



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center Walla Walla, Washington

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 employees.

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 May 12-16, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Jonathan M. Wainwright Memorial VA Medical Center (facility), which is part of Veterans Integrated Service Network (VISN) 20. The purpose of the review was to evaluate selected facility 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 86 employees.

Results of Review

An advanced clinic access model was implemented that resulted in improved processes and greater patient satisfaction. The Inventory, Purchasing, and Distribution (IPD) section effectively managed medical supply inventory using VA's Generic Inventory Package (GIP). QM employees maintained an effective provider profiling system for use in the biennial renewal of provider privileges. Unliquidated obligations were reviewed monthly and canceled when not needed. To improve operations, the VISN and Facility Directors needed to:

- Improve pharmacy security and strengthen controlled substances accountability.
- Strengthen contracting procedures and review technical representative designation and training.
- Enhance QM by improving aggregated review analyses, documentation, and medication usage evaluation (MUE).
- Correct information technology (IT) security deficiencies.
- Correct safety deficiencies in the Behavioral Health Unit and the Nutrition and Food Service (NFS).
- Reduce prosthetics and engineering inventories and improve inventory management controls.
- Improve community nursing home contract documentation.

VISN 20 Director and Facility Director Comments

The VISN and Facility Directors agreed with the CAP review findings and provided acceptable improvement plans (See Appendixes A and B, pages 12-21 for the full text of the Directors' comments). We will follow up on planned actions until they are complete.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Based in Walla Walla, WA, the facility is a primary and secondary care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics (CBOCs) located in Yakima and Richland, WA. The facility is part of VISN 20 and serves a veteran population of about 60,000 in a primary service area that includes seven counties in Washington, Oregon, and Idaho.

Programs. The facility provides medical, surgical, behavioral health, and long-term care services. The facility has 14 hospital beds, 30 nursing home beds, and 22 behavioral health and Substance Abuse Residential Rehabilitation Program beds.

Affiliations. The facility is affiliated with several colleges and universities and provides clinical training opportunities for nursing, social work, optometry, physician assistant, and computer science students.

Resources. In FY 2002, facility medical care expenditures totaled \$37.1 million. The FY 2003 medical care budget is \$38.5 million, 3.8 percent more than FY 2002 expenditures. FY 2002 staffing was 329 full-time equivalent employees (FTEE), including 13 physician and 56 nursing FTEE.

Workload. In FY 2002, the facility treated 11,847 unique patients, a 7.5 percent increase from FY 2001. The inpatient care workload totaled 1,142 discharges, and the average daily census, was 47. The outpatient workload was 78,845 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 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 facility operations for FY 2002 and FY 2003, through April 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:

Accounts receivable	Laboratory security
Acute medical-surgical units	Long-term care
Behavioral health care	Medical Care Collections Fund
Community nursing home contracts	Pharmacy security
Controlled substances accountability	Primary care clinics
Enrollment and resource utilization	QM
Environment of care	Service contracts
Government Purchase Card Program	Supply inventory management
IT security	Unliquidated obligations

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–11). For these activities, we made 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 facility managers 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. Questionnaires were sent to all facility employees, 60 of whom responded. We also interviewed 30 patients during the review. The survey and interview results were discussed with facility managers.

During the review, we also presented three fraud and integrity awareness briefings for facility employees. Eighty-six 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

Advanced Clinic Access. The Advanced Clinic Access model was implemented to improve quality, satisfaction, and timeliness of care. The model measures and monitors multiple phases in a clinic visit, including demand for care, timeliness of appointment, and total time spent in the clinic. These measurements have promoted changes that have resulted in improved processes and greater patient satisfaction.

Medical Supply Inventory Management Was Effective. The IPD section effectively managed medical supply inventory using VA's GIP. We found that reported inventory levels were accurate and stock levels were appropriately monitored. The IPD inventory manager had a high level of expertise in GIP and used various GIP reports and other inventory control tools, such as bar-coding and automatic reordering, to monitor stock levels.

Credentialing and Privileging. QM employees maintained an effective provider profiling system for use in the biennial renewal of provider privileges. The profiles included information from many quality measures for each individual provider as well as comparison data.

Unliquidated Obligations Were Reviewed Monthly and Canceled When Not Needed. The Business Support Service was reviewing unliquidated obligations every month, contacting facility services to determine whether the obligations were still needed, and promptly canceling obligations that were no longer needed.

