer improperly allowed the contractor to continue performance beyond the base year. Not having signed documents to exercise the option year increases the potential for disputes regarding terms, performance, or payments. We also noted that by awarding this $438,000 contract, the contracting officer exceeded his basic level warrant authority of $100,000 or less.

- Another contract for specialized medical care valued at $65,000 did not contain documentation supporting the quality of service rendered to veterans required to justify exercising the option year.

Contract Administration and Management Oversight Needed Improvement. The administration and management oversight of contractor activities needed to be improved to ensure that contractual requirements were met in compliance with the FAR and VA policies. Examples of administrative and management deficiencies found in these contract files reviewed follows.

- Thirteen contracts valued at $4.4 million had no evidence of supervisory review by the HCA. Such a review enables the HCA to determine the completeness and accuracy of the solicitation/contract documentation process.

- A telecommunications contract valued at $840,000 expired on September 30, 2000; however, the vendor continued to provide services, submit invoices, and receive payments over the past 29 months without a contract.

- Contracting officer's technical representatives (COTRs) were not appointed and designated in writing for eight contracts valued at $692,000. Contracting officers rely on COTRs to monitor contractor performance, ensure that services are being provided in accordance with contract terms, validate the accuracy of invoices received from contractors, and certify invoices for payment.

- Two contracts valued at $477,000 required background investigations of contractor personnel needing access to VA computer systems. The contracting officer did not request these investigations. VA policy requires that background investigations of contractor personnel be requested prior to their gaining access to VA computer systems.

- One contract valued at $281,000, with a community-based homeless program, expired on September 30, 2001. However, unsigned purchase orders were issued on January 1, 2002, and October 1, 2002, exercising nonexistent options to extend contract performance to September 30, 2002, and September 30, 2003, respectively. Without the benefit of a contract, the vendor has continued performance to the present day and continues to submit invoices and receive payments.

- The contracting officer telephonically solicited three contracts valued at $61,200. These contracts were each for a 1-year period. The contractor was required to provide the labor and materials necessary to perform maintenance for the hospital's heating, ventilation, and

air conditioning (HVAC) systems. The contracting officer contacted three sources telephonically for each contract and each time received a bid from only one source. Each contract was awarded to the same contractor. The FAR requires the contracting officer to solicit a minimum of three sources to promote maximum competition. The contracting officer believes he had complied with FAR requirements. We also noted that the same contractor was awarded similar contracts in November 2001 (three contracts) and October 2000 (three contracts). We believe that the contracting officer did not seek adequate competition and should make a greater effort to obtain bids from more than one contractor for these services.

**Recommended Improvement Action 2.** We recommended that the VISN Director ensures that the hospital Director implements procedures and controls to:

(a) improve organization and documentation of contract files;
(b) improve contract administration and management oversight in accordance with the FAR and VA policies; and
(c) correct specific identified deficiencies.

The VISN and hospital Directors agreed with the findings and recommendations, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

## Controlled Substances Accountability — Internal Controls Needed To Be Strengthened

**Conditions Needing Improvement.** Hospital management needed to ensure that controlled substances inspections were properly conducted, hospital policies and procedures incorporated VHA guidance, and Pharmacy Service inventory controls were followed.

To evaluate controlled substances accountability, we reviewed monthly controlled substances inspection reports for the 12-month period ending November 2002, and local hospital policies related to controlled substances. We also observed an unannounced controlled substances inspection and conducted interviews with Pharmacy Service personnel, controlled substances inspectors, and the Controlled Substances Inspection Coordinator.

Inspection Deficiencies. Monthly-unannounced controlled substances inspections of all Schedule II-V controlled substances should be conducted in all areas where these controlled substances are stored or dispensed. Excess, outdated, and unusable controlled substances being held in the pharmacy for destruction should also be inspected monthly. As part of the monthly controlled substances inspections, inspectors should sample an adequate number of records to verify that controlled substances were appropriately removed from inventories. A program for training controlled substances inspectors should be established, followed, and documented. The results of all monthly inspections should be trended to identify potential problem areas for improvement. Our review disclosed the following.

- Controlled substances inspectors failed to inspect Schedule III-V controlled substances on the wards and in the clinics. Only Schedule II drugs were inspected at these sites.
- Controlled substances stored in the Documed, an automated medication dispensing machine used on nights and weekends, had not been inspected during the 12-month period reviewed.
- The monthly controlled substances inspection for October 2002 was not conducted.
- Controlled substances inspectors were not conducting monthly inspections of controlled substances returned to the pharmacy to await destruction. Also, controlled substances held for destruction were not stored in sealed containers with the seals dated and signed by two witnesses, as required.
- The controlled substances inspectors only verified the administration of controlled substances for 10 patients during a 12-month period. We believe a larger sample should be used.
- Ten of the 11 inspections conducted during the period reviewed were completed in 2 to 22 days, after the inventory lists were obtained, with an average of 7 days. Inventory efficiency and accuracy could be enhanced by using current inventory lists and completing inventories on the day inventory lists are obtained.
- Inspectors did not have formal, documented training as required.
- Results of the controlled substances inspections were not evaluated by the Controlled Substances Inspection Coordinator to identify trends that might have required management action.

Local Policy Was Not Comprehensive. The hospital's policy did not include pertinent VHA guidance, such as the requirement that the Director report the loss of controlled substances to the OIG Office of Investigations and the hospital police. Pharmacy Service had not developed required local policies covering:

- Procedures for ordering and receiving controlled substances.
- Procedures for outpatient prescriptions not picked up at the outpatient window.
- Instructions for controlled substances inspectors to follow when inspecting controlled substances in the Documed.

Pharmacy Control Issues. The following issues also came to our attention:

- A pharmacist informed us that he was improperly accepting deliveries of Schedule III, IV, and V controlled substances without a required witness.
- VA policy requires that Pharmacy Service verify an inventory of all controlled substances in pharmacy stock at a minimum of every 72 hours. These inventories were not conducted as required for a 3-month period of October through December 2002. Thirty inventories should have been conducted for Schedule II-V controlled substances; however, only 24 inventories of Schedule II and 21 inventories of Schedule III, IV, and V were actually performed.
- The Veterans Health Information Systems and Technology Architecture (VistA) Controlled Substances Module monitors and tracks the receipt, inventory, and dispensing of all

controlled substances. This module was not used for Schedule II controlled substances. Schedule II controlled substances inventories were maintained manually rather than electronically.

**Recommended Improvement Action 3.** We recommended that the VISN Director ensures that the hospital Director improves controlled substances accountability by requiring that:

(a) all Schedule II-V controlled substances, including those stored in the Documed and those being held for destruction, be inspected monthly;
(b) controlled substances inspectors verify a sufficient number of clinic and ward dispensing entries during each monthly inspection;
(c) inspectors print out inspection area specific controlled substances inventory listings on the day of inspection and complete that area specific inspection on that same day;
(d) a formal training program for controlled substances inspectors is established, followed, and documented;
(e) inspection results are trended;
(f) comprehensive local policies and procedures, including reporting requirements regarding the loss of controlled substances, are developed and followed; and
(g) pharmacy control issues are corrected, including the requirement that the receipt of all controlled substances be witnessed, 72-hour inventories be completed as required, and the local VistA Controlled Substances Module be updated to include Schedule II controlled substances.

