Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Coatesville VA Medical Center Coatesville, Pennsylvania

Report No. 03-02278-08

October 29, 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 July 21–25, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Coatesville VA Medical Center (medical center), which is part of Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 266 employees.

Results of Review

Fiscal Service staff had effective controls in place for identifying and pursuing health insurance and current and former employee accounts receivable. Unliquidated obligations were reviewed monthly and canceled when not needed. Fiscal Service staff performed annual quality assurance reviews and monthly reconciliations of General Post Funds and Personal Funds of Patients. To improve operations, the VISN and medical center Directors needed to:

- Reduce excess engineering supply inventory and strengthen inventory management controls.
- Seek competition for procurements greater than $2,500 and properly safeguard engineering equipment and supplies purchased by cardholders.
- Strengthen accountability over controlled substances.
- Improve documentation of QM peer review results and follow-up.
- Improve oversight of the Community Residential Care Program.
- Correct an information technology security deficiency.
- Implement controls over physician conflict of interest.
- Consider establishing contracts for recurring procurements.
- Correct minor environment of care issues.

VISN 4 Director and Medical Center Comments

The VISN 4 Director and medical center Director agreed with the CAP review findings and provided acceptable improvement plans. (See pages 13-22 for the full text of the Directors' comments.) We consider all review issues to be resolved but may follow up on implementation of planned improvement actions.

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

Introduction

Medical Center Profile

Organization. Located in Coatesville, PA, the medical center is a specialty referral, transitional care, and neuropsychiatric facility. Primary care and mental health services are provided at five community-based outpatient clinics (CBOCs) located in Springfield, Spring City, Philadelphia, Reading, and Lancaster, PA, as well as two CBOCs located in Ventnor and Vineland, NJ. The medical center is part of VISN 4 and serves a veteran population of about 761,250 in a primary service area that includes 22 counties in Pennsylvania, Delaware, and New Jersey.

Programs. The medical center provides inpatient bed programs in medicine, psychiatry, nursing home care, and domiciliary care. The medical center also provides care in many specialized programs such as; geriatrics, dementia, substance abuse, post-traumatic stress, homelessness, mental health intensive case management, and women's health. The medical center has 533 hospital beds that include 225 in nursing home care. Other specialized services include contract nursing home, community residential care, mental hygiene clinic, physical medicine and rehabilitation therapies, homemaker/home health aide, end of life care, neurology, and pulmonary medicine. Two community-style living programs for discharged veterans are operated on the grounds of the medical center through sharing agreements.

Affiliations and Research. For nursing programs, the medical center maintains affiliations with Villanova University, Temple University, West Chester University, Immaculata University, Wilmington College, and Brandywine Hospital School of Nursing. Physician assistant affiliations are held with Hahnamann University and the Philadelphia College of Osteopathic Medicine. In Fiscal Year (FY) 2002, the medical center research program had 34 projects and a budget of about $850,000. Important areas of research include post-traumatic stress, neuroscience, clinical drug trials, and dietetic studies.

Resources. In FY 2002, medical center medical care expenditures totaled $99.2 million. The FY 2003 medical care budget is $107.4 million, 8.3 percent more than FY 2002 expenditures. FY 2002 staffing was 1,085 full-time equivalent employees (FTEE), including 34.4 physician and 320.4 nursing FTEE.

Workload. In FY 2002, the medical center treated 21,246 unique patients, a 14 percent increase from FY 2001. Medical center management attributed the increase in unique veterans treated to Medicare Health Maintenance Organizations dropping prescription drug coverage and these veterans using the medical center. The inpatient care workload totaled 1,513 discharges, and the average daily census, including nursing home patients, was 494. The outpatient workload was 134,534 visits.