Opportunities for Improvement

Pharmacy Administration – Security and Accountability of Controlled Substances Needed To Be Strengthened

Conditions Needing Improvement. We reviewed pharmacy security and controlled substances accountability to determine if controls were adequate to prevent the loss or diversion of drugs and to ensure that controlled substances were properly accounted for. We found seven deficiencies in pharmacy access controls, physical security, and controlled substances accountability.

Pharmacy Access. Veterans Health Administration (VHA) policy requires that access to the pharmacy be strictly controlled and monitored. We identified three deficiencies in this area.

- Nineteen non-pharmacy employees had access to the pharmacy, including nurses and managers from the Ambulatory Care Clinic and Multi-Care Unit. VHA policy requires that the number of employees with access to the pharmacy be kept to a minimum. Although controls were in place for night and weekend access, nurses often entered the pharmacy during regular pharmacy hours to obtain drugs for use in clinics.
- Pharmacy access was not adequately monitored. VHA policy requires that accountability of access to the pharmacy be maintained and documented. The keypad lock system installed on the doors did not provide the Pharmacy Chief the ability to obtain an access record easily or without the assistance of the facility locksmith. In addition, employees did not maintain a log of individuals entering the pharmacy area or of the drugs that non-pharmacy employees removed from the area.
- VHA security standards require that all pharmacy doors have two lock sets, that exterior hinges have non-removable pins, and that windows have stainless steel security mesh screening. Several pharmacy doors had only a single lock, and the exterior hinges had removable pins. A window in the inpatient pharmacy did not have security mesh screening.

These problems occurred because facility managers and the former Pharmacy Chief believed the existing access controls and physical security measures to be adequate. In February 2003, a new Pharmacy Chief started work at the facility and he agreed these areas needed to be strengthened.

Controlled Substances Access. We identified two controls over access to controlled substances that needed to be improved.

- VHA policy requires that facilities limit the number of pharmacy employees who have access to controlled substances to no more than 10 within a 24-hour period. Access to the outpatient pharmacy controlled substances storage and dispensing area was not monitored electronically or with a logbook. Twelve of 13 pharmacy employees had access to the room, and there was no way for pharmacy employees to monitor how many individuals accessed the room within

a 24-hour period. In addition, there was no log or record of non-pharmacy employees or visitors that entered the room.

- Storage and dispensing areas did not meet VHA requirements. According to VHA policy, controlled substances storage must include day gates for vaults and burglary-resistant protection for safes. The outpatient pharmacy controlled substances vault did not have a day gate to restrict unauthorized access while pharmacy employees were working in the vault, and employees routinely left the vault door open. In the inpatient pharmacy, controlled substances were stored in an older model safe that did not meet current specifications.

Controlled Substances Accountability. We identified two weaknesses with the facility's inventory and inspection programs.

- Pharmacy employees did not count controlled substances every 72 hours, as required by VHA policy. During the 4-month period January-April 2003, pharmacy employees performed only 9 (23 percent) of the 40 required counts in the inpatient pharmacy and only 13 (33 percent) of the 40 required counts in the outpatient pharmacy.
- VHA policy requires facility managers to perform monthly unannounced inspections of all stocks of controlled substances. Inspections at this facility did not cover all controlled substances. The facility's controlled substances inspection policy needed to be revised to require a 100-percent physical count of all controlled substances. Instead, the inspectors randomly selected only 10 drugs in certain controlled substances categories to count for the monthly inspections. The Controlled Substances Inspection Coordinator stated that monthly inspections were performed this way because there was such a large number of controlled substances.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Facility Director implements procedures to: (a) review pharmacy access requirements for all non-pharmacy employees; (b) monitor access to the main pharmacy and controlled substances storage areas; (c) correct pharmacy door, lock, and window deficiencies; (d) ensure that controlled substances storage and dispensing areas meet current standards for vaults and security containers; (e) ensure that 72-hour counts are conducted; and (f) include all controlled substances in monthly inspections.

The VISN and Facility Directors agreed with the findings and recommendations, and provided plans to improve pharmacy security and controlled substances accountability. We will follow up on the planned actions until they are completed.

Service Contracts – Contracting Procedures Needed To Be Improved

Conditions Needing Improvement. Facility managers needed to improve both the documentation of the contract award process and the administration of current contracts. To determine if contracts were properly awarded and administered, we reviewed 10 service contracts, 3 of which were competitive and 7 of which were noncompetitive.