The VISN and hospital Directors agreed with the findings and recommendations, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

## Engineering Supplies Management — Controls Over Engineering Supplies Needed Improvement

**Conditions Needing Improvement.** Engineering supplies include all parts, tools, and other supplies used for maintaining and repairing equipment, buildings, furnishings, utility systems, and grounds. Our review of the management and oversight of engineering supplies identified numerous internal control deficiencies. No inventory system existed for engineering supplies. Because of the lack of an inventory system and the manner in which supplies were maintained, the quantities and dollar value of engineering supplies on-hand could not be readily determined; nor was it possible to readily identify whether or not engineering supplies currently on-hand were overstocked or adequate to meet hospital needs.

To determine the appropriateness of controls over engineering supplies we conducted interviews with the Chief, Acquisition and Material Management Service (A&MMS); the Chief, Fiscal Service; the Chief, Information Resources Management (IRM); the industrial hygienist; the Chief, Facilities Management Service (FMS); and FMS staff members. We also inspected the engineering supplies storage areas. We identified the following conditions involving inadequate controls over engineering supplies.

- There was no inventory system in place, and there were no records of any physical inventories having been conducted to verify counts of engineering supplies listed on hand-written logs.

- Significant amounts of outdated engineering supplies were found in several storage areas.

- Engineering supplies were not adequately safeguarded.

- Ordering and receiving duties for engineering supplies were not separated.

As a result, we were unable to determine if all purchases of engineering supplies made during FY 2002 (total value of $691,831) were necessary. A summary of each of these issues is described below.

GIP Not Used. The hospital was not utilizing the Generic Inventory Package (GIP) to manage engineering supplies. Established inventory management principles emphasize that inventory levels reflect the current operating needs of the facility. Inventories should contain enough supplies to meet user needs, and purchases above these needs should be avoided in order to prevent scarce funds from being tied up in excess inventory.

The Chief, IRM, stated that when VHA's directive to install GIP software was issued in Calendar Year (CY) 2000, the hospital's computer server was inadequate; implementing GIP at that time would have resulted in insufficient capacity to run clinical support applications. As a result, GIP had not been implemented. In June 2002, the hospital converted to a new, more powerful computer system with enough capacity to implement GIP. Engineering supplies data is currently being entered into the system; however, as of February 2003, GIP was not fully implemented at the hospital.

According to the Chief, FMS, there are approximately 17,000 different engineering supply items on-hand. FMS staff stated that they relied on intuitive judgments about the quantities for each item that should be stocked, as well as when and how much to order. Our inspection of the secured storeroom areas for engineering supplies found that the vast majority of items were loosely stored in unlabeled plastic bins. Normal stock levels and reorder points had not been established for engineering supply items.

Excess Stock Disposal Untimely and Improperly Documented. During our inspection of the HVAC supply storeroom, we found numerous small engineering supplies strewn haphazardly throughout the room, as well as in an adjacent room. FMS staff identified several items in this storage area that were obsolete and should have been excessed. For example, FMS staff identified residual parts for a project that was completed in 1995 and informed us that these parts will never be used. We observed a large hamper that had been filled with excess electrical and HVAC supply items. The hamper contained hundreds of parts and supplies, large and small, most of them outdated. One particular item had a handwritten tag dated August 1961. FMS staff stated that three or four more hampers could easily have been filled up with excess stock from the electrical and HVAC storeroom alone.

Security and Accountability Controls Were Lacking. FMS staff working the evening or night (off-tour) shifts were able to gain access to secure engineering storage areas by disarming the electronic security system in the office of the Chief, FMS, and obtaining keys. Local FMS policy states that the "off-tour supervisor" is to be notified, but the policy is not clear on whether a supervisor is required to disarm the security system and obtain the keys. These keys were to be signed for in a daily log, as well as any parts or supplies that were removed from the engineering storage areas. Local FMS policy states that off-tour FMS employees are to "…enter in the electronic daily log each and every time access is needed to a secure area and identify the need for secure keys." The policy further states, "A weekly/monthly audit of this procedure will be accomplished using the printouts from the hospital police of all security areas, validating against the sign in and out logs."

The Chief, FMS, could not provide any evidence that these procedures were followed, if daily logs were maintained, or if audits had been done. The Chief, FMS, stated that such audits would only be conducted "when needed" and that "there hadn't been any type of activity lately which would warrant it." However, FMS staff informed us that problems had recently been encountered where off-tour FMS personnel removed items from secured engineering supply areas, but no entries were made in the logs to account for the type or quantity of supplies taken, nor were these log books ever reviewed or comparisons made to actual stock on hand by FMS management to determine if trends existed which could point to pilferage. Without audits, FMS management cannot be assured that off-tour FMS personnel are following proper procedures, nor can the security of FMS storage areas be evaluated.

No Segregation of Duties. We determined that the material handler responsible for ordering engineering supply items was also confirming the receipt of goods. This violates the segregation of duties principle. There were no controls in place to prevent the same person from ordering as well as receiving engineering supplies.

**Recommended Improvement Action 4.** We recommended that the VISN Director ensures that the hospital Director:

(a) implements GIP;
(b) requires that a physical inventory of all engineering supply areas be conducted to obtain an accurate count of all items to be included in GIP;
(c) requires that staff identify all excess and obsolete items, and follow proper procedures for turning in such items;
(d) requires adherence to FMS policy regarding the periodic review of off-tour FMS personnel access to secure areas of engineering supplies; and
(e) improves internal controls over the ordering and receipt of engineering supplies.

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

## Electronic Work Order System — Effective Implementation Could Help Improve Resource Management and Customer Service

**Conditions Needing Improvement.** FMS shop supervisors were not always reviewing work orders listed in the hospital's electronic work order system, and follow-up actions to ensure services were provided were not taken. As a result, some work orders listed as outstanding were almost 12-months old, and no follow-up reviews were performed to determine the status of these orders.

We interviewed the Chief, Engineering Section, and reviewed the hospital's electronic work order system to determine if existing procedures for processing work orders were effective, and if internal controls were in place to monitor the adequacy of the system. We also reviewed current listings of outstanding work orders for FY 2002, as well as hospital policies and procedures related to the processing of work order requests.

The electronic work order system is a component of the Automated Engineering Management System/Medical Equipment Reporting System that enables hospital staff to enter work requests via computer terminals within the hospital. Once entered, work order requests are placed on hold until the end of each day, at which point FMS staff review them individually to determine the level of priority. The FMS work order clerk assigns a permanent number to each work order request, prints out the work orders, and delivers them to shop supervisors within FMS. The shop supervisors distribute the work orders to the appropriate shop personnel to be completed.

A listing of work orders as of February 6, 2003, showed a total of 160 outstanding work orders in the electronic work order system. Of the 160 outstanding work orders, 62 (39 percent) were submitted from May through September 2002. We reviewed work order log books maintained by FMS managers that showed that several patient area staff members complained about how long it took to complete work order requests. It was not apparent what follow up actions, if any, were initiated on the part of FMS managers as a result of these complaints. We also reviewed FMS customer satisfaction surveys and found no assessments or follow-ups on the complaints submitted on the survey forms. The Chief, Engineering Section, informed us that listings of outstanding work orders were compiled and sent to the shop supervisors every month to review the status of each established work order request, to determine which work orders have been completed and can be closed, and to annotate in the electronic system those work orders that require further attention. However, we found no evidence that actions were taken by the shop supervisors to address the work orders on the monthly lists.

