Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through June 2003

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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) effort to ensure that high quality health care is 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 on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare inspectors evaluate how well the facility is meeting quality standards in specific core areas and the level of patient satisfaction with overall treatment.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct fraud and integrity awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, Members of Congress, or others.

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at the Veterans Health Administration Medical Facilities October 2002 through June 2003

1. This report summarizes recommendations and suggestions made in reports of Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews at the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities published during the period October 2002 through June 2003. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls.

2. During the period covered by this summary report, the OIG published 18 reports for CAP reviews conducted at VHA medical facilities. Each of the issues highlighted in this report resulted from identifying conditions at two or more medical facilities. We also provided fraud and integrity awareness training for about 4,300 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. The Office of the Under Secretary should ensure that all VHA directors and managers are advised of the issues identified in this summary report. We may follow up on the issues reported here in future CAP reviews and include new areas of inquiry.

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

Introduction

Background

During the period October 2002 through June 2003, the OIG published 18 reports for CAP reviews conducted at VHA medical facilities.

Scope of CAP Reviews

The scope of our CAP reviews is tailored to address both national and facility specific issues. Because the scope of review has been modified through time, the areas of inquiry described below were not necessarily reviewed at each medical facility included in this report. This report summarizes issues, reported in two or more CAP reports, for which recommendations or suggestions were made.

- Community Residential Care
- Contracting for Clinical Services and Sharing Agreements
- Contracting for Non-Clinical Services
- Controlled Substances Accountability
- Environment of Care
- General Post Funds
- Government Purchase Cards
- Homemaker/Home Health Aide Program
- Information Management Security
- Management of Equipment Inventories
- Management of Supply Inventories
- Management of Violent Patients
- Medical Care Collection Fund
- Patient Care and Quality Management
- Pharmacy Waiting Times, Security, and Prescription Refills
- Prosthetics
- Time and Attendance of Part-Time Physicians
- Vendor Visits/Gratuities

Fraud and integrity awareness briefings were also conducted during each of the 18 CAP reviews and about 4,300 VHA employees attended the briefings. The briefings included a film on the types of fraud that can occur in VA programs, discussions of the OIG's role in investigating criminal activity, and question and answer sessions.

CAP Reports Issued

The following 18 VHA medical facility CAP reports were issued during the period of October 2002 through June 2003.

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Lexington, KY	9	02-01933-3	10/16/2002
Combined Assessment Program Review, VA Medical Center Bronx, NY	3	02-01760-06	10/18/2002
Combined Assessment Program Review, VA Medical Center San Juan, PR	8	02-00868-15	11/13/2002
Combined Assessment Program Review, VA Medical Center Boise, ID	20	02-02582-36	12/20/2002
Combined Assessment Program Review, VA Medical Center Birmingham, AL	7	02-01432-39	12/24/2002
Combined Assessment Program Review, Northern Arizona VA Health Care System, Prescott, AZ	18	01-02641-40	12/26/2002
Combined Assessment Program Review, Chalmers P. Wylie VA Outpatient Clinic, Columbus, OH	10	02-01430-50	1/23/2003
Combined Assessment Program Review, VA Medical Center West Palm Beach, FL	8	02-01273-55	2/3/2003
Combined Assessment Program Review, VA Medical Center Atlanta, GA	7	02-02757-63	2/25/2003
Combined Assessment Program Review, VA Salt Lake City Health Care System	19	02-03263-68	3/7/2003
Combined Assessment Program Review, VA Medical Center Alexandria, LA	16	02-01985-77	3/26/2003

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Huntington, WV	9	02-02939-82	4/15/2003
Combined Assessment Program Review, VA Roseburg Healthcare System, Roseburg, OR	20	03-00699-83	4/22/2003
Combined Assessment Program Review, North Chicago VA Medical Center, North Chicago, IL	12	02-02171-89	4/30/2003
Combined Assessment Program Review, San Francisco VA Medical Center	21	02-00987-96	5/20/2003
Combined Assessment Program Review, James A. Haley VA Medical Center, Tampa, FL	8	02-03094-101	5/22/2003
Combined Assessment Program Review, VA Medical Center, Marion, IL	15	03-00760-102	5/27/2003
Combined Assessment Program Review, Houston VA Medical Center, Houston, TX	16	03-01379-115	6/19/2003