Contract Award Process. Contract files for competitive contracts should include selection documentation. Noncompetitive contract files should contain sufficient information to support the price reasonableness and price negotiation memorandums (PNM) that document the negotiation process. For sole source contracts with estimated values of \$500,000 or more, contracting officers must request pre-award audits. Because of the lack of documentation in the 10 contract files, it was difficult to verify the competitive or noncompetitive basis of any of the contracts. Two of the three competitive contracts did not contain evidence of solicitations or documentation supporting contractor selection. None of the seven noncompetitive contract files contained PNMs or determinations of the price reasonableness. For one sole source contract with an estimated value of \$600,000, the contracting officer did not request a pre-award audit.

Three contracts were inappropriately extended. All were 1-year contracts without option years. Two of these contracts allowed for maximum 6-month extensions. However, both contracts were extended for 1 year. The third contract's 1-year period ended in October 2000. That contract stipulated that the total duration could not exceed 3 years. Thus, it should not have been extended beyond October 2002. There was no evidence in the file that any action was taken to extend the contract at the end of its 1-year term in October 2000. However, both parties continued to honor the contract. Documentation in the file showed that in October 2002 the contract was extended for 1 year to October 2003. Even if the contract had been properly extended in October 2000 and was still valid in October 2002, it would have been at the end of its 3-year duration and should not have been extended.

Contract Monitoring. For each contract, a contracting officer's technical representative (COTR) should be designated and properly trained to monitor performance and ensure that services are provided in accordance with contract terms. This responsibility includes reviewing contractor invoices to ensure that they accurately reflect the work completed in accordance with the requirements of the contract and certifying acceptance of contractor charges. COTRs may not re-delegate their authority to other persons. Although 7 of the 10 contract files did not contain letters designating COTRs, we found that, for all 10 contracts, someone was fulfilling the performance monitoring duties of a COTR. These individuals were aware that they were the designated COTRs, despite the absence of appointment letters in the files. However, four of these COTRs were allowing others to approve bills and invoices before they were submitted to the Business Support Service to be paid. In addition, none of the COTRs had received recent training on COTR duties.

The facility's contracting problems occurred because there had been little or no oversight of the contracting program at either the local or VISN level, and the contracting officers routinely bypassed required procedures to expedite contract processing.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Facility Director requires that contracting officers: (a) comply with policies and procedures pertaining to the contracting process and administration; (b) follow policies and procedures to properly extend contracts when applicable; and (c) provide COTRs with the necessary training and review designations of COTRs to determine that they are current and appropriate.

The VISN and Facility Directors agreed with the findings and recommendations, and provided plans to improve contracting procedures. We will follow up on the planned actions until they are completed.

Quality Management – Aggregated Review Analyses, Documentation, and Medication Usage Evaluation Needed To Be Strengthened

Conditions Needing Improvement. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files. We concluded that the QM program generally provided appropriate oversight of patient care. However, improvement was needed in three areas.

Incomplete Patient Safety Aggregated Review Analyses. Facility managers and program coordinators had not analyzed their aggregated review data in the areas of adverse drug events, patient falls, missing patients, or parasuicidal behaviors. VHA policy requires facilities to conduct these aggregated review analyses on a quarterly basis.

Inconsistent Documentation. Facility managers and program coordinators did not consistently document the use of statistical tools in their data analyses. Documentation of corrective actions also needed improvement. We found inconsistent identification of evaluation criteria to use in measuring the effectiveness of actions. For example, the patient complaints report did not reflect analysis or actions taken regarding complaint findings, although the Patient Advocate asserted that analysis and actions had occurred.

Inadequate Medication Usage Evaluations. A review of Pharmacy and Therapeutics Committee minutes revealed that MUE activities were inadequate. For example, minutes did not demonstrate the monitoring and evaluation of selected drugs or drug classes, or the thorough analyses of adverse drug events.

Suggested Improvement Actions 1. We suggested that the VISN Director ensure that the Facility Director takes action to: (a) initiate thorough quarterly patient safety aggregated review analyses in adverse drug events, patient falls, missing patients, and parasuicidal behaviors; (b) ensure consistent QM documentation of data analyses, corrective actions, and evaluation criteria; and (c) improve MUE activities and documentation.