Hospital policies did not require shop supervisors to document follow-up actions taken on these work orders, and there was no oversight from FMS management in tracking the monthly work order lists. In addition, FMS staff brought to our attention completed work orders that were listed as outstanding and some work orders processed during the period of our review that had been closed although the work had not been completed. The lack of accountability for the status of work orders negatively impacts the ability of FMS to effectively manage its maintenance and repair work and improve customer service.

**Recommended Improvement Action 5.** We recommended that the VISN Director ensures that the hospital Director:

(a) requires FMS shop supervisors to review the status of all outstanding work orders monthly;
(b) establishes procedures to ensure appropriate actions are taken to complete open work orders and that these actions are documented;
(c) coordinates a complete review of all work orders currently listed as outstanding to determine if the work is still needed;
(d) requires that the Chief, Engineering Section, conduct monthly meetings with FMS shop supervisors to review what actions were taken on outstanding work orders still listed in the system and what needs to be done to complete and close out the work orders; and
(e) enhances periodic customer satisfaction surveys to monitor the quality and timeliness of FMS services.

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

## Accrued Services Payable and Undelivered Orders — Obligations Needed To Be Reviewed and Deobligated in a Timely Manner

**Conditions Needing Improvement.** Hospital management needed to ensure that reviews of delinquent undelivered orders and accrued services payable were conducted in compliance with VA policy. VA policy requires that accrued services payable and undelivered orders be reviewed monthly by Fiscal Service staff, who should follow-up with the initiating services on obligations inactive for more than 90 days. Furthermore, as part of the year-end closing procedures, all documents in the accrued services payable and undelivered orders files should be reviewed, and when there is a high possibility that a service or order will not be received, action should be taken to have the service or order cancelled to make the funds available for other hospital needs.

Accrued Services Payable Not Reviewed Monthly. Accrued services payable are services that have been ordered and for which funds have been obligated but which have not been received. The Chief of Accounting did not perform reviews of the accrued services payable file monthly as required by VA policy. In addition, some delinquent accrued services obligations were not reviewed at all during the fiscal year to determine if they were still needed. We reviewed 33 accrued services payable valued at $2,319,493 that were over 90 days old as of December 31, 2002. In 31 of the 33 cases reviewed, Fiscal Service was able to obtain justifications from the requesting services to keep the orders open. However, it was determined that two outstanding obligations should have been deobligated prior to the end of FY 2002. The two obligations were for gas service contracts utilized at the facility during FY 2002 that had residual balances of $78,326 and $130,162, respectively. The Chief, Fiscal Service, agreed that both orders should have been deobligated prior to the end of the fiscal year in whole or in part, and the funds used

for other hospital purposes. Fiscal Service deobligated funds for both orders as a result of our review.

Undelivered Orders Not Reviewed Properly. Undelivered orders are goods that have been ordered and funds obligated for but which have not been received. Reviews of undelivered orders were not always performed within required timeframes. While the Chief of Accounting performed some reviews, the reviews were not always done monthly as required, nor were all outstanding obligations reviewed prior to the end of the fiscal year as required by VA policy.

We reviewed 18 undelivered orders valued at $1,219,046 that were over 90 days old as of December 31, 2002. Fiscal Service obtained justifications from the requesting services to keep 13 of the undelivered orders open. However, 5 of the 18 orders needed to be addressed further. These five orders were placed to purchase computer-related equipment and services for other VISN 1 hospitals. Officials from VISN 1 Headquarters, which is located at the hospital, initiated these five purchases in August and September of 2002. The value of the five orders totaled $478,984. In all five cases, the hospital's Chief of Accounting conducted inquiries of each of the VISN 1 facilities in November 2002 to determine the status of each order. However, the queried facilities provided no response and no further follow-up actions had been taken by Fiscal Service personnel to ascertain the status of these five orders as of January 31, 2003.

**Recommended Improvement Action 6.** We recommended that the VISN Director ensures that the hospital Director establish controls and procedures for:

(a) conducting monthly analyses of undelivered orders and accrued services payable;
(b) promptly canceling those obligations determined to be no longer needed; and
(c) following up with VISN 1 on the purchase orders we identified that were processed through the hospital.

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

## Delinquent Accounts Receivable — Controls Needed To Be Improved

**Conditions Needing Improvement.** Hospital management needed to ensure that Federal accounts receivable were billed and collection actions were initiated. VA policy requires that aggressive efforts be utilized in pursuing collection of accounts receivable. Billing and follow-up collection activities for outstanding accounts receivable owed by other Government agencies were not performed as required. This was due to a lack of oversight and monitoring of these accounts by Fiscal Service personnel. Reviews had not been conducted to ascertain the status of outstanding Federal accounts receivable. As of December 31, 2002, the hospital had 83 Federal accounts receivable totaling $71,134. All 83 were over 90 days old, and in some cases were established as far back as 1991. We reviewed each of these accounts through the facility's computerized Accounts Receivable Profile module. Most of these debts were owed by the U.S. Department of Labor and Hanscom Air Force Base. We determined that the Federal agencies

that owed these debts had not been billed. Consequently, no payments had been received. Fiscal Service staff needs to contact the appropriate officials (i.e., Chief Financial Officer) at each debtor agency in order to collect these debts.

**Recommended Improvement Action 7.** We recommended that the VISN Director ensure that the hospital Director establishes procedures to bill and collect all outstanding Federal accounts receivable.

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

## Government Purchase Card Program — Controls Needed To Be Strengthened

**Conditions Needing Improvement.** Hospital management and the Purchase Card Coordinator needed to ensure that the Government Purchase Card Program was administered effectively. During the period October 1, 2001 through November 30, 2002, 96 Government purchase cardholders at the hospital made 7,785 purchases totaling $4.2 million. To evaluate purchase card controls, we reviewed purchase orders and supporting documentation and conducted interviews with the Purchase Card Coordinator, the Chief, A&MMS, and other pertinent staff. Our review identified three areas needing management attention.

Untimely Reconciliations. Cardholders did not reconcile purchase card transactions in a timely manner. VA policy requires cardholders to reconcile 75 percent of their payments within 10 days, and 95 percent within 17 days. All charges must be reconciled or disputed before they are 30 days old. The hospital met the 10-day standard, but did not meet either the 17-day or 30-day standards. Cardholders processed 88 percent of transactions within 17 days and 92 percent within 30 days.

Incomplete Reviews of Cardholders Transactions. Weekly reviews of questionable cardholder transactions needed to be strengthened. Rather than accepting verbal explanations, the accounting technician who conducts the weekly reviews should verify the existence of supporting documentation, such as vendor invoices and receiving reports for all questionable transactions.