Objectives and Scope of the 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 medical center operations for FY 2002 and FY 2003 through June 30, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Accrued Services Payable and Undelivered Orders
Clinic Appointment Scheduling
Community Residential Care Program
Contract Award and Administration
Controlled Substances Accountability
Delinquent Accounts Receivable
Engineering Supply Management
Environment of Care
General Post Funds
Government Purchase Card Program
Information Technology Security
Medical Care Collections Fund Billing
Medical/Surgical Supplies Management
Non-Contract Procurements
Personal Funds of Patients
Pharmacy Security
Physician Conflict of Interest
Physician Time and Attendance
Prompt Payment and Interest Payments
Quality Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-12). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center 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 medical center employees, 110 of whom responded. We also interviewed 13 inpatients and 21 outpatients during the review. The full survey results were provided to medical center management.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 266 employees, 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

Accounts Receivable Billing and Collection Efforts Were Effective. Fiscal Service had effective controls in place for identifying and pursuing health insurance and current and former employee accounts receivable. Medical Care Collections Fund staff were timely billing insurance carriers and forwarding unpaid bills to the collection agency 91 days after the bills' due dates. The current and former employee debts were aggressively pursued for collection through offset from current salary and/or referral to the Treasury Offset Program.

Unliquidated Obligations Were Properly Monitored. Fiscal Service staff reviewed unliquidated obligations monthly, contacted the appropriate services to determine the continued validity of obligations, and promptly cancelled obligations that were no longer needed.

General Post Funds Controls Were Sound. Fiscal Service staff performed annual quality assurance reviews and completed monthly reconciliations of General Post Funds. A review of General Post Funds activity showed that expenditures were made for the benefit of the patients.

Personal Funds of Patients Were Monitored. Fiscal Service staff conducted required annual quality assurance reviews and performed monthly reconciliations. A review of inactive accounts found that follow-up attempts were being made to locate next of kin to disburse a patient's funds upon their death or discharge from the medical center.

Opportunities for Improvement

Supply Inventory Management – Excess Inventory Needed To Be Reduced and Controls Strengthened

Conditions Needing Improvement. Engineering supply inventory levels needed to be reduced and inventory management strengthened. The following conditions required management attention:

- Engineering Service had not effectively implemented the Generic Inventory Package (GIP) to manage the engineering supply inventory. The engineering supply inventory exceeded the 30-day standard.

- Engineering Service maintained a supply inventory of 1,631 line items valued at $143,710 as of June 30, 2003. We found that 1,256 (77 percent) of the 1,631 line items valued at $110,196 were in excess of the 30-day standard. The engineering supplies ranged from a 10-month supply to several years worth of supplies.

- Acquisition & Materiel Management Service (A&MMS) staff had taken steps in the past to reduce excess supply items by making some items available to other VA facilities and the General Services Administration (GSA). However, greater effort in this area is needed.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the medical center Director implements controls to monitor engineering supply usage and reduce excess engineering supply inventory levels.

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

Government Purchase Card Program – Purchases Needed To Be Made Competitively and Accountability of Engineering Items Improved

Conditions Needing Improvement. Cardholders needed to seek competition for purchases over $2,500 and management needed to improve accountability of engineering items purchased by cardholders. The following conditions required management attention:

- Cardholders did not seek competition or document sole source justifications for purchases exceeding $2,500 made on the open market. Four cardholders did not seek competition for 28 (56 percent) of 50 sampled transactions totaling $133,594. The Federal Acquisition Regulation (FAR) requires purchasing officials to promote competition, to the maximum

extent possible, to obtain supplies and services from the source whose offer is most advantageous to the Government.

- The 28 purchases in question included 22 stair lifts, and 6 orders of immune globulin. The stair lifts and immune globulin were available from Federal Supply Schedule (FSS) vendors. We obtained information from the National Acquisition Center database that showed that the medical center could have received lower prices for the stair lifts and immune globulin. A comparison of prices paid by the medical center to prices offered by FSS vendors indicated the medical center could have paid $14,375 less for the stair lifts and $37,627 less for the immune globulin. Based on these estimates, VA could have potentially saved $52,002 by procuring these supplies from FSS vendors.

- Purchase cardholders did not consider FSS vendors offering durable medical equipment and pharmaceuticals prior to procuring these supplies on the open market. The FAR requires cardholders to consider FSS vendors before making open market purchases.