The VISN and Facility Directors agreed with the findings and suggestions, and provided plans to improve the quality management program. The planned improvement actions are acceptable.

Information Technology Security – Security Deficiencies Needed To Be Corrected

Conditions Needing Improvement. We reviewed IT security controls to determine if they adequately protected automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. With the recent change from a part-time to full-

time Information Security Officer (ISO), the facility had implemented several new IT security improvements. However, we identified five areas that required corrective actions.

Contingency Plan. The facility's contingency plan was incomplete. The plan should address procedures for responding to emergencies, ensuring that essential business functions can be conducted after disruption to IT support, and restoring facility processing capability. However, we found that sections of the plan that addressed major systems were only in draft format. The Chief of Information Management and the ISO stated that development of these sections was initiated in April 2003, with estimated completion at the end of June 2003.

System Testing. Testing of unplanned system downtime had only occurred on weekends, which excluded most of the weekday employees. CBOC employees were not included in the tests because the two CBOCs were not open on the weekends. An important purpose of system downtime testing is to familiarize using employees with procedures needed to ensure continuity of patient care and integrity of patient medical records during an unplanned loss of computer functions. The ISO agreed with the need for weekday testing to ensure effective employee response during emergencies.

Backup Data Storage. IT employees stored computer system backup tapes in a secured storage room approximately 220 yards from the main computer. VHA policy requires that the backup tapes be stored offsite, providing enough distance from the facility so that the backups would not be subject to the same vulnerabilities or catastrophic events.

Background Investigations. Human Resources Management Service (HRMS) employees, in conjunction with the ISO, did not consistently follow up on requests for background investigations sent to the VA Personnel Security Office. For example, background investigations for eight employees were requested in February 2001, but HRMS employees and the ISO had not followed up to determine if investigations had been completed.

Physical Security. The computer room did not have adequate entry controls to restrict and monitor access. VHA policy requires that all access to the computer room should be logged and reviewed. Access to the computer room at this facility was only logged intermittently.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the Facility Director takes action to: (a) complete the contingency plan; (b) perform system downtime testing during both weekday and weekend operations; (c) store system backup tapes offsite; (d) follow up on requests for background investigations; and (e) log and review access to the computer room.

The VISN and Facility Directors agreed with the findings and suggestions, and provided plans to improve information technology security. The planned improvement actions are acceptable.

Environment of Care – Safety Deficiencies in the Behavioral Health Unit and Nutrition and Food Service Needed To Be Corrected

Conditions Needing Improvement. Facility managers maintained a generally clean and safe environment of care. To ensure patient and employee safety, managers needed to make improvements in the inpatient Behavioral Health Unit and the NFS. To evaluate the environment of care, we toured selected clinical and non-clinical areas for general cleanliness, safety, infection control, and facility and equipment maintenance. We also inspected food preparation, service, dining, delivery, storage, and disposal areas in the Canteen Service and in the NFS. In addition, we interviewed managers and reviewed policies and procedures, committee minutes, and pest control logs.

Behavioral Health. The inpatient Behavioral Health Unit had wall-mounted fans and air conditioning units with lengthy electrical cords in unmonitored patient rooms. Patients could use these cords to harm themselves or others. Some of the cords were shortened before we left the facility.

Nutrition and Food Service. The NFS did not have an emergency eye wash station for employees. In the dry food storage area, the room temperature was too high for proper food storage. The Food Service Manager and the Safety Officer corrected some of these deficiencies before we left the facility.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the Facility Director takes action to: (a) remove or shorten exposed electrical cords in the inpatient Behavioral Health Unit and (b) install an emergency eye wash station and maintain proper temperatures in the NFS dry food storage area.

The VISN and Facility Directors agreed with the findings and suggestions, and provided plans to improve the environment of care. The planned improvement actions are acceptable.

Supply Inventory Management – Excess Prosthetics and Engineering Inventories Needed To Be Reduced and Controls Improved

Conditions Needing Improvement. Prosthetic and engineering supply inventories needed to be reduced and inventory management strengthened. VHA policy establishes a 30-day stock level goal and mandates that medical facilities use VA's Prosthetics Inventory Package (PIP) to manage prosthetics inventory, and Generic Inventory Package (GIP) to manage engineering inventory. The PIP and the GIP automated inventory control systems assist inventory managers to monitor inventory levels, analyze usage patterns, and order supply quantities necessary to meet current demands.