Incomplete Documentation Supporting the Purchase and Receipt of Services and Goods. We found that cardholders were not always obtaining vendor invoices or other supporting documentation to provide assurance that goods were received and services performed. VA policy requires that documentation be available to support the purchase and receipt of services and goods. Documentation should consist of purchase orders, vendor invoices, receiving reports for goods, and verification that services have been performed and accepted. We made two judgmental samples to determine whether there was adequate documentation to support the purchase and receipt of services and goods. One sample consisted of 15 purchases for services

valued at $50,427; the second consisted of 35 purchases for goods valued at $90,573. Our review identified numerous control deficiencies.

Thirteen deficiencies were found in the sample of 15 purchases for services:

- Eleven transactions valued at $43,098 lacked appropriate reviews by approving officials or COTRs to verify that the services were performed and accepted. Based on our inquiry, three of these transactions valued at $26,145, for services performed 6–8 months earlier, were subsequently verified as having been performed and accepted. In addition, vendor invoices were not available for five of these transactions valued at $15,780.

- Services related to two transactions valued at $3,065 were completed during July and August 2001, according to the vendors' invoices and work orders. However, the cardholder initially thought this work was covered under an existing contract and failed to establish and process the transactions in FY 2001. In October 2001, FMS staff discovered that the work was not under contract, necessitating the establishment and processing of the purchase card transactions in FY 2002. We brought these transactions to the attention of the Chief, Fiscal Service. He stated that cardholders would be retrained to ensure purchase card transactions are established and processed properly.

Twelve deficiencies were found in the sample of 35 purchases for goods:

- There were no receiving reports documenting that goods were received for eight purchases valued at $30,559. In addition, for one of these purchases with a value of $16,582, the cardholder did not obtain a written bid or provide a sole source justification.

- There were no vendor invoices for three purchases valued at $7,864.

- For one purchase valued at $2,492, the vendor was paid for goods before delivery.

The appropriateness of a purchase card transaction is questionable without independent evidence verifying descriptions, quantities, and unit prices. Approving officials need to review documentation during the certification and oversight process to ensure that supplies and services were authorized and received.

**Recommended Improvement Action 8.** We recommended that the VISN Director ensures that the hospital Director:

(a) requires cardholders to reconcile purchase card transactions within VA established timeframes;
(b) requires that reviews of cardholders' purchasing activities include physical verifications of the supporting documentation; and
(c) requires cardholders to retain, and approving officials to review, supporting documentation for purchase card transactions.

The VISN and hospital Directors agreed with the findings and recommendations, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

## Information Technology Security — Automated Information System Controls Needed To Be Strengthened

**Conditions Needing Improvement.** Hospital management needed to improve compliance with VA information technology (IT) security policies. We reviewed IT security to determine whether controls were adequate to protect automated information system (AIS) resources from unauthorized access, disclosure, modification, loss, destruction, or misuse. We identified two IT security deficiencies that needed corrective actions.

Contingency Plan Was Not Comprehensive. The hospital's contingency plan did not contain the following elements that would provide for interim processing and the resumption of normal operations in the event of a disruption to the AIS:

- The identification of an alternate processing facility that could be used during disaster recovery.
- The identification and prioritization of mission critical functions, such as restoring VistA.
- The identification of resources needed to support mission critical functions.

VA policy requires annual testing of the AIS contingency plan to update and improve implementation of the plan. At the time of our review, annual testing of the contingency plan had never been conducted.

Documentation for Computer Security Awareness Training Lacking. Documentation of completed annual computer security awareness training was not available for 487 of the 927 (53 percent) hospital employees who required such training during CY 2002. VA policy requires that all facility personnel who are authorized access to VA computer systems attend initial training and annual refresher AIS security awareness training. This training informs employees of the vulnerabilities that exist with computer systems and how to protect sensitive data stored on computers.

**Recommended Improvement Action 9**. We recommended that the VISN Director ensures that the hospital Director:

(a) develops a comprehensive contingency plan for AIS and tests it annually; and
(b) adheres to documentation requirements relative to computer security awareness training and mandates that all employees attend refresher training on an annual basis.

The VISN and hospital Directors agreed with the findings and recommendations, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director

provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

## Violence Prevention Program — Program Enhancements Are Needed

**Conditions Needing Improvement.** Our review of the hospital's program for preventing and managing incidents of patient violence showed that the program needed improvement. VHA's Task Force on Workplace Violence report, published in CY 2001, concluded that an effective violent patients program should be coordinated at the VISN and facility levels and include employee education on managing patients with violent behavior. Our review revealed the following areas needed improvement.

No Designated Program Coordinators. There were no designated coordinators at the VISN and facility levels to coordinate a Violence Prevention Program. Coordinators enhance education, training, policy development, emergency/response procedures, and management and reporting of data related to violent incidents. Also, they ensure facility tracking and trending of violent patient incidents. Establishing designated coordinators would strengthen the program.

Prevention and Management of Disturbed Behavior (PMDB) Training Not Provided. Direct patient care employees, other than certain nurses, were not required to complete PMDB training. This training emphasizes techniques that are useful in defusing a threatening or potentially violent situation. All employees (e.g., doctors, social workers, clerks, and technicians) working in high-risk areas would benefit from this training.

No Computerized Violent Patient Alerts. Computer alerts on potentially violent patients needed to be visible in VistA and the Computerized Patient Record System (CPRS). We reviewed uniform offense reports on 10 patients who had documented incidents of violent or threatening behavior in CY 2002. Four of these patients were repeat offenders who had at least one other documented violent episode during the year. None of the 10 patients were identified in either VistA or CPRS with alerts indicating that they had histories of violent behavior. Computerized alerts on these patients should be visible to employees in both systems to ensure that employees have access to this important information.

**Recommended Improvement Action 10.** We recommended that the VISN Director designates a VISN program coordinator and ensures that the hospital Director:

(a) designates a hospital program coordinator to manage all aspects of a Violence Prevention Program;
(b) provides annual PMDB training to employees working in high-risk areas; and
(c) ensures that employees are always alerted by VistA or CPRS when potentially violent patients present themselves for treatment.

The VISN and hospital Directors agreed with the findings and recommendations, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director

provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

## Research Laboratory Security — Security Improvements Are Needed

**Conditions Needing Improvement.** Security for the research laboratory needed to be improved. VHA facilities were directed to improve security for research laboratories after September 11, 2001. In response, VHA's Office of Research and Development issued a revised policy on research laboratory security in November 2002. Our review revealed the following areas needed improvement.

Personnel Identification Badges Should Be Worn. Employees in the research laboratory did not wear or display identification badges with photos and valid expiration dates. VHA's policy requires all personnel engaged in research to wear photo identification badges with valid expiration dates at all times. We found identification badges were issued without expiration dates and research employees also told us that they normally did not wear their badges in their work areas. Use of proper identification at all times in sensitive areas such as the research laboratory would improve security.

Background Investigations Are Needed for Without Compensation (WOC) Employees. Although full-time employees in the research laboratory were subject to immediate background checks, Human Resource Management Service (HR) officials were not requiring background investigations on new WOC employees, including those who might work in research areas. VHA policy states that the Office of Security and Law Enforcement is responsible for conducting personnel security background investigations for employees working in controlled access areas. HR officials should initiate timely background investigations on WOC employees to ensure that only appropriate persons are authorized to access research areas.

**Recommended Improvement Action 11**. We recommended that the VISN Director ensures that the hospital Director:

(a) requires that all employees assigned to work in research laboratory areas wear identification badges with photos and valid expiration dates at all times; and
(b) requires background investigations on all WOC employees.