- Approving officials did not ensure appropriate efforts were made to support competition. Approving officials certified the transactions without ensuring the existence of documentation to support efforts to seek competition. VA policy requires that approving officials ensure compliance with the FAR.

- We were unable to locate 12 (16 percent) of 75 Engineering Service items valued at approximately $2,000 that were purchased with Government purchase cards and that could easily be converted to personal use. These items included grounds maintenance equipment totaling $1,087 and automotive components totaling $919 purchased from two vendors from July 22, 2002 to April 23, 2003. Accountability over Engineering Service items should be strengthened to better safeguard Government property. This could be accomplished by maintaining a log to document who received the item, date received, date placed in service, description, warranty, model number, serial number, and location. We referred the missing items to the OIG Office of Investigations for review.

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

(a) Cardholders to seek competition and use FSS vendors for procurements exceeding $2,500 or document sole source justifications.

(b) Approving officials ensure that cardholders document efforts to support competition.

(c) The Chief, Engineering Service to strengthen accountability over Engineering Service items.

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

Controlled Substances Accountability – Policy, Inspection Procedures, and Pharmacy Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to improve local controlled substances policy, controlled substances inspection procedures, and pharmacy controls. The following conditions required management attention:

- The medical center policy did not include the requirement that the Director report the loss of controlled substances to the OIG Office of Investigations and the medical center Police Service. Also, the local policy did not include required Veterans Health Administration (VHA) policies covering: procedures for the ordering and receiving of controlled substances, and procedures for outpatient prescriptions not picked up at the outpatient window.

- Controlled substances contained in automated dispensing machines at the CBOCs in Springfield and Spring City were not inspected, as required.

- Controlled substances held for destruction in the pharmacy vault were not inspected monthly, as required.

- Medical center procedures for ordering and receiving controlled substances did not comply with VHA policy. Separation of duties did not exist because the same pharmacy technician ordered and received controlled substances.

- Discrepancy resolution was not timely for 72-hour inventories conducted for the 3-month period of March 1, 2003 through May 31, 2003. For example, during an April 8, 2003 inventory, there were 10 less Lorazepam tablets on hand compared to the inventory record. The discrepancy was resolved 17 days later on April 25, 2003. Action should be taken to resolve discrepancies when they are identified.

- Controlled substances held for destruction were not stored in a sealed envelope with two dated signatures on the seal and the closure of the envelope reinforced with clear cellophane tape covering the signatures, as required by VA policy.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the medical center Director improve controlled substances accountability by requiring that:

(a) Comprehensive local policy relating to controlled substances inspections is developed and followed, including reporting requirements regarding the loss of controlled substances.

(b) Controlled substances at the CBOCs be inspected monthly, including those held for destruction.

(c) Separation of duties be maintained for the ordering and receiving of controlled substances and that a Pharmacy Service employee and an A&MMS employee are the receipt witnesses.

(d) Pharmacy Service resolves discrepancies in 72-hour inventories when they are identified.

(e) Controlled substances held for destruction are stored in sealed envelopes with two dated signatures and reinforced with clear cellophane tape covering the signatures.

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

Quality Management – Documentation of Peer Review Results and Follow-up Needed To Be Improved

Conditions Needing Improvement. The QM program policies and procedures on documentation of peer review results and follow-up needed to be improved. The following conditions required management attention:

- Medical center policy governing peer reviews requires that providers that are subjects of peer reviews be informed of peer review results and be given an opportunity to respond to the peer review conclusions. Our review of the peer review process showed that the medical center did not document follow-up with providers on peer review results or other issues discussed during peer reviews. The Chief of Staff (COS) told us that he meets with the provider after each peer review to inform the provider of the peer review result and to provide an opportunity for a response. However, because these meetings are not documented, there is no evidence that providers subject to peer reviews have been informed of peer review results or that providers were given the opportunity to respond to the peer review conclusions. The COS agreed to revise the peer review policy to require documentation of communication of results to the provider as well as the provider's response.