Prosthetics Supplies. Although the Prosthetics and Sensory Aids Service (PSAS) used PIP to manage the prosthetics inventory, the inventory amount exceeded the 30-day standard. As of April 2003, the PSAS stocked 395 items valued at \$42,882. To determine the accuracy of PIP-reported information and the reasonableness of inventory levels, we evaluated a judgment

sample of 10 items (value = \$8,819). For 5 of the 10 items, PIP-reported inventory balances were inaccurate because PSAS employees did not consistently update the PIP when items were issued. For 8 of the 10 sampled items, the stock levels exceeded 30-day supplies, with inventory levels ranging from 50 to 500 days of stock. For the 8 items, the estimated value of stock exceeding 30 days was \$3,000 or 34 percent of the total value of the 10 items. Excess inventory occurred because normal stock levels were not always consistent with current demands. By applying the 34 percent estimate of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock was about \$14,580 (34 percent x \$42,882 actual PIP value of stock).

Engineering Supplies. The Facilities Support Service (FSS) had substantial quantities of old electrical and plumbing supplies that had been purchased during the 1980s. However, few items in stock had current demand because FSS employees purchased most engineering supplies locally as needed. The FSS did not use the GIP or any other formal method to manage engineering supply inventory. To determine whether stock levels were reasonable, we reviewed a judgment sample of 10 engineering supply items (value = \$13,815). For seven sampled items that did not have regular use (value = \$12,870), stock levels were reasonable. However, for the other three items (value = \$945) FSS employees estimated that inventory would last about 1 year. Stock levels for these items could have been reduced to 30 days if appropriate controls such as normal stock levels and written inventory records had been established. For engineering supply items with current and recurring use, the GIP can be an effective inventory management tool and should be implemented in accordance with VHA guidance. Because FSS employees did not use the GIP or any other formal inventory systems, we could not determine the value of stock on hand or the value of excess stock for the entire inventory.

Suggested Improvement Action 4. We suggested that the VISN Director ensure that the Facility Director requires: (a) the PSAS to reduce prosthetics inventory and improve the accuracy of PIP data and (b) the FSS to reduce excess engineering inventory and implement the GIP.

The VISN and Facility Directors agreed with the findings and suggestions, and provided plans to improve supply inventory management. The planned improvement actions are acceptable.

Community Nursing Home Contracts – The Negotiation Process and Justification for Higher Rates Needed To Be Documented

Conditions Needing Improvement. VHA permits medical facilities to contract for community nursing home care to provide veteran patients a greater choice of nursing homes in close proximity to their families. Nursing home contract files should include PNMs that document the negotiation process, memorandums delegating authority to designated COTRs, and justifications and authorizations for prices that exceed the VA benchmarks. Such documentation is necessary to explain the purpose of the negotiations, establishment of contract prices, services procured, and the authority and limitations of the COTR.

As of May 2003, the facility had 16 nursing home contracts (estimated annual cost = \$417,000) to provide care for veterans at community nursing homes located throughout the state of Washington. Six contracts were active, with veteran patients placed in the nursing homes, at the time of our review. We reviewed the six contract files and found that none contained PNMs or memorandums designating COTRs. Three files did not have justifications or authorizations for rates that exceeded VA benchmark rates. Contract employees acknowledged that they had not obtained authorization from the facility Director for the higher rates.

Suggested Improvement Action 5. We suggested that the VISN Director ensure that the Facility Director implements procedures to: (a) prepare PNMs and memorandums designating COTRs for all nursing home contracts, and (b) document justifications and authorizations for rates that exceed VA benchmark rates.

The VISN and Facility Directors agreed with the findings and suggestions, and provided plans to improve community nursing home contracting processes. The planned improvement actions are acceptable.

VISN 20 Director Comments

Department of Veterans Affairs

Memorandum

Date: July 15, 2003

From: Network Director, VISN 20 (10N20)

Subj: Office of Inspector General Combined Assessment Program Report for the VISN 20 Jonathan M. Wainwright Memorial VA Medical Center (10N20/687)

To: Regional Director for Healthcare Inspections (OIG)
Director Management Review and Administration (105E)

1. Attached is the response for the Office of Inspector General Combined Assessment Program survey report from the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington. Also included are my comments and comments from the Director of the facility.
2. I appreciate the courtesy and cooperativeness shown by all members of your team throughout this review process.
3. If you have any questions regarding the report, please contact Kathie Buchholz, Walla Walla Quality Management Coordinator, at (509) 525-5200, extension 22995.