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

## Community-Based Outpatient Clinic — Security Needed To Be Enhanced

**Condition Needing Improvement.** Security for Haverhill CBOC staff, patients, and patient data needed to be enhanced. The Haverhill CBOC is a VA staffed clinic, located in Haverhill, MA with a patient population of about 2,300. During our on site visit, we identified two security issues requiring management attention as discussed below.

Disconnected Panic Alarms. The CBOC is wired for four panic alarms to be used in the event of emergency situations, but only two were connected to the office of the hospital police. The two functioning alarms are located in the reception area and a nearby nurse's office. The wiring is in place for additional panic alarms in two psychiatry offices; however, they had not been connected to the office of the hospital police at the time of our visit. Connecting the two alarms will enhance staff and patient security.

Computer Security. During our tour of the CBOC, the Patient Services Representative was briefly called away from her reception station and we observed patient data on her computer screen. We asked the clinical team leader if password-protected screensavers were being used on the CBOC computers. The clinical team leader told us they were not. Password-protected screensavers would help prevent unauthorized access to patient data and VA computer systems.

**Suggested Improvement Action.** We suggested that the VISN Director ensures that the hospital Director requires that:

(a) the Haverhill CBOC's remaining panic alarms be connected to the office of the hospital police; and
(b) password-protected screensavers be used on all CBOC computers.

The VISN and hospital Directors agreed with the findings and suggestions, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

## Environment of Care Inspections — Some Areas Needed Cleaning or Minor Maintenance

**Conditions Needing Improvement.** We inspected the acute psychiatry unit, an extended care unit, the Food and Nutritional Service, the Canteen dining area and kitchen, and the Canteen retail store to review the hospital's physical environmental conditions. Overall, we found that the extended care unit was well maintained and the Canteen retail store revealed no environmental deficiencies. There were minor issues involving the need for cleaning and minor maintenance in the other areas. For example, the Food and Nutrition Service storage area needed cleaning, as did some floors in that area. There were also some floor tiles near the grill that needed grout replaced. We provided details of our environment inspections to hospital managers for appropriate action.

**Suggested Improvement Action.** We suggested that the VISN Director ensures that the hospital Director requires that cleaning and minor maintenance be performed in the areas identified in our inspection.

The VISN and hospital Directors agreed with the finding and suggestion, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

## Medical Care Collections Fund Billing — Bills Were Not Issued Promptly

**Conditions Needing Improvement.** Hospital management needed to ensure that Medical Care Collections Fund (MCCF) staff issued bills promptly. Federal law authorizes VA to recover the reasonable cost of medical care from third-party health insurers for services furnished to insured veterans for treatments of a non-service connected conditions.

We obtained a listing of 70 third-party accounts receivable, each exceeding $1,000, for care provided during FY 2002. From this universe we made a judgmental sample of 26 MCCF billings, totaling $449,760, to determine the timeliness of third party billings. We found that it took an average of 88 days to prepare a bill following a patient's treatment, due to the backlog in coding the episodes of care. Although there is no standard set by VA stipulating the number of days allowed before a bill is sent out, delays in billing the insurance companies result in delays in collecting monies owed to the Government.

**Suggested Improvement Action.** We suggested that the VISN Director ensures that the hospital Director takes action to issue MCCF bills promptly.

The VISN and hospital Directors agreed with the finding and suggestion, and the VISN Director agreed with the hospital Director's corrective action plan. The hospital Director provided acceptable improvement plans and we consider this issue closed.

**Appendix A**

# VISN 1 Director Comments

**Department of Veterans Affairs**

Memorandum

Date: May 16, 2003

From: Network Director (VISN 1)

Subj: Status Report – DRAFT Combined Assessment Program (CAP) Review, Bedford VAMC, Project Number 2003-00821-RI-0056

To: Assistant Inspector General for Auditing (52)

1. Attached for your review are our comments and corrective action plan relating to the DRAFT Combined Assessment Review.

2. If you have any questions or need additional information, please feel free to contact Mr. Michael Carey, Quality Manager at (781) 687-3080.

Jeannette Chirico-Post, MD
Network Director
/s/

Attachment – DRAFT Bedford VAMC CAP Response

**Appendix A**

## Recommended Improvement Action 1

Although the Performance Clinics were meeting the required time frame and eight of the Specialty Clinics were not, we plan to do the following for all clinics:

1. Review Ten Key Changes for Advanced Clinic Access. Test and adapt other ACA Key Changes as appropriate.
2. Review appointments for scheduling errors – correct and prevent as needed.
3. Measure demand for two-week period and balance capacity with demand.
4. Develop service agreements with all clinics.
5. Assess and improve referral appropriateness through communication of service agreement referral criteria and feedback to clinicians.

We believe that current staff can accommodate current demand. If this is not possible or if demand increases beyond capacity we will supplement current providers after Resources Allocation Committee (RAC) approval.

We recommend that the VISN Director ensure that the VAMC Director**:**

**Recommendation 1a:** Publicize and enforce the no-show policy.

**Response:** Agree with recommendation.

**Plan for Improvement:**

1. We have re-communicated the policy to our staff.
2. New patient orientation has been expanded to emphasize importance of no-show policy.
3. We will develop and deploy a communication plan for patients using the Communication Suggestions and Templates REFERENCE GUIDE for Advanced Clinic Access developed by the National ACA Steering Committee (available at http://vaww.vhacowebapps.cio.med.va.gov/waitingtimes/ACA_Resources.asp?type=AC verified 5/5/03) (e.g. deploy the patient poster "Don't be a No-show" for waiting rooms).
4. Clinic Recall successfully tested at Fitchburg CBOC. To be deployed to other Primary Care sites.

**Target Completion Date:** Item #1 and #2 completed; Item #3 and #4, June 30, 2003.

**Recommendation 1b:** Increase provider panel sizes to 100 percent of capacity.

**Response:** Agree with recommendation.

**Plan for Improvement:** At the time of the OIG review we had one full time RNP who was on maternity leave and her capacity was included in our panel calculations. She has since resigned thus bringing our panel capacity to 100.5%. In addition, we are recruiting for two additional providers that will enhance capacity and eliminate the current Primary Care waiting list and meet expected future demand.

**Target Completion Date:** Completed.

**Recommendation 1c:** Review and correct the Enrolled Wait List and establish enrollment process procedures to identify the veteran's purpose for enrollment and medical need.

**Response:** Agree with recommendation.

**Plan for Improvement:** The Enrolled Wait List has been reviewed and corrected. The structured enrollment process for new Primary Care patients to ascertain their need for a primary care appointment, and a preferred site of care has been re-emphasized with staff. The new patient orientation process has also been expanded to highlight the importance of this information.

**Target Completion Date:** Completed.

## Recommended Improvement Action 2

We recommend that the VISN Director ensure that the VAMC Director implements procedures and controls to:

**Recommendation 2a:** Improve organization and documentation of contract files.

**Response:** Agree with the recommendation.

**Plan for Improvement:** To ensure that contract files are neat, organized, and comprehensive, Contract Contents File Checklists (CCFC) have been developed and will be used for all contracts with an estimated cost greater than $2,500. The CCFC will be completed by the assigned Contracting Officer (CO) as they process the contractual agreement and then, prior to award, reviewed and approved by a separate CO with disagreements resolved by the Head of the Contract Activity (HCA). In addition, the service's Quality Assurance Plan has been enhanced to include a monthly review of this process, with reporting of results and actions taken through the Administrative Performance Improvement Council to the Quality Management Board.