- Medical center policy requires that the medical center Medical Executive Board (MEB) follow up on administrative and clinical process issues that are addressed during peer reviews and that the Quality Improvement (QI) coordinator include such issues in the annual QI program. Our review of three peer reviews of medical center providers showed that medical center managers did not consistently follow up to correct administrative and clinical process problems discussed during the peer review process.

- Administrative and clinical issues that were discussed during peer reviews were not reported to the MEB for follow up. The QI coordinator told us that follow up of peer review results was the responsibility of the COS. The COS told us that he addressed administrative and clinical process issues discussed during peer reviews but that confidentiality requirements of peer reviews prohibited disclosing peer review results to the MEB. This process prevented follow up of administrative and clinical process deficiencies by the MEB and inclusion of these issues in the QI program. The COS agreed with us that administrative and clinical issues discussed during the peer review process could be reported separately to the MEB without violating confidentiality requirements.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the medical center Director revise the peer review policy and require:

(a) Documentation of communication of peer review results to the provider as well as the provider's response.

(b) Administrative and clinical process issues discussed during peer reviews are reported separately to the MEB for follow up and included in the QI program.

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

Community Residential Care Program – Several Program Areas Needed Improvement

Conditions Needing Improvement. Medical center management needed to improve controls over the Community Residential Care (CRC) Program. A review of 10 patients' medical records and medical center records for 10 CRC homes identified the following conditions that required management attention:

- For the 10 patients reviewed, we found that changes in medications and mental or physical status were not recorded in the medical records. CRC sponsors were not informed about changes in the 10 patients' medical conditions. VA policy requires the medical center case manager or social worker to provide CRC sponsors with updated medical information and document this in patients' medical records.

- For 9 of 10 veterans who had fiduciaries and received VA funds, there was no evidence in the veterans' medical records that showed that Veterans Benefits Administration (VBA) field examiners and medical center clinicians communicated annually to discuss relevant patient information, as required by VA policy.

- Memoranda of Understanding (MOUs) and fee schedules were not included in CRC sponsor's home records, as required by VA policy.

- VA program managers did not obtain documentation that CRC employees were in compliance with state regulations requiring CRC employees to sign statements that they have no criminal record. The State of Pennsylvania requires that CRC employees sign a statement that they have no criminal record and provide this document to the CRC sponsor.

- CRC home records contained no documentation that annual employee training had been provided, as required. The annual training is to include providing personal care, medication management, nutritional care, and fire and safety procedures.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the medical center Director requires that:

(a) Case managers or social workers document changes in medical conditions in patient medical records and inform CRC sponsors of these changes.

(b) Medical center clinicians communicate annually with VBA field examiners concerning patients with fiduciaries.

(c) MOUs addressing CRC services and fees for services provided are developed and placed in the CRC sponsors' records.

(d) CRC employees are in compliance with the State of Pennsylvania's regulations concerning criminal background statements.

(e) Annual employee training is provided and documented.

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

Information Technology Security – Deficiency Needed To Be Corrected

Condition Needing Improvement. The following information technology security condition required management attention:

- The contingency plan did not include a designated alternate processing facility. One key element of an effective contingency plan is the designation of an alternate processing facility that can be used during disaster recovery. An alternate processing facility can provide backup automated information system (AIS) services in the event that the primary facilities are severely damaged or the AIS could not be accessed. VHA policy requires facilities to develop and implement information system contingency and recovery plans.

Suggested Improvement Action. We suggested that the VISN Director ensure that the medical center Director takes action to designate an alternate processing facility that could be used during disaster recovery.

The VISN Director and medical center Director agreed with the finding and suggestion, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans.

Physician Conflict of Interest – Controls Needed To Be Implemented

Conditions Needing Improvement. The following physician conflict of interest issue required management attention:

- VA policy requires that the COS and each physician, clinician, or allied health supervisor or manager receives a copy of VHA Handbook 1660.3 and signs a VA Form 10-21009, Acknowledgement Form. The acknowledgement form requires a signature, acknowledging that the individual has received, read, and agrees to abide by the guidance in the handbook pertaining to the conflict of interest aspects of contracting for scarce medical service contracts. Medical center managers indicated that this policy had not been implemented.

