Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana

Report No. 03-01396-131 **July 17, 2003**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) 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 week of April 28-May 2, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Overton Brooks VA Medical Center Shreveport, Louisiana (the medical center). The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided fraud and integrity awareness training to 152 employees.

Results of Review

Patient care and QM activities reviewed were generally effective. Overall, the QM Program was comprehensive and provided effective oversight of the quality of patient care; however, some areas needed to be improved. Financial and administrative activities reviewed generally required some improvement. To improve operations, the Veterans Integrated Service Network (VISN) Director should ensure that the Medical Center Director improves:

- Controls over the purchase of eyeglasses.
- The Community Nursing Home Program and the physician peer review process.
- Procedures for requesting employee background investigations.
- Physical security of the clinical laboratory.
- Management of violent patients.
- Internal controls over controlled substances.
- Automated information systems security.
- Reporting of patient waiting time for primary care clinics.

We also made suggestions regarding the environment of care, Government Purchase Card Program, and verification of invoices for the courier services contract.

VISN Director Comments

The VISN and Medical Center Directors agreed with the findings, recommendations, and suggestions and provided acceptable improvement plans. (See pages 11-17 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The Overton Brooks VA Medical Center, Shreveport, Louisiana is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient services are provided in the medical center outpatient clinics and three community-based outpatient clinics (CBOCs) located in Monroe, Louisiana, and Longview and Texarkana, Texas. The medical center is part of VISN 16 and serves a veteran population of about 131,000 in a primary service area that includes 12 parishes in northwest Louisiana, 15 counties in northeast Texas, and 5 counties in southeastern Arkansas.

Programs. The medical center has 112 hospital beds and provides medical, surgical, neurology, and psychiatry inpatient services. The medical center has sharing agreements with Barksdale Air Force Base and the Louisiana State University Health Sciences Center.

Affiliations and Research. The medical center is affiliated with the Louisiana State University School of Medicine and supports 43 medical resident positions in 17 training programs. In Fiscal Year (FY) 2002, the medical center research program had 128 projects and a budget of about $866,000. Areas of research include hepatitis-C virus, endocrinology, pharmaceutical studies, oncology, and neurophysiology.

Resources. In FY 2002, medical care expenditures totaled about $121 million. The FY 2003 medical care budget was over $129 million. FY 2002 staffing totaled 1,018 full-time equivalent employees, including 70 physicians and 285 nursing employees.

Workload. In FY 2002, the medical center treated 36,147 unique patients. The medical center provided 30,981 inpatient days of care in the hospital. The inpatient care workload included 5,063 discharges, and the average daily census for the hospital was 85. The outpatient workload was about 299,000 visits.

Objectives and Scope of CAP Review

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

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

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

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 programs and activities:

- Automated Information Systems
- Clinical Laboratory Security
- Community-Based Outpatient Clinic Operations
- Contract Award and Administration
- Controlled Substances Security
- Employee Background Investigations
- Environment of Care
- Government Purchase Card Program
- Management of Violent Patients
- Patient Waiting Time
- Quality Management

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 surveyed 15 inpatients and 15 outpatients, and received 157 responses to our electronic survey from medical center employees. The survey results were provided to medical center management.

In conjunction with the CAP review, we also presented four fraud and integrity awareness briefings for medical center employees. A total of 152 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.

Our review covered medical center operations for October 1, 1999, through May 2, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Results of Review

Opportunities for Improvement

Eyeglasses – Internal Controls Over the Purchase of Eyeglasses Need Improvement

Conditions Needing Improvement. The medical center needs to improve internal controls to document what was ordered from the eyeglass contractor, determine what the contractor actually delivered, or determine if the contractor's invoices were accurate. In addition, Prosthetics Service staff did not verify the contractor's invoices before making payments and were 4 months behind in paying invoices. It was estimated that the medical center would purchase about 3,500 pairs of eyeglasses at a cost of about $137,000 during the first year of the 5-year contract. However, during the 9-month period ending March 2003, the medical center paid for 3,060 eyeglasses at a cost of about $202,000. At the time of our review there were pending invoices for an additional 1,300 eyeglasses totaling about $72,000. The average price paid per pair of eyeglasses during this period was about $66, compared to an estimated contract cost of $39. These contracting issues have been referred to the OIG Office of Investigations.