**Target Completion Date:** Completed & Ongoing.

**Recommendation 2b:** Improve contract Administration and Management Oversight in accordance with FAR and VAOA policies.

**Response:** Agree with recommendation.

**Plan for Improvement**: To improve contract administration and management oversight the CCFC process, referenced in 2a above, will be utilized as described. This checklist process includes specific entries for contract award/amendment/modification/option year award to address specific concerns with this portion of the contract administration process. This process

will be reviewed as part of the services Quality Assurance Plan with monthly reporting through the Administrative Performance Improvement to the Quality Management Board.

**Target Completion Date:** Completed & Ongoing.

**Recommendation 2c:** Correct specific identified deficiencies.

**Response:** Agree with recommendation.

**Plan for Improvement:** Each of the specific discrepancies noted in the report have been addressed and corrected. In addition the CCFC process includes provisions to address future compliance.

**Target Completion Date:** Completed.

## Recommended Improvement Action 3

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 3a:** Requires that all Schedule II through V controlled substances, including those stored in the Documed and those being held for destruction, be inspected monthly.

**Response:** Agree with recommendation.

**Plan for Improvement:** Immediate implementation of Hospital Memorandum No. 119.05, "Controlled Substances", updated on April 23, 2003. Controlled Substance Inspectors will now inspect all controlled substances as recommended. Results of these inspections will be reported to the Controlled Substance Coordinator with quarterly reporting to our Quality Management Board (QMB).

**Target Completion Date:** Completed.

**Recommendation 3b:** Controlled substances inspectors verify a sufficient number of clinic and ward dispensing entries during each monthly inspection.

**Response:** Agree with recommendation.

**Plan for improvement:** Updated Hospital Memorandum No. 119.05 includes an attachment that resolves this issue. Implemented for inspections conducted in April 2003. Results reported to the Controlled Substance Coordinator who will report quarterly to our QMB.

**Target Completion Date:** Completed.

**Recommendation 3c:** Inspectors should print off inspection area specific controlled substances inventory listings on the day of review and complete that area specific inspection on that day.

**Appendix A**

**Response:** Agree with recommendation.

**Plan for Improvement:** To enhance the validity of the inspection process, we have amended our policy to require the inspector to print off the area specific controlled substance sheets, on the day of review, and to complete that area specific inspection on that day. This will be monitored by our Controlled Substance Coordinator and reported quarterly to our QMB.

**Target Completion Date:** Completed.

**Recommendation 3d:** A formal training program for controlled substances inspectors is established, followed and documented.

**Response:** Agree with recommendation.

**Plan for Improvement:** A formal Controlled Substance Inspector Training Program has been developed to include the following:

- Review of Hospital Memorandum No. 119.05 "Controlled Substances",
- Power Point presentation entitled "ENRM Veterans Hospital Controlled Substance Inspection Process",
- Review of Controlled Substances Inspector's Manual, and
- Actual on-line use of the VistA Controlled Substance Inspector's package.

All current inspectors have now completed this formal training program. Our Controlled Substance Coordinator will ensure that all new inspectors are fully trained and that all inspectors are apprised of any program changes. An annual program review will be reported to the QMB.

**Target Completion Date:** Completed.

**Recommendation 3e:** Inspection results are trended.

**Response:** Agree with recommendation.

**Plan for Improvement:** A Controlled Substance Inspection Trending Report has been developed and implemented. This will be routinely reported through the facility Quality Management Process.

**Target Completion Date:** Completed.

**Recommendation 3f:** Comprehensive local policies and procedures on the use of controlled substances and inspections, including reporting requirements regarding the loss of controlled substances, are developed and followed.

**Response:** Agree with recommendation.

**Plan for Improvement:** We have updated our local policies and procedures to included the following:

- Hospital Memorandum No. 119.05, titled "Controlled Substances", dated April 23, 2003 now includes requirements that the Hospital Director report the loss of controlled substances to the OIG Office of Investigations and the hospital police.

- Pharmacy Service Memo 01-01, titled "Pharmacy Service Standard Operating Procedures for Controlled Substances", dated April 28, 2003 specifically covers the following: a the ordering and receiving of controlled substance, b. procedures for outpatient prescriptions not picked up at the outpatient window and c. instructions for controlled substances inspectors to follow when inspecting controlled substance in the Documed.

**Target Completion Date:** Completed.

**Recommendation 3g:** Pharmacy control issues are corrected, including the requirement that the receipt of all controlled substances be witnessed, 72-hour inventories be completed as required, and the local VistA Controlled Substances module be updated to include Schedule II controlled substances.

**Response:** Agree with recommendation.

**Plan for Improvement:** Pharmacy Service Memo 01-1, titled "Pharmacy Service Standard Operating Procedures (SOP) for Controlled Substances" developed and implemented. The monthly, unannounced controlled substances inspection verifies the implementation of this SOP. The results will be reported to the Controlled Substance Coordinator who will incorporate them into the Controlled Substance Trending report that will be reported to the QMB. The VistA package for Controlled Substance is currently in a training account of VistA in order to train nursing, pharmacy and the controlled substances inspectors on the use of the electronic system. The VistA Controlled Substance package went live on Sunday, May 4, 2003. The April 2003 unannounced inspection report verified inclusion of items listed above.

**Target Completion Date:** Completed.

## Recommended Improvement Action 4

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 4a:** Implements GIP.

**Response:** Agree with the recommendation.

**Plan for Improvement:** The Generic Inventory Package (GIP) system is in the process of being implemented.

**Target Completion Date:** June 30, 2003.

**Appendix A**

**Recommendation 4b:** Requires that a physical inventory of all engineering supply areas be conducted to obtain an accurate count of all items to be included in the GIP system.

**Response:** Agree with the recommendation.

**Plan for Improvement:** In accordance with GIP procedures, a wall-to-wall inventory will be conducted with the implementation of GIP and yearly thereafter.

**Target Completion Date:** June 30, 2003.

**Recommendation 4c**: Requires that all staff identify all excess and obsolete items, and follow proper procedures for turning in such items.

**Response:** Agree with the recommendation.

**Plan for Improvement:** Training has been provided on appropriate disposal and excess of products since this visit. It should be noted that as some of our building service systems are 30-40 years old, the parts while appearing old and unnecessary are actually valuable for use. As we manage our inventory with GIP, we will continue to assess the need to retain parts as we replace older systems and will dispose of outdated parts.

**Target Completion Date:** Completed.

**Recommendation 4d:** Requires adherence to established FMS procedures regarding the periodic review of off-tour personnel access to secure areas of engineering supplies.

**Response:** Agree with the recommendation.

**Plan for Improvement:** The primary supply area is alarmed and manned throughout the day and is not on the area master key system. However, while a procedure was in place to document entry into this area, the procedure was not followed with regards to auditing these entries. The procedure is being revised to strengthen oversight and once complete staff will be trained in the new procedure.