Sincerely,

/s/ Leslie M. Burger
Leslie M. Burger, MD, FACP

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: July 15, 2003

From: Director, Jonathan M. Wainwright Memorial VA Medical Center (687/00)

Subj: Office of Inspector General Combined Assessment Program Report for the
VISN 20 Jonathan M. Wainwright Memorial VA Medical Center (10N20/687)

To: Regional Director for Healthcare Inspections (OIG)
Director Management Review and Administration (105E)

We appreciated the opportunity for the Office of Inspector General to evaluate the programs of the Jonathan M. Wainwright Memorial VA Medical Center through the Combined Assessment Program. The Survey Team provided helpful guidance to our staff in an educational and productive manner. As we are a continuously improving organization, we welcome their recommendations and suggestions that will only help us to become a better organization. Thank you.

/s/ Timothy B. Williams
Timothy B. Williams
Director

**JONATHAN M. WAINWRIGHT MEMORIAL
VA MEDICAL CENTER**

Response to the Office of Inspector General Combined Assessment Report

Comment and Implementation Plan

1. Pharmacy Administration – Security and Accountability of Controlled Substances

Recommended Improvement Action 1. OIG recommended that the VISN Director ensure that the Facility Director implements procedures to: (a) review pharmacy access requirements for all non-pharmacy employees; (b) monitor access to the main pharmacy and controlled substances storage areas; (c) correct pharmacy door, lock, and window deficiencies; (d) ensure that controlled substances storage and dispensing areas meet current standards for vaults and security containers; (e) ensure that 72-hour counts are conducted; and (f) include all controlled substances in monthly inspections.

Concur with recommended improvement actions

a. Review pharmacy access requirements for all non-pharmacy employees:

Planned Action: Explore and decide on either eliminating non-pharmacist access by using pharmacy on-call to respond to off-tour medication needs or restrict access to off tour Medical Officer of the Day and VA Police by **August 29, 2003**. Incorporate disposition along with other security changes into a Pharmacy specific Access station policy and disseminate by **November 30, 2003**.

b. Monitor access to the main pharmacy and controlled substances storage areas:

Planned Action: Review and identify an alternative, cost effective, viable automated electronic security system that fully conforms with all VHA regulatory guidance; will be managed by the Chief of Pharmacy Service, incorporate staff identification with each access to controlled Pharmacy space; and allow for aggregate access reviews over defined timelines by individual, by **July 31, 2003**. Formulate a project proposal with required funding that includes this system with the other physical plant security renovations needed, i.e., doors, locks, window security, and procurement of a replacement class 5 series inpatient pharmacy safe for Medical Center Projects and Space Committee action **August 21, 2003**.

If adequate station funding is available, all planning and design work is to be completed and actual construction to begin by **November 1, 2003** and be completed by **April 1, 2004**. If VISN funding is required, the time frame may need to be extended.

c. Correct pharmacy door, lock, and window deficiencies:

Planned Action: As stated in b above - Formulate a project proposal with required funding that includes this system with the other physical plant security renovations needed, i.e., doors, locks, window security, and procurement of a replacement class 5 series inpatient pharmacy safe for Medical Center Projects and Space Committee action **August 21, 2003**. If adequate station funding is available, all planning and design work is to be completed and actual construction to begin by **November 1, 2003** and be completed by **April 1, 2004**. If VISN funding is required, the time frame may need to be extended.

d. Ensure that controlled substances storage and dispensing areas meet current standards for vaults and security containers:

Planned Action: As stated in b above - Review and identify an alternative, cost effective, viable automated electronic security system that fully conforms with all VHA regulatory guidance; will be managed by the Chief of Pharmacy Service, incorporate staff identification with each access to controlled Pharmacy space; and allow for aggregate access reviews over defined timelines by individual, by **July 31, 2003**. Formulate a project proposal with required funding that includes this system with the other physical plant security renovations needed, i.e., doors, locks, window security, and procurement of a replacement class 5 series inpatient pharmacy safe for Medical Center Projects and Space Committee action **August 21, 2003**. If adequate station funding is available, all planning and design work is to be completed and actual construction to begin by **November 1, 2003** and be completed by **April 1, 2004**. If VISN funding is required, the time frame may need to be extended.

e. Ensure that 72-hour counts are conducted:

Planned Action: Revise current pharmacy technician coverage by scheduling their weekly rotations as the "Controlled Substance Technician" with an alternate and one pharmacist. This coverage will incorporate the required 72-hour count of controlled substances and be implemented by **August 1, 2003**.

f. Include all controlled substances in monthly inspections:

Planned Action: Action to increase the monthly inspection from a sampling of controlled substances to include all controlled substances was taken on **July 1, 2003**. All future training will also address the requirement of a 100% review.