Suggested Improvement Action. We suggested that the VISN Director ensure that the medical center Director requires the COS and each physician, clinician, or allied health supervisor or manager to receive a copy of VHA Handbook 1660.3 and sign the acknowledgment form regarding conflict of interest.

The VISN Director and medical center Director agreed with the finding and suggestion, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans.

Non-Contract Procurements – Contracts Should Be Established For Recurring Needs

Conditions Needing Improvement. Facility management should consider establishing contracts for supplies that are procured on a recurring basis. The following conditions required management attention:

- Prosthetics Service made repetitive non-contract procurements for prosthetic appliances from one vendor totaling $107,000. As part of our review, we also found that improvement was needed in monitoring prosthetic procurements. Required quarterly reviews to ensure that prosthetic activities were in compliance with applicable acquisition and accounting regulations were not conducted.

- Engineering Service made repetitive non-contract purchases for electrical and industrial supplies from two vendors totaling $127,000.

- Environmental Management Service made repetitive non-contract purchases for sanitation supplies from one vendor totaling $112,000.

- The Chief Information Officer made repetitive non-contract purchases for computer supplies from one vendor totaling $46,000.

Suggested Improvement Action. We suggested that the VISN Director ensure that the medical center Director:

(a) Consider establishing contracts for the above recurring procurements.

(b) Conduct quarterly reviews of prosthetic purchasing activities.

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

Environment of Care – Minor Cleanliness, Security, and Repair Issues Needed To Be Addressed

Conditions Needing Improvement. We inspected all clinical and administrative areas of the medical center and found the environment of care to be generally acceptable. However, we found several minor problems such as: paint peeling around the walls and broken tiles in the sterile processing room; a prescription pad left unsecured in an office desk in the Primary Care Clinic; and no splash guards on the bottom of storage shelving throughout the medical center. The medical center Director agreed with our suggestion to correct these minor deficiencies and submitted an action plan to resolve the issues.

Suggested Improvement Action. We suggested that the VISN Director ensure that the medical center Director implements planned corrective actions.

The VISN Director and medical center Director agreed with the finding and suggestion, and the VISN Director agreed with the medical center Director's corrective action plan. The medical center Director provided acceptable improvement plans.

Appendix A

VISN 4 Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 2, 2003

From: Network Director, VA Stars and Stripes Healthcare Network (10N4)

Subject: Response/Action Plan to Office of Inspector General Combined Assessment Program Report (Project No. 2003-02278-R1-0122)

To: Assistant Inspector General for Auditing (52)

1. I appreciate the opportunity to review the Office of Inspector General Combined Assessment Program draft report of the recent visit to the Coatesville VA Medical Center in July 2003. I have reviewed the comments and the implementation plan submitted by the Medical Center Director and concur with his remarks.

2. Please extend my appreciation to the review team for their thorough evaluation and report of their visit to the Coatesville VA Medical Center. Thank you.

/s/

LAWRENCE A. BIRO

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2003

From: Director, VAMC, Coatesville, PA.

Subject: Response/Action Plan to Office of Inspector General Combined Assessment Program Report (Project No. 2003-02278-R1-0122)

To: Assistant Inspector General for Auditing (52)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program draft report of the Coatesville VA Medical Center. I concur with all of the final recommendations, suggestions and monetary benefits identified in the OIG's report. Comments and the implementation plan are included with transmittal of this memorandum.

2. I am pleased with the outcome of the review. Please express my appreciation to the auditors and reviewers who conducted the review during the week of July 21, 2003 for their professionalism and efforts to assist in improving the medical center's operations and controls.

3. Should you have any questions regarding the comments or implementation plan, do not hesitate to contact me. Thank you.

/s/

GARY W. DEVANSKY

Appendix B

Medical Center Director's Comments
DRAFT REPORT OF COMBINED ASSESSMENT PROGRAM REVIEW
COATESVILLE VA MEDICAL CENTER
(Project Number 2003-02278-R1-0122)

OIG Recommendations

1. Supply Inventory Management – Excess Inventory Needed To Be Reduced and Controls Strengthened

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the medical center Director implements controls to monitor engineering supply usage and reduce excess engineering supply inventory levels.