**Target Completion Date:** July 5, 2003.

**Recommendation 4e:** Improve internal controls over the ordering and receipt of engineering supplies.

**Response:** Agree with the recommendation.

**Plan for Improvement:** The procedure is being revised to provide separation of duties and for receipt of all FMS stock supplies through the A&MMS warehouse.

**Target Completion Date:** June 30, 2003.

**Appendix A**

## Recommended Improvement Action 5

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 5a**: Require FMS shop supervisors to review the status of all outstanding work orders monthly.

**Response:** Agree with the recommendation.

**Plan for Improvement:** Although a procedure was in place for staff to review and closeout work orders, it was not consistently followed, thus it is being revised and staff will be retrained. It should be noted that despite shortcomings, this procedure resulted in only 160 uncompleted work orders out of 11,052 processed by the time of the review (99.9% completion rate).

**Target Completion Date:** June 30, 2003.

**Recommendation 5b:** Establishes procedures to ensure actions are taken to complete open work orders and that these actions are documented.

**Response:** Agree with recommendation.

**Plan for Improvement:** Although a procedure was in place for staff to review and closeout work orders, it was not consistently followed, thus it is being revised, staff will be retrained and results of these reviews will be reported through our QA program by the Chief, FMS through the Administrative Performance Improvement Council to the QMB.

**Target Completion Date:** June 30, 2003.

**Recommendation 5c:** Coordinates a complete review of all work orders currently listed as outstanding to determine if the work is still needed.

**Response:** Agree with recommendation.

**Plan for Improvement:** All work orders identified have been completed since the review or have been scheduled. All outstanding work orders will be managed as discussed in 5b above.

**Target Completion Date:** Completed.

**Recommendation 5d:** Requires that the Chief, Engineering Section conduct monthly meetings with shop supervisors to review what actions were taken on outstanding work orders still listed in the system and what needs to be done to complete and close out the work orders.

**Response:** Agree with recommendation.

**Plan for Improvement:** The Chief, Engineering Section will begin monthly meetings as recommended. In addition, the existing procedure is being revised to increase managerial

oversight through the Chief, Engineering Section's review of QA monitors, proposed corrective actions and achievement of corrective actions.

**Target Completion Date:** June 30, 2003.

**Recommendation 5e:** Enhance periodic customer satisfaction surveys to monitor the quality and timeliness of FMS services.

**Response:** Agree with recommendation.

**Plan for Improvement:** While a procedure was in place to obtain customer satisfaction data from various customers, we concur that it needs improvement. It is being revised to strengthen the components for inclusion of all customers, for assessment of data gathered and for development and achievement of action plans, which will be monitored within the QA process.

**Target Completion Date:** June 30, 2003.

## Recommended Improvement Action 6

We recommend that the VISN Director ensure that the VAMC Director establishes controls and procedures for:

**Recommendation 6a:** Conducting monthly analysis of outstanding undelivered orders and accrued services payable.

**Response:** Agree with recommendation.

**Plan for Improvement:** Fiscal Service was previously reviewing undelivered orders and accrued services payable on a quarterly basis. We will now comply with VA regulations to conduct these reviews monthly. The Chief Fiscal Service has communicated this change to his accounting staff.

**Target Completion Date:** June 1, 2003.

**Recommendation 6b:** Promptly canceling those obligations determined to be no longer needed.

**Response:** Agree with recommendation.

**Plan for Improvement:** As stated above there was a procedure in place, however, for the two transactions referenced in the report, errors were made in estimating the balances to remain in place. Staff have been reminded of the importance of these reviews. The Chief, Fiscal Service will continue to monitor their performance to minimize these types of errors in the future.

**Target Completion Date:** Ongoing.

**Appendix A**

**Recommendation 6c:** Following up on VISN 1 purchase orders processed through the VAMC.

**Response:** Agree with recommendation.

**Plan for Improvement:** Although follow up on the referenced VISN 1 orders was attempted, it was not finalized. The procedure is being strengthened to require Fiscal Service to notify VISN 1 officials of any outstanding orders and for VISN 1 officials to perform required follow-up actions.

**Target Completion Date:** June 1, 2003.

## Recommended Improvement Action 7

We recommend that the VISN Director ensure that the VAMC Director establishes procedures to:

**Recommendation 7:** Strengthen controls over Federal accounts receivable, initiate billing and collection actions for all outstanding federal accounts receivable, and cancel those deemed uncollectable.

**Response:** Agree with the recommendation.

**Plan for Improvement:** A procedure for more aggressive follow up of federal receivables has been instituted to provide for quarterly reviews, prompt follow up action, appropriate close out and quarterly reporting by the Chief, Fiscal Service through the Administrative Performance Improvement Council to the QMB.

**Target Completion Date:** Completed and Ongoing.

## Recommended Improvement Action 8:

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 8a:** Requires cardholders to reconcile purchase card transactions within the VA established timeframes.

**Response:** Agree with recommendation.

**Plan for Improvement:** We have strengthened the existing procedure to include follow-up memos sent from Fiscal Service through the Associate Hospital Director to the supervisor of the cardholder who does not reconcile credit card purchases within VA established timeframes.

**Target Completion Date:** June 1, 2003.

**Recommendation 8b:** Requires that reviews of cardholders' purchasing activity include a physical verification of the supporting documentation.

**Response:** Agree with recommendation.

**Plan for Improvement:** Fiscal Service has implemented the process of requiring that cardholders send them a copy of the supporting documentation that the goods or services have been received for their review.

**Target Completion Date:** Completed and Ongoing.

**Recommendation 8c:** Requires cardholders to retain, and approving officials to review, supporting documentation for purchase card transactions.

**Response:** Agree with recommendation.

**Plan for Improvement:** Fiscal Service is now complying with the Purchase Card Program VA Handbook that requires the cardholder to send them a copy of the supporting documentation that goods or services have been received for their review.

**Target Completion Date:** Completed and Ongoing.

## Recommended Improvement Action 9

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 9a**: Develops a comprehensive contingency plan for AIS and tests it annually.

**Response:** Agree with recommendation.

**Plan for Improvement:** Our contingency plan has been updated to include the following:

- Alternate On-Site and Off-site locations for disaster recovery.
- Clearly identified Mission Critical functions.
- Clearly labeled Call Back listings to support the resources needed for Mission Functions.

**Target Completion Date:** Full testing of the contingency plan occurred on March 31, 2003 and April 14, 2003.

**Recommendation 9b:** Adheres to documentation requirements relative to computer security awareness training and mandates that all employees attend refresher training on an annual basis.

**Response:** Agree with recommendation.

**Plan for Improvement:** The review gathered data from the LearnNet, automated education tracking system, however, difficulties with that system (resulting in it's replacement this FY)

resulted in it containing only partial data. The ISO personally surveyed each service and obtained manual records on service level training sessions, staff meeting etc., which contained appropriate awareness training. These manual records increase our percentage to 94%. To ensure proper data reporting a new automated system will be implemented as well as duplicative manual records.

**Target Completion Date:** September 30, 2003.

## Recommended Improvement Action 10

We recommend that the VISN Director designate a VISN workplace violence prevention program coordinator.