The following conditions require management attention:

- The medical center's Eye Clinic retained copy 5 of the 5-part patient prescription form[1] (VA Form 10-2914(R). Copies 3-5 of the 5-part form usually were not legible.
- Patients hand-carried the original plus three copies (copies 1-4) of the prescription form directly from the Eye Clinic to the contractor's area in the Veterans Canteen Service Retail Store, with no copy going to Prosthetics Service.
- Prosthetics Service did not obligate funds or enter data into the National Prosthetic Patient Database (NPPD) until the contractor's invoice was received and processed.
- The contractor's invoices did not itemize the services provided.
- Prosthetics Service staff did not verify the accuracy of the contractor's invoices before authorizing payments.
- Prosthetics Service was 4 months behind in paying about 1,300 invoices valued at about $72,000.
- Prosthetics Service staff responsible for certifying invoices did not have copies of the eyeglass prescriptions, the contract, or the contractor's price list.

Given the condition of the medical center records and lack of internal controls, we could not determine whether the contractor's invoices were accurate, whether VA was ordering more "extra services-per-script" than planned, or if the contractor was providing more services than were prescribed.

[1] This form included the original script for the contractor (copy 1), and copies for the patient (copy 2), Fiscal Service (copy 3), prescription authorization for Prosthetics Service (copy 4), and the Eye Clinic (copy 5).

Recommended Improvement Action 1. The VISN Director should ensure that the Medical Center Director assesses the medical center's process for prescribing and obtaining eyeglasses, and establishes necessary internal controls to ensure that:

a. The Eye Clinic maintains a legible copy of the original prescription for its records and sends a copy to Prosthetics Service for certification of contractor invoices for payment.
b. Prosthetics Service obligates funds for prescribed eyeglasses upon receipt of the prescription copy and enters the data into the NPPD.
c. Prosthetics Service staff verify the accuracy of contractor invoices in regard to eyeglasses prescribed and the price.
d. Contractor invoices are paid timely.

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

Quality Management Program – The Community Nursing Home Program and the Physician Peer Review Process Need To Be Improved

Conditions Needing Improvement. The medical center's QM and Performance Improvement (QM/PI) Program was generally comprehensive and effective. However, the following two areas need to be improved:

Community Nursing Home (CNH) Program. The scope of the medical center's QM/PI Program did not specifically address the CNH Program. While Social Work Service was monitoring the program on an ongoing basis, results of indicators of care such as falls, restraint-use, and bedsores were not aggregated and trended. We did not find discussions concerning the overall quality of care provided in the CNH Program in the minutes of the multi-disciplinary Medical Executive Committee or other appropriate facility-wide committees for the 12-month period reviewed.

Clinician Peer Review. We reviewed Physician/Clinician Profile records of the three clinicians who received level-3 ratings[2] during the last 18 months and found the following conditions:

- One clinician contested the peer reviewer's findings and provided support for reconsideration; however, there was not a process in place to address contested peer reviewer findings.
- In two of the three case records, clinical service managers had not clearly documented their remedial actions for preventing reoccurrence of the physicians' substandard levels of care.

[2] A level-3 rating indicates that most practitioners would have handled the case differently.

- Clinical managers had not clearly documented follow-up evaluations of the effectiveness of their actions in any of the three records.