Concur with recommended improvement actions:

A&MMS will continue to review the long supply items and reduce them if warranted. During August, A&MMS identified the long supply items and reduced this amount by 7 percent. The excess items were reported to other facilities and GSA. A&MMS is in the process of developing a secondary for "on call" items which will be charged out to the secondary. This will reduce the slow moving items and increase the turnover rate.

Target Date: December 1, 2004

2. Government Purchase Card Program – Purchases Needed To Be Made Competitively and Accountability of Engineering Items Improved

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the medical center Director require:

(a) cardholders to seek competition and use FSS vendors for procurements exceeding $2,500 or document sole source justifications;
(b) approving officials ensure that cardholders document efforts to support competition; and
(c) the Chief, Engineering Service to strengthen accountability over engineering service items.

a. Cardholders:

Concur with recommended improvement action:

A&MMS has met with Prosthetics Service and identified the mandatory source for stair lifts. Training will be provided during the quarterly reviews of prosthetic procurements to ensure mandatory sources and sole justifications are being utilized. A review of Globulin was conducted. We found the contract source was out of stock and had to be purchased from an open-market source. Prosthetics and Pharmacy staff was provided training on developing sole source justification memorandums and documenting competition on orders exceeding the threshold. The Purchase Card Coordinator will monitor the Citibank 041 report to identify possible procurements infractions.

Target Date: Ongoing

b. Approving Officials:

Concur with recommended improvement action:

A&MMS conducts the required follow-up training for cardholders and approving officials. Seeking competition and documenting sources is one of our training elements. A&MMS has developed a training announcement that is electronically sent to all cardholders and approving officials reminding them of this requirement. Failure to attend required training will result in discontinuation of purchase card use until training is accomplished. This requirement has also been added to the Financial Management and A&MMS audits for compliance.

Completed September 22, 2003

c. Chief, Engineering Service:

Concur with recommended improvement action:

FES has enhanced the internal controls of equipment purchased under the credit card program through development of a log for all purchases. The log will be completed for each control point by FES supervisors for equipment purchased. The log will include who received item, date received, date placed in service, description of item, warranty information, model number, serial number, location, and date taken out of service.

Target Date: October 1, 2003

3. Controlled Substances Accountability – Policy, Inspection Procedures, and Pharmacy Controls Needed To Be Strengthened

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the medical center Director improve controlled substances accountability by requiring that:

(a) comprehensive local policy relating to controlled substances inspections is developed and followed, including reporting requirements regarding the loss of controlled substances;
(b) controlled substances at the CBOCs be inspected monthly including those held for destruction;
(c) separation of duties be maintained for the ordering and receiving of controlled substances and that a Pharmacy Service employee and an A&MMS employee are the receipt witnesses;
(d) Pharmacy Service resolve discrepancies of 72-hour inventories when they are identified; and
(e) controlled substances held for destruction are stored in sealed envelopes with two dated signatures and reinforced with clear cellophane tape covering the signatures.

a. Comprehensive Local Policy

Concur with recommended improvement action:

The plan is to review and update, as necessary, CVAMC's MCP "Inspection & Review of Alcohol, Schedule II, III, IV and V Controlled Substances & Drug Records" (PC 32-03) to ensure compliance with the recently updated/revised VHA Handbook 1108.2 (Inspection of Controlled Substances). The updated/revised policy will include reporting requirements regarding the loss of controlled substances.

Target Date: Initiate needed procedure changes, beginning October 1, 2003. Issue revised policy by November 30, 2003.

b. Controlled Substances at CBOCs:

Concur with recommended improvement action:

CBOCs (Spring City & Springfield) having controlled substances (automatic dispensing carts) will be inspected as part of the monthly audit schedule. Inspection will include substances being held for destruction.