**Response:** Agree with recommendation.

**Plan for Improvement:** A Network program coordinator has been appointed and will coordinate all aspects of the Network violence prevention program.

**Target Completion Date:** Completed.

**Recommendation 10a:** Designate a VAMC program coordinator to manage all aspects of a workplace violence program.

**Response:** Agree with recommendation.

**Plan for Improvement:** Hospital Memorandum #116A.26 titled, "Violence Prevention Committee", has been updated to clearly state that our Chief of Staff is appointed as chairperson of the committee as well as overall coordinator of the Violence Prevention Program. This committee has arranged for facility wide mandatory training related to violence in the workplace, has addressed specific episodes of violence and potential violence in the Bedford population, has addressed the issue of arming of the hospital police, and multiple facility and VISN training issues regarding violence prevention. Over the past few years the committee has initiated, sponsored, and set up conferences on violence prevention advertised to the entire VISN. The most recent conference was October 24, 2002 and was done in conjunction with VISN 1 Educational Network. The conference title was "Prediction and Prevention of Violence; Current Clinical Concepts". Although the committee, in the past, has not duplicated tasks carried out by other groups in the VAMC, we will ensure inclusion on the agenda of those committee reviews of all tracking/trending, incidents, training programs, and other education, to ensure thorough coordination and oversight.

**Target Completion Date:** Completed.

**Recommendation 10b:** Provide annual PMDB training to employees working in high-risk areas.

**Response:** Agree with recommendation.

**Appendix A**

**Plan for Improvement:** We have assessed all our high-risk areas and have identified a total of 67 staff who require training. Of the 67 staff, 25 have already received the training. We will continue to train the remaining staff. This effort will be coordinated and monitored by our Violence Prevention Committee and reported to both our QMB and Mental Health Performance Improvement council.

**Target Completion Date:** December 31, 2003.

**Recommendation 10c:** Ensures that VistA or CPRS always alerts employees when potentially violent patients present themselves for treatment.

**Response:** Agree with recommendation.

**Plan for Improvement:** We currently have, in place, an alert system in CPRS-GUI in the form of the "CWAD" button which, when pressed gives immediate information about certain patients who may be violence prone. There is also an alerting mechanism in VistA list manager. While we agree a more reliable alert system is desirable, there are various issues that remain challenges for a more active and comprehensive alerting system, such as:

Not everyone has access to CPRS-GUI at the present time. Those without access use list manager in VistA. In the case of CPRS-GUI, the alert is visible only if the user pushes the "CWAD" button. Although this is a common and easy maneuver for most people bringing up a patient record, the user does have to press the button to see the alert. In the case of VistA list manager, the alert comes up only when the user accesses patient progress notes. In other words, in neither case is there an "automatic pop up alert". An additional challenge is that there is no link between the CPRS patient record and the Security VistA package.

We will continue to use all our current alert systems to meet this recommendation, but we would support a national programming initiative that would greatly improve the alerting system through CPRS. Currently CPRS does not provide functionality required to perform this function. This enhancement would require major changes of coding on the part of System Design and Development, not at the local level. This request has been submitted to SD&D in the form of an E3R, and is awaiting implementation to be included in a future update.

**Target Completion Date:** Current system in place – Completed.

## Recommended Improvement Action 11

We recommend that the VISN Director ensure that the VAMC Director:

**Recommendation 11a:** Requires all persons assigned to work in research laboratory areas to wear ID badges with photos and valid expiration dates at all times.

**Response:** Agree with recommendation.

**Plan for Improvement:** Our outdated software for the photo ID system was altered to include expiration dates and all research staff has been issued a new badge. The facility has ordered new software and equipment.

**Target Completion Date:** Completed.

**Recommendation 11b:** Requires background checks on all WOC employees in the same manner required for other employees.

**Response:** Agree with recommendation.

**Plan for Improvement:** Human Resource Management Service has obtained the names of all current WOC appointments and is in the process of submitting them to the office of Security and Law Enforcement for background checks. This will become routine procedure for all future research WOC appointees.

**Target Completion Date:** June 30, 2003.

## Suggested Improvement Action

We suggest that the VISN Director ensure that the VAMC Director:

**Suggestion:** Connect the Haverhill CBOC's remaining panic alarms to the office of the hospital police.

**Response:** Agree with suggestion.

**Plan for Improvement:** Haverhill CBOC panic alarms have been connected and are functioning properly.

**Target Completion Date:** Completed.

**Suggestion:** Ensure that password-protected screensavers are used on all CBOC computers.

**Response:** Agree with suggestion.

**Plan for Improvement:** Screen savers have been installed on all hospital and CBOC computers to protect confidentiality of patient information.

**Target Completion Date:** Completed.

## Suggested Improvement Action

We suggest that the VISN Director ensure that the VAMC Director:

**Suggestion:** Requires that cleaning and maintenance attention be given to areas identified in the IG inspection.

**Response:** Agree with suggestion.

**Plan for Improvement:** The inspection of the entire facility, 1.2 million square footage of space, noted minor cleaning of areas was needed. We agreed with the discrepancies and have completed and addressed the sanitation issues as noted before the IG/CAP inspection was completed.

**Target Completion Date:** Completed.

## Suggested Improvement Action

We suggest that the VISN Director ensure that the VAMC Director:

**Suggestion:** Take action to issue MCCF bills promptly.

**Response:** Agree with suggestion.

**Plan for Improvement:** The backlog in coding episodes of care was reviewed and steps were instituted to prevent further backlog. At the time of the OIG CAP review the coding backlog was 90 days. To address the backlog, the Bedford Health Information Management Section employed the help of the VISN coding pool. In addition, VISN 1 established a coding monitor for reporting any backlog greater than 30 days. As of April 1, 2003 Bedford episodes of care were coded within 28 days with a goal to remain under 30 days at all times.

The VISN has chartered several teams to develop implementation plans for the consolidation of VISN-wide MCCF activities, in accordance with the recently proposed National Business Office presentation. These plans will be developed by June 30, 2003 with full implementation occurring by September 30, 2003.

**Target Completion Date:** September 30, 2003.

**Appendix B**

# Monetary Benefits in Accordance with IG Act Amendments

**Report Title:** Combined Assessment Program Review - Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts

**Report Number:** 03-00821-141

| Recommendation | Explanation of Benefit | Better Use of Funds |
|---|---|---|
| 6 | Better use of funds by deobligating unneeded accrued services payable. | $208,488 |
| 7 | Better use of funds by improving collection of Federal accounts receivable. | $ 71,134 |
| | Total | $279,622 |

**Appendix C**

# Report Distribution

## VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Deputy Chief of Staff (00A1)
Executive Secretariat (001B)
Under Secretary for Health (105E)
Chief of Staff to the Under Secretary for Health (10B)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Operations (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Management and Financial Reports Service (047GB2)
Medical Inspector (10MI)
VHA Chief Information Officer (19)
Director, National Center for Patient Safety (10X)
Veterans Integrated Service Network Director (10N1)
Director, Edith Nourse Rogers Memorial Veterans Hospital (518/00)

## Non-VA Distribution

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Senator Edward Kennedy
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Congressman John Tierney
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

**Appendix C**

Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives
Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

This report will be available in the near future on the VA Office of Inspector General Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.