CAP Findings by VISN and by Medical Facility

Veterans Integrated Service Networks																			
CAP Findings	3	7		8			9		10	12	15	16		18	19	20		21
	VAMC Bronx, NY	VAMC Birmingham, AL	VAMC Atlanta, GA	VAMC San Juan, PR	VAMC West Palm Beach, FL	James A. Haley VAMC, Tampa, FL	VAMC Lexington, KY	VAMC Huntington, WV	Chalmers P. Wylie VA Outpatient Clinic, Columbus, OH	North Chicago VAMC, IL	VAMC Marion, IL	VAMC Alexandria, LA	Houston VAMC, Houston, TX	Northern Arizona VA HCS, Prescott, AZ	VA Salt Lake City HCS	VAMC Boise, ID	VAMC Roseburg, OR	San Francisco VAMC
Community Residential Care			●									●						
Contracting for Clinical Services and Sharing Agreements	●	●	●	●	●		●	●	●	●				●				●
Contracting for Non-Clinical Services	●	●	●	●	●	●							●					
Controlled Substances Accountability	●	●	●	●	●		●	●	●	●	●	●		●		●	●	●
Environment of Care	●		●			●	●		●	●	●				●		●	
General Post Funds							●									●		
Government Purchase Cards	●	●		●	●	●	●		●	●	●		●	●			●	●
Homemaker/Home Health Aide Program		●		●	●		●	●	●			●		●		●		●
Information Management Security	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Management of Equipment Inventories							●						●			●	●	
Management of Supply Inventories		●		●			●		●			●	●	●	●	●	●	
Management of Violent Patients										●	●		●				●	
Medical Care Collection Fund											●		●				●	
Patient Care and Quality Management	●	●	●	●		●			●			●		●	●	●	●	●
Pharmacy Waiting Times, Security, and Prescription Refills			●	●		●			●					●				●
Prosthetics		●	●	●								●				●		
Time and Attendance of Part-Time Physicians	●	●	●	●	●	●	●			●								
Vendor Visits/Gratuities	●	●														●		

SHADED = AREA REVIEWED AT THIS SITE
● = IMPROVEMENT NEEDED AT THIS SITE

Summary of CAP Findings

1. Community Residential Care (findings at 2 of 5 medical facilities)

- Ensure VA clinicians visit patients every 30 days as required.
- Document informed consent when patients are placed in homes that are not approved by VA.
- Provide employees with annual ethics training, including the subject of conflict of interest.

2. Contracting for Clinical Services and Sharing Agreements (findings at 11 of 18 medical facilities)

- Pursue a more cost effective contract arrangement with the university to provide compensation and pension examinations.
- Ensure contracting officers obtain cost data to support contract and VA/Department of Defense agreements and document price negotiation memorandums in contract files.
- Ensure officials developing, soliciting, awarding, and administering contracts comply with conflict of interest statutes.
- Ensure contracting officer's technical representatives (COTRs) effectively monitor contractor performance and compliance with contract terms.
- Ensure clinical services contracts include required clauses that facilitate performance monitoring.
- Verify time and attendance, and services provided by a service chief prior to paying for those services.
- Pursue recovery of overcharges in a timely manner.
- Implement controls to improve contract administration and compliance with VA procurement policies and procedures.
- Ensure network contracts for community nursing homes contain the required price negotiation memorandums and supporting documentation to justify actions such as exercising option years.

3. Contracting for Non-Clinical Services (findings at 7 of 14 medical facilities)

- Improve documentation of contract price determination and award decisions.
- Ensure COTRs verify work performed to detect and prevent over billing.
- Monitor contractor performance.
- Negotiate prices for noncompetitive contracts as required by Federal Acquisition Regulations.
- Provide refresher training to COTRs and Financial Resource Section staff regarding their responsibilities.