Recommended Improvement Action 2. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. A QM/PI Program for the CNH Program is implemented, and reported findings and discussions are documented in appropriate medical center committee minutes.
b. The peer review process is revised to ensure that clinicians' appeals are considered and addressed, results are documented, and service chiefs and clinicians are informed of the outcomes.
c. The peer review process is revised to ensure that clinical managers clearly outline implemented level-3 peer review remedial actions and ensure they document follow-up of the effectiveness of their actions.

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

Employee Background Investigations – Investigations Need to Be Completed

Conditions Needing Improvement. Human Resources Management (HRM) Service could not certify that all employees who have been employed for more than 1 year have valid and up-to-date background investigation clearances in their Official Personnel Files, in accordance with Executive Order 10450. The Chief, HRM, confirmed that background investigations were not consistently ordered for all employees, including Without Compensation affiliate employees. While we were onsite, the Director developed a plan of action to address these background investigation issues.

Recommended Improvement Action 3. The VISN Director should ensure that the Medical Center Director implements a plan of action to complete background investigations on all employees.

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

Clinical Laboratory Security – Security Needs to Be Improved

Conditions Needing Improvement. Both entrances to the medical center's clinical laboratory, housing the two BioSafety Level-III laboratories[3] were unlocked, allowing unrestricted access to the area. Laboratory employees did not maintain entry logs, which should include entries by visitors, maintenance workers, repairmen, and others needing one-time or occasional entry. In addition, the door to the incubator containing mycobacterium tuberculosis (a bacterial pathogen) did not have a lock. While we were onsite, the Director submitted an action plan to limit access to the clinical laboratory, and to lock the incubator.

Recommended Improvement Action 4. The VISN Director should ensure that the Medical Center Director implements the plan of action for resolving the security access issues of the clinical laboratory.

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

Management of Violent Patients – Employees Need To Follow Policies

Conditions Needing Improvement. We found that clinicians did not consistently follow medical center policies when responding to incidents of disruptive patient behavior. In addition, clinicians did not complete Patient Incident Reports (PIR) (VA Form 10-2633) for violent patient incidents.

We reviewed the medical records and VA Police Uniform Offense Reports for 10 patients who had committed acts of violent behavior during the last 12 months. We found that during incidents of patient violence, clinicians had only called the VA Police, rather than calling a "Code Purple" as required in the medical center Disruptive Behavior Prevention Program policy. Members of the "Code Purple" team consisted of unit employees, the nurse supervisor, and the VA Police. We found that PIRs were not completed for any of the 10 incidents as required by medical center policy.

Recommended Improvement Action 5. The VISN Director should ensure that the Medical Center Director requires clinicians to follow established policies for the management of violent patients.

[3] A laboratory requiring safety precautions from indigenous or exotic agents which carry potential for harm or aerosol exposure.

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

Controlled Substances Security – Internal Controls Over Controlled Substances Need Improvement

Conditions Needing Improvement. Pharmacy Service did not consistently perform 72-hour inventories of controlled substances, and controlled substances inspectors did not obtain receiving reports and independently count controlled substances during monthly unannounced inspections. Veterans Health Administration (VHA) policy requires that medical centers inventory all Schedule II-V controlled substances every 72 hours. Also, VHA policy requires that controlled substances inspectors compare receiving reports to posted receipts in the inventory records, and physically count all controlled substances during monthly unannounced inspections.

Recommended Improvement Action 6. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. Pharmacy Service performs 72-hour inventories of controlled substances.
b. Inspectors obtain receiving reports during monthly unannounced inspections and compare them to inventory records.
c. Inspectors physically count all controlled substances.

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

Automated Information Systems – Security Needs Improvement

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

Contingency Plans Were Not Comprehensive. The medical center's contingency plans generally did not:

- Identify mission-critical functions and the resources needed to support those functions.
- Identify a disaster recovery team, specifying roles key personnel would play in the disaster recovery process.
- Identify an alternate processing facility that could be used during disaster recovery.
- Identify an off-station storage location for the contingency plans and back-up tapes.