2. Service Contracts – Contracting Procedures

Recommended Improvement Action 2. OIG recommended that the VISN Director ensure that the Facility Director requires that contracting officers: (a) comply with policies and procedures pertaining to the contracting process and administration, (b) follow policies and procedures to properly extend contracts when applicable, and (c) provide COTRs with the necessary training and review designations of COTRs to determine that they are current and appropriate.

Concur with recommended improvement actions**a. Comply with policies and procedures pertaining to the contracting process and administration:**

Planned Actions: We have initiated a review, with the assistance of the newly appointed VISN Chief Logistics Officer, to identify specific areas that require procedural changes and to develop a comprehensive training program for staff. The VISN is working on a standardized format for contracts, and we will be working closely with the VISN CLO to follow VISN standards. In the meantime, we have developed the following plan:

- Create a modified checklist of documents appropriate for each contract.
- Set up a tabbed folder system to insure all necessary documents are on file and all contracts are completed in a standardized manner.
- Competitive contracts—include selection documentation for competitive contracts.
- Noncompetitive contracts—include sufficient information to support the price reasonableness and a price negotiation memorandum (PNM) that documents the negotiation process.
- Send all contracts as necessary to VACO for pre-award audits.

All new contracts will be monitored and adhered to by **January 1, 2004**.

b. Follow policies and procedures to properly extend contracts when applicable:

Planned Action: We comply with all policies and procedures to properly extend contracts as of **July 1, 2003**.

- c. **Provide COTRs with the necessary training and review designations of COTRs to determine that they are current and appropriate:**

Planned Action: We will provide training using the COTR training CD and COTR Handbook. Business Support Service will monitor and log all COTR training to assure compliance to VA policies and procedures. Initial training to all COTRs will be completed by **September 30, 2003**.

3. Quality Management – Aggregated Reviews, Documentation, and MUE

Suggested Improvement Actions. OIG suggested that the VISN Director ensure that the Facility Director takes action to: (a) initiate thorough quarterly patient safety aggregated review analyses in adverse drug events, patient falls, missing patients, and parasuicidal behaviors; (b) ensure consistent QM documentation of data analyses, actions, and evaluation criteria; and (c) improve MUE activities and documentation.

Concur with suggested improvement actions

- a. **Initiate thorough quarterly patient safety aggregated review analyses in adverse drug events, patient falls, missing patients, and parasuicidal behaviors:**

Planned Action: Since the visit by the Team, the Patient Safety SPOT database has been upgraded to enable data collection. Data collection for third quarter using SPOT will be completed by **July 30, 2003**. Aggregated reviews for adverse drug events, patient falls, missing patients, and parasuicidal behaviors will be completed by **September 30, 2003** and will continue each quarter as required.

- b. **Ensure consistent QM documentation of data analyses, actions, and evaluation criteria:**

Planned Action: Training for all appropriate committee chairs and recorders will occur by **September 30, 2003**. Continuous monitoring will be performed by the QM Coordinator.

- c. **Improve MUE activities and documentation:**

Planned Action: P&T Committee members will review their current MUE activities and make improvements to enhance MUE review by **October 1, 2003**.

The Chair of the P&T Committee and the recorder will attend the documentation training that will occur by **September 30, 2003**.

4. Information Technology Security – Security Deficiencies

Suggested Improvement Actions. OIG suggested that the VISN Director ensure that the Facility Director takes action to: (a) complete the contingency plan, (b) perform system downtime testing during both weekday and weekend operations, (c) store system backup tapes offsite, (d) follow up on requests for background investigations, and (e) log and review access to the computer room.