4. Controlled Substances Accountability (findings at 15 of 18 medical facilities)

- Properly schedule and conduct controlled substances inspections in all areas where these substances are stored.
- Correct physical security weaknesses.
- Maintain complete accountability records for all Schedule II-V controlled substances.
- Store unusable and expired controlled substances in sealed containers in the pharmacy vault, and properly witness and document custody and destruction of these substances.
- Account for unusable and expired controlled substances in monthly inspections.
- Develop and document a training program for controlled substances inspectors.
- Complete monthly controlled substances inspections within 1 day.
- Reduce excessive inventories of controlled substances.
- Report missing controlled substances to the OIG.
- Update facility policies to include reporting requirements regarding the loss of controlled substances and reference to current VHA policies.

5. Environment of Care (findings at 9 of 11 medical facilities)

- Improve pest control.
- Initiate work orders timely and complete work satisfactorily.
- Provide clean and odor-free patient care areas and public areas, including public restrooms.
- Conduct frequent random environmental rounds.
- Improve patient safety by storing potentially dangerous objects and substances out of reach of patients.
- Keep patient care and food preparation areas clean and establish deep-cleaning schedules.
- Thoroughly clean and maintain all Canteen areas.

6. General Post Funds (findings at 2 of 3 medical facilities)

- Obtain donation letters specifying how donations are to be used.
- Document the purpose of expenditures.
- Monitor deposits and expenditures.

7. Government Purchase Cards (findings at 13 of 18 medical facilities)

- Ensure acquisition personnel, including purchase cardholders, use the designated Federal Supply Schedule or national contracts before making open market purchases.
- Ensure purchase cardholders do not engage in "purchase splitting."[1]
- Ensure purchase cardholders and approving officials reconcile and certify invoices timely.
- Provide purchase cardholders and approving officials adequate, documented training.

[1] Purchase splitting involves separating a single purchase into two or more procurements to circumvent the purchase card dollar limit or cardholder's warrant limitation. Purchase splitting is also employed to avoid requirements for competition in the procurement of higher value goods and services.

- Ensure adequate separation of duties over purchase card activities.
- Conduct monthly and/or quarterly audits of purchase card transactions, as required.
- Ensure telecommunications services are not procured with purchase cards.
- Provide appropriate warrants to purchase cardholders with purchase limits in excess of $2,500 and ensure interim warrants are properly granted and used.
- Cancel purchase cards for employees routinely failing to comply with purchase card policies and procedures.

8. Homemaker/Home Health Aide Program (findings at 10 of 12 medical facilities)

- Consider the prevailing state Medicaid rates when contracting for services.
- Complete and document interdisciplinary assessments for all patients referred to the program.
- Ensure program coordinators and billing staff coordinate when a patient is hospitalized or otherwise no longer receiving services.
- Obtain and review quarterly performance improvement and patient assessment reports to evaluate the quality of care and need for continued service.
- Ensure clinicians reassess the need for services at 90-day intervals.
- Conduct visits or make telephone contacts with veterans to assess their satisfaction with services.
- Ensure all bills are reconciled timely and program coordinators are notified of discrepancies between services authorized and services actually provided.
- Ensure patients receiving services meet clinical eligibility requirements.
- Complete and document interdisciplinary initial and follow-up assessments for all patients referred to the Homemaker/Home Health Aide Program.

9. Information Management Security (findings at 18 of 18 medical facilities)

- Develop a consolidated and comprehensive information security contingency plan that contains all required elements.

- Monitor access to the computer rooms.
- Perform background checks on Information Resources Management (IRM) Service staff.
- Ensure major information systems are certified and accredited.
- Ensure the Information Security Officer is qualified, trained, and reports to the Director or Associate Director.
- Monitor access to computer-based employee-patient records.
- Periodically review authorized users to determine if they still have a legitimate need for access.
- Store computer back-up tapes in a secure off-site location.
- Remind all employees to log off computers when leaving their workstations.
- Require IRM Service employees to back-up server configurations on a computer at the back-up facility.
- Issue policy on, and monitor, remote Local Area Network usage.
- Terminate employee system access when employment ends.
- Certify that sensitive data has been removed from equipment with storage media before disposing of the equipment.
- Correct physical security deficiencies in computer rooms and other information technology locations.
- Document appropriate security clearances and sensitivity level information for key employees.