Monitoring of AIS Access Needs Improvement. The Information Security Officer (ISO) did not perform quarterly reviews of the continued need for AIS access. As of April 8, 2003, the medical center had 826 Veterans Health Information Systems and Technology Architecture (VISTA) accounts and 178 remote access accounts. We found:

- Twelve VISTA accounts had not been accessed in over 90 days, ranging from 91 to 4,175 days. These accounts should be reviewed and action taken to terminate accounts where appropriate.
- Five employees had system administrator level access to VISTA. This level of access should be limited to the System Administrator and Assistant System Administrator.
- The VISTA administrator established three generic AIS VISTA access accounts. Generic accounts prevent identification of individuals making system changes and are prohibited by VA policy and should be discontinued.

Monitoring of Access to Employees' Electronic Medical Records Needs Improvement. Monitoring of employee access to other employees' electronic medical records was not consistently performed. The ISO monitored this access infrequently and did not determine why employees accessed other employees' electronic medical records. Monitoring of access to employee electronic records is an important internal control procedure that is designed to detect inappropriate access to sensitive records.

Recommended Improvement Action 7. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. Contingency plans are comprehensive.
b. Quarterly reviews of VISTA and remote access users are performed.
c. System administrator level access to VISTA is limited to the System Administrator and Assistant System Administrator.
d. Generic AIS VISTA access accounts are terminated.
e. Access to employees' electronic medical records is monitored regularly.

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

Patient Waiting Time – Average Waiting Time for Combined Primary Care Clinics Was Understated

Conditions Needing Improvement. The medical center had taken action to reduce patient waiting time; however, staff underreported the average patient waiting time for new appointments in primary care clinics. VA policy requires medical centers to accurately report performance measures for patient waiting time. The medical center reported an average of 47

days for a new patient to receive an appointment with a primary care provider. Our test of the data used to compute the average showed that it actually took an average of 115 days to receive a new appointment in primary care clinics during the 7-month period September 1, 2002, through March 31, 2003. The underreporting occurred because clinic staff used the date that the patient was assigned to a primary care provider panel slot as the appointment request date, rather than the date the patient requested the appointment, to calculate waiting time.

Recommended Improvement Action 8. The VISN Director should ensure that the Medical Center Director takes action to ensure that patient waiting time is accurately reported.

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

Environment of Care – Minor Cleanliness, Security, and Repair Issues Need to Be Addressed.

Conditions Needing Improvement. We inspected all clinical and administrative areas of the facility, including the Longview CBOC and found the environment of care (EOC) to be generally acceptable. However, we found several minor problems, such as, dirt build-up around the walls and behind the equipment in Supply Processing and Distribution; prescription pads in unlocked office desks in the medical center's Primary Care Clinic and Longview CBOC; and dirty or damaged gaskets on the refrigerators inspected throughout the facility. While we were onsite, managers took immediate steps to correct some of the EOC deficiencies and the Director submitted a plan of action to address the unresolved issues.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director implements the plan of action for correcting unresolved EOC issues.

The VISN and VAMC Directors agreed with the finding and suggestions, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Government Purchase Card Program – Monitoring of Cardholder Accounts Needs to Be Improved

Conditions Needing Improvement. During the 18-month period ending March 31, 2003, cardholders completed about 25,000 transactions totaling $13 million. Neither Fiscal or Acquisition and Materiel Management Service staff conducted quarterly audits of cardholders' accounts. VHA policy requires quarterly audits of cardholder accounts not reviewed during monthly statistical sampling conducted by the VA Financial Service Center.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that quarterly audits are conducted of all purchase cardholder accounts not reviewed during the monthly audits conducted by the VA Financial Service Center.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Courier Services Contract – Invoices Should Be Properly Verified

Conditions Needing Improvement. Contracting Officer's Technical Representatives (COTRs) at the medical center's three CBOCs certified courier service invoices for payment without verifying that the services were provided. The contractor billed the medical center about $220,000 for courier services during the period October 1, 1999, through March 31, 2003. The COTRs did not reconcile the number of trips made by the courier service to the invoices, prior to certifying the invoices for payment. VHA policy requires COTRs to ensure that contractor invoices are correct before certifying them for payment.