Concur with suggested improvement actions

a. Complete the contingency plan:

Planned Action: The Contingency Plan was completed on **June 30, 2003**.

b. Perform system downtime testing during both weekday and weekend operations:

Planned Action: Complete testing of systems, to include all shifts and all sites will be conducted by **August 30, 2003**.

c. Store system backup tapes offsite:

Planned Action: Weekly tape backups have been taken to a secure computer room site at the Walla Walla Corps of Engineers since **May 29, 2003**.

d. Follow up on requests for background investigations:

Planned Action: Human Resources managers have followed up on requests and results of background investigations since **May 27, 2003**.

e. Log and review access to the computer room:

Planned Action: Logs are now being used consistently. We are exploring a swipe-card electronic system for computer and PBX rooms. Plan completion by **July 31, 2003**.

5. Environment of Care – Safety Deficiencies in Behavioral Health and Nutrition and Food Service

Suggested Improvement Actions. OIG suggested that the VISN Director ensure that the Facility Director takes action to: (a) remove or shorten exposed electrical cords in the inpatient Behavioral Health Unit and (b) install an emergency eye wash station and maintain a proper temperature in the dry food storage area in the NFS.

Concur on all Suggested Improvement Actions

a. Remove or shorten exposed electrical cords:

Planned Action: All exposed electrical cords were removed or shortened by **June 30, 2003.**

b. Install an emergency eye wash station and maintain a proper temperature in the NFS dry food storage area:

Planned Action: The emergency eye wash station has been ordered and received on site. It is scheduled for installation by **August 15, 2003.**

The heavy-duty air conditioner to cool the dry food storage area and maintain proper storage temperatures was installed on **June 18, 2003.**

6. Supply Inventory Management – Prosthetics and Engineering Inventories

Suggested Improvement Actions. OIG suggested that the VISN Director ensure that the Facility Director requires: (a) the PSAS to reduce prosthetics inventory and improve the accuracy of PIP data and (b) the FSS to reduce excess engineering inventory and implement GIP.

Concur with suggested improvement actions

a. The PSAS to reduce prosthetics inventory and improve the accuracy of PIP data:

Planned Actions: A revised Medical Center policy is under development with specific CPRS Prosthetic consult templates that articulate specific criteria for provider use in requesting devices or sensory aids. This policy will address access control requirements (i.e., keeping store rooms locked and accessible only to authorized staff, for all decentralized prosthetic inventory locations) and a standardized method of ensuring accountability for all items issued, whether during the day or off-tour. Since these changes will require modification of

provider behavior and processes, education and training will be provided to amplify the critical need for accountability, the benefits of PIP and the greater efficiencies that can be achieved by early PSAS involvement with veterans requiring prosthetic assistance, before the policy is formalized and distributed. Concurrently, a complete physical inventory of all prosthetics supplies is being conducted to adjust present PIP balances to match the inventory. Thorough usage data, stock, and reorder levels will be established for each item in the PIP. All actions targeted for completion by **January 15, 2004**.

b. The FSS to reduce excess engineering inventory and implement GIP:

Planned Actions: Facility Support Service staff has initiated a review of inventory stock levels in all shops and will excess or otherwise dispose of items determined to be of low or no demand by **November 1, 2003**. Facility Support Service staff has started to work with Business Support Service staff to review and establish 30-day inventories for recurring items (materials, supplies and parts) and include them in the GIP automated inventory control system for routine ordering. This will be completed by **April 1, 2004**.

7. Community Nursing Home Contracts – Negotiation Process and Justification for Higher Rates

Suggested Improvement Actions. OIG suggested that the VISN Director ensure that the Facility Director implements procedures to: (a) prepare PNMs and memorandums designating COTRs for all nursing home contracts and (b) document justifications and authorizations for rates that exceed VA benchmark rates.

Concur with Suggested Improvement Actions

a. Prepare PNMs and memorandums designating COTRs for all nursing home contracts:

Planned Actions: All Community Nursing Home Contracts now have PNM and COTR designations on file as of June 30, 2003. Future new contracts will also have designations. We have implemented a tabbed system on all our contract files to insure the proper location of each of these items.

b. Document justifications and authorizations for rates that exceed VA benchmark rates:

Planned Actions: We have developed documentation for all rates that exceed Medicare as of June 30, 2003. In the future, all Nursing Home Medicaid rates will be reviewed prior to contract negotiations. Any nursing home falling out of the guidelines will be sent to the Medical Center Director for approval prior to awarding the contract.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit</u>	<u>Better Use of Funds</u>
(See Suggestion 3a)	Better use of funds by reducing excess prosthetics supply inventory	\$14,580

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Appendix D

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