10. Management of Equipment Inventories (findings at 4 of 6 medical facilities)

- Validate and update equipment inventory lists annually.
- Conduct equipment inventories.
- Implement procedures to correct and update inaccurate and incomplete equipment inventory lists.

11. Management of Supply Inventories (findings at 10 of 12 medical facilities)

- Fully implement the Generic Inventory Package (GIP) for all inventory points.
- Improve accuracy and update GIP data.
- Provide GIP training to all inventory managers.
- Eliminate stock in excess of a 30-day supply.

12. Management of Violent Patients (findings at 4 of 4 medical facilities)

- Document analyses of violent patient incidents in committee minutes and post alerts about potentially violent patients in the Veteran Health Information System and Technology Architecture computer system.
- Provide annual Prevention Management of Disturbed training to all employees working in high-risk areas.
- Establish an interdisciplinary committee to review violent or threatening patient incidents and make recommendations about the management of patients who display these behaviors.
- Establish processes that ensure Psychiatric Crisis Teams conduct debriefing sessions after emergency responses.
- Implement procedures for involving clinicians in violent patient incident reviews.

13. Medical Care Collection Fund (findings at 3 of 3 medical facilities)

- Implement procedures to obtain and update veteran insurance information at the time of treatment.
- Pursue Medical Care Collection Fund accounts receivable more aggressively.
- Eliminate the backlog of unprocessed insurance bills and bill promptly.

14. Patient Care and Quality Management (findings at 12 of 18 medical facilities)

- Ensure employees consistently follow procedures to positively identify patients.
- Monitor all significant Quality Management (QM) action items until resolved.
- Consider peer review data in re-privileging decisions.
- Monitor safety and quality control.
- Develop and document appropriate corrective actions for Level 2 and Level 3 peer review findings.
- Document and analyze patient complaints and direct patient complaints to service chiefs or QM program staff.
- Develop procedures for the implementation and tracking of Root Cause Analysis corrective actions until issues are resolved.
- Perform better follow-up on recommendations from boards of investigations and improve documentation of resolution and follow-up of QM reviews.
- Aggregate and trend peer review outcomes.
- Analyze and use QM data to improve the quality of patient care.
- Ensure the Professional Standards Board reviews and documents Level 3 peer review findings.
- Improve reviews of responses to cardio-pulmonary episodes.
- Collect and trend performance improvement data, and use the data to make patient care decisions.
- Analyze mortality data to identify patterns or trends.

15. Pharmacy Waiting Times, Security, and Prescription Refills (findings at 6 of 10 medical facilities)

- Verify that the patient receives all medications before he/she leaves the dispensing window.
- Reduce waiting times for prescriptions.

- Improve the physical security of the dispensing area.
- Provide privacy hoods for access keypads.
- Provide an alarm for the pharmacy.

16. Prosthetics (findings at 5 of 6 medical facilities)

- Obtain physicians' prescriptions before issuing equipment, supplies, and accessories.
- Inventory durable medical equipment stored in a contractor's warehouses and reconcile with VA records.
- Determine veterans' eligibility for eyeglasses before ordering eyeglasses from vendors.
- Properly enter data into the national prosthetics database.

17. Time and Attendance of Part-Time Physicians (findings at 8 of 14 medical facilities)

- Ensure physicians are present at the medical center during their tours of duty.
- Cease improper payments to part-time physicians for on-call status.
- Ensure timekeepers verify physicians' attendance, and conduct semi-annual audits of timekeepers' records.
- Ensure part-time physicians designate their core hours.
- Provide required training to all timekeepers.
- Adjust surgeons' hours of work consistent with their workload levels.
- Train all physicians and their supervisors on VA time and attendance policies.

18. Vendor Visits/Gratuities (findings at 3 of 9 medical facilities)

- Prohibit vendor representatives from visiting the medical facility without appointments.
- Discontinue allowing vendors to provide employees with meals that exceed annual dollar limitations on such gifts.

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