Suggested Improvement Actions. The VISN Director should ensure that the Medical Center Director requires that COTRs reconcile the number of trips made by the courier service prior to certifying invoices for payment.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Appendix A

VISN 16 Director Comments

June 24, 2003

Network Director (10N16), South Central VA Health Care Network (SCVAHCN)

OIG Combined Assessment Draft Report (CAP), VAMC, Shreveport, LA
Facility Responses to Recommendations
Office of Inspector General (53B)
Thru: Management Review and Administration (105E)

1. The SCVAHCN 16 has reviewed the responses included in the CAP Report for the VA Medical Center, Shreveport, Louisiana, and concur.

2. If you have questions or need additional information, please contact Ms. Barbara Watkins, Acting Medical Center Director, VAMC, Shreveport, at 318.424.6037.

/s/Robert Lynch, M.D.

Robert Lynch, M.D.

Attachment

Appendix B

Medical Center Director Comments

CAP Improvement Recommendations
Action Plan
Shreveport VAMC

Internal Controls Over Purchase of Eyeglasses

The Medical Center Concurs with the recommendation

Recommended Improvement Action 1. The VISN Director should ensure that the Medical Center Director assesses the medical center's process for prescribing and obtaining eyeglasses, and establish necessary internal controls to ensure that:

a. The Eye Clinic maintains a legible copy of the original prescription for its records and sends a copy to Prosthetics Service for certification of contractor invoices for payment.
b. Prosthetics Service obligates funds for prescribed eyeglasses upon receipt of the prescription copy and enters the data into the NPPD.
c. Prosthetics Service staff verify the accuracy of contractor invoices in regard to eyeglasses prescribed and the price.
d. Contractor invoices are paid timely.

Planned Action:
a. The process for prescribing eyeglasses has been completely revised and computerized. All prescriptions from this medical center are ordered using the CPRS Consult package. The prescription is printed out and sent to the vendor on hard copy, and is available in the patient's medical record (CPRS). P&SAS reviews the CPRS consult to review the original prescription. **Target Date: 05/19/03.**
b. P&SAS must be 95% compliant using the credit card method. The service uses the credit card method to pay for all services rendered by contractors. Purchase card transactions are electronically linked to the NPPD system for future monitoring of prosthetic funds and acquisitions transactions. Prosthetics will monitor compliance of this process quarterly. **Target date: 07/01/03.**
c. P&SAS has received an updated contractor's price list to check for accurate pricing. Eyeglass prescriptions are in CPRS system for review by Purchasing Agent. COTR training will be scheduled for the service. **Target date: 06/24/03.**
d. P&SAS is still currently paying backlog invoices of four months, along with the new incoming invoices. The service is now paying May invoices. The service is about 1-½ months behind in payments. This is due to the increase in eyeglasses ordering and other hospital workload for the Purchasing Agents. **Target date: 09/01/03.**

Quality Management

The Medical Center Concurs with the recommendation

Recommended Improvement Action 2. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. A QM/PI Program for the CNH Program is implemented, and reported findings and discussions are documented in appropriate medical center committee minutes.

b. The peer review process is revised to ensure that clinicians' appeals are considered and addressed, results are documented, and service chiefs and clinicians are informed of the outcomes.
c. The peer review process is revised to ensure that clinical managers clearly outline implemented level-3 peer review remedial actions and ensure they document follow-up of the effectiveness of their actions.

Planned Actions:
a. Develop Corrective Action Plan to implement a QM/PI Program for Contract Nursing Homes. **Target date: 06/01/03.**
    1. Obtain a best practice quality monitoring program from the Milwaukee VAMC. **Target date: 06/10/03.**
    2. Appointment of a Contract Nursing Home Subcommittee of the Extended Care Oversight Committee to report findings of quality monitors. **Target date: 07/31/03.**
    3. Identification of quality monitoring for trending, aggregation, and analysis of the CNH Program. **Target date: 07/13/03.**
    4. Completion of OSCAR 3 (History Facility Profile) and Oscar 4 (Full Facility Profile). Ongoing. **Target date: 07/01/03.**
    5. Completion of MDS QI Profile. Ongoing. **Target date: 07/01/03.**
    6. Establishment of an Extended Care Oversight Committee to review findings of quality monitors. This committee will meet at least quarterly and submit report to the CEB through Chief, Social Work Service. **Target date: 07/31/03.**
    7. CNH Program will be added to overall QM Plan. **Target date: 07/01/03.**
b. An MEC Peer Review Subcommittee has been formed and all level-3 peer reviews will be presented at this committee for final disposition. The clinician reviewed will have the option of being present at this committee and present his case. The Subcommittee minutes are attached to the Medical Executive Committee Peer Review and copies will go to the service chiefs. Service chiefs will share the results with the clinician. **Target date: 06/11/03.**
c. The new process is incorporated in the Peer Review Policy. **Target date: 07/31/03.**

Employee Background Investigations

The Medical Center Concurs with the recommendation

Recommended Improvement Action 3. The VISN Director should ensure that the Medical Center Director implements a plan of action to complete background investigations on all employees.

Planned Action: Plan/process has been devised to identify all current employees, including WOC employees, who require an appropriate background investigation to be completed, and to complete those background investigations. This includes post-audit and follow-up to assure that the background investigation processing cycle of each is consistently fully complete on each. Implementation of this action item has already begun. **Target date: 01/09/04.**

Physical Security of the Clinical Laboratory

The Medical Center Concurs with the recommendation.

Recommended Improvement Action 4. The VISN Director should ensure that the Medical Center Director implements the plan of action for resolving the security access issues of the clinical laboratory wing.

Planned Actions:

- A work order has been placed with the Engineering Service to place a chain and lock around the TB (Mycobacteria) incubator in 2E4. **Target date: 07/01/03.**
- A logbook will being maintained in this area to record activity of enteries by visitors, maintenance workers, repairman, and others needing one-time or occasional entry. **Target date: 06/25/03.**
- P&LMS has made a top priority on their station equipment list for the purchase of a refrigerator and replacement incubator with a factory installed key/lock system for 2E6 and 2E21. **Target date: 08/23/03.**
- When the inspection team was in the lab, Engineering Service and the inspector discussed the possibility of placing a card-entry or key-panel entry door at the end of the 2-East hallway. This could be used as the first barrier to the area which the inspector indicated needed at least two barriers (first, the door and the second, another locked door or lock on the incubator/refrigerator). **Target date: 09/30/03.**

Management of Violent Patients

The Medical Center Concurs with the recommendation.

Recommended Improvement Action 5. The VISN Director should ensure that the Medical Center Director requires clinicians to follow established policies for the prevention and management of violent patients.

Planned Actions:

- Complete revision of the current policy on Management of Disruptive Behavior, which will clearly define when a code should be called and the requirements for reporting of incidents. **Target date: 07/31/03.**
- Educate medical center staff regarding the policy and procedures for handling of disruptive behavior. **Target date: 08/23/03.**

Controlled Substances Security

The Medical Center Concurs with the recommendation.

Recommended Improvement Action 6. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. Pharmacy Service performs 72-hour inventories of controlled substances.

b. Inspectors obtain receiving reports during monthly unannounced inspections and compare them to inventory records.
c. Inspectors physically count controlled substances.

Planned Actions:
a. Pharmacy Service has been consistently performing the 72-hour inventories of controlled substances since March 2003, when the VISTA Controlled Substance package was implemented. We will continue to conduct the 72-hour inventories of controlled substances. **Target date: 06/23/03.**
b. Inspectors are now obtaining their receiving reports during monthly unannounced inspections from a purchasing agent in the pharmacy office rather than the receiving report copy located in the pharmacy vault. This information has been added to the Controlled Substance Inspector's Procedural Training Guide and distributed to all Inspectors. In addition, it is reported on a revised monthly controlled substance inspection report. **Target date: 05/15/03.**
c. Inspectors have been informed of the necessity to consistently do a physical count of the controlled substances in the pharmacy vault. This information is included in the Controlled Substance Inspectors Procedural Training Guide and the P&O. **Target date: 05/15/03.**

Automated Information Systems

The medical center concurs with the recommendation to limit system administrator privileges to the System Administrator and Assistant System Administrator, but the facility at a later date will reassess whether we have vulnerability with limiting administrator privileges to only two employees.

Recommended Improvement Action 7. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. Contingency plans are comprehensive.
b. Quarterly reviews of VISTA and remote access users are performed.
c. System administrator level privileges to VISTA are limited to only the System Administrator and Assistant System Administrator.
d. Generic AIS accounts are terminated.
e. Access to employee electronic medical records is monitored regularly.

Planned Actions:
a. Recommendations by auditor have been completed. These items have been added to the contingency plans:
1. Mission critical systems.
2. Alternate computing site.
3. Location of off-site storage.

Target date: 05/15/03.

b. A full time ISO has been appointed and currently has implemented quarterly audits of VISTA and remote access and the following three actions: **Target date: 06/01/03.**

c. System Planned Action: Administrator privileges have been limited to only appropriate individuals. **Target date: 05/02/03.**
d. Generic AIS accounts have been terminated. **Target date: 05/15/03.**
e. Audit is in place to review access to employee electronic medical records. **Target date: 06/01/03.**

Patient Waiting Time

The Medical Center Concurs with the recommendation.

Recommended Improvement Action 8. The VISN Director should ensure that the Medical Center Director takes action to ensure that patient waiting time is accurately reported.

Planned Action: June 1, 2003, the facility began using the following formula for calculating waiting times: The calculation will be based on the date the patient requested the appointment instead of the previous method of date the patient was assigned to a primary care provider panel. We will make appropriate changes in the future based on VHA policy changes in regards to calculations of waiting times. **Target date: 06/01/03.**

Environment of Care

The Medical Center Concurs with the recommendation.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director implements the plan of action for correcting unresolved EOC minor problems.

Planned Action: Action plans are in place to correct all areas that were cited. There is a system of surveillance in all services in place to identify future issues if they should occur. **Target date: 08/01/03.**

Government Purchase Card Program

The Medical Center Concurs with the recommendation.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that quarterly audits are conducted of all purchase cardholder accounts not reviewed during the monthly audits conducted by the VA Financial Service Center.

Planned Action: A schedule was developed to review cardholders delegated to use the cards under the micro-purchase threshold. Results of the audits will be prepared by Fiscal Service in writing and submitted timely to the Chief, A&MMS for review and action if required. Dates, times and specifies are necessary in order to take the appropriate action that may be necessary. Services are given deadlines to respond with corrective action that will prevent future recurrences of errors and non-compliance. **Target date: 05/21/03.**

Appendix B

Courier Services Contracts CBOCs

The Medical Center Concurs with the recommendation.

Suggested Improvement Actions. The VISN Director should ensure that the Medical Center Director requires that COTR's reconcile the number of trips the courier service made prior to certifying invoices for payment.

Planned Action: Assignment of COTR staff at each CBOC to monitor the visits of the vendor and certify payment for all authorized visits. A&MMS will prepare delegation of authority for each COTR and provide training on duties and responsibilities. **Target date: 07/15/03.**

Appendix C

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