Target Date: October 1, 2003

c. Separation of Duties:

Concur with recommended improvement action:

Two-party receipt witnessing is in effect. A Pharmacy staff member, along with the PCL Business Manager (or designee), as of September 16, 2003, is assigned to document receipt of controlled substances.

Completed September 16, 2003

d. Pharmacy Service:

Concur with recommended improvement action:

As of September 15, 2003, 72 hr. inventory discrepancies are now resolved by COB on the inventory day.

Completed September 15, 2003

e. Controlled Substances Held For Destruction:

Concur with recommended improvement action:

Implemented this procedure change August 31, 2003.

Completed August 31, 2003

4. Quality Management – Documentation of Peer Review Results and Follow-up Needed To Be Improved

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the medical center Director revise the peer review policy and require:

(a) documentation of communication of peer review results to the provider as well as the provider's response; and
(b) administrative and clinical process issues discussed during peer reviews be reported separately to the MEB for follow-up and included in the QI Plan.

a. Documentation of Communication:

Concur with recommended improvement action:

The Medical Center Policy "Medical Staff Engagement in Quality Improvement and Peer Review" (MS-07-02) will be amended to require written documentation of communication of peer review results to the provider, as well as the provider's response. A template documenting these events will support this requirement

Target Date: November 15, 2003

b. Issues Discussed During Peer Reviews:

Concur with recommended improvement action:

The MCP "Medical Staff Engagement in Quality Improvement and Peer Review" (MS-07-02) will be amended to articulate the process for reporting peer review results to the MEB in a way that protects provider confidentiality but still gives accountability to the MEB. Administrative and clinical process issues will be followed by the MEB and included in the Medical Center's QI Plan. The above amendments will be included in a larger overhaul of the current MCP, in response to the new VHA Directive on Peer Review (currently in draft).

Target Date: November 15, 2003

5. Community Residential Care Program – Several Program Areas Needed Improvement

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the medical center Director requires that:

(a) case managers or social workers document changes in patient medical records and inform CRC sponsors of these changes;
(b) medical center clinicians communicate annually with VBA field examiners concerning patients with fiduciaries;
(c) MOU's addressing CRS services and fees for services provided are developed and placed in the CRS sponsor's records;
(d) CRC employees' are in compliance with the State of Pennsylvania's regulations concerning criminal background statements; and
(e) annual employee training is provided and documented.

a. Case Managers, Social Workers:

Concur with recommended improvement action:

All CRC homes have been assigned to a nurse and a social worker to provide continuity of care. Nurses will be available to sponsors to address the medical component of a patient's disease process. They will visit the homes monthly to specifically address changes in medication and medical status. Each visit will be documented in the patient's record and as well as in the sponsor's file.

Completed September 1, 2003

b. Medical Center Clinicians:

Concur with recommended improvement action:

On June 3, 2003, case management met with representatives from VBA to establish lines of communication concerning beneficiaries with fiduciaries who are receiving VA funds. These meetings will be planned annually and will address relevant patient information. All pertinent discussion will be documented in the patients' record.

Completed June 3, 2003

c. MOU's, Fees For Services

Concur with recommended improvement action:

Prior to July 23, 2003, a Memorandum of Understanding, identifying services provided to patients in a CRC home and individual room and board rates had been maintained in a separate file. On July 24, 2003, all CRC sponsor files were reviewed. An MOU, detailing services provided to the patients in the home and a schedule of fees for those services were placed in respective sponsor files.

Completed July 24, 2003

d. CRC Employees:

Concur with recommended improvement action:

A sponsor's agreement has been drafted, stating that the CRC home will be expected to have all applicants comply with State regulations regarding background security checks. Coatesville's CRC program requires all state approved homes' sponsors and their employees to sign a statement that they have no criminal record and provide documentation of same to the CRC coordinator.

Completed August 1, 2003

e. Annual Training

Concur with recommended improvement action:

Prior to July 23, 2003, training records for all sponsors were maintained in a separate file. On July 24, 2003, training records were consolidated and placed into sponsor files. In addition, copies of state training records were obtained and filed accordingly.

Completed August 1, 2003

OIG Suggestions

6. Information Technology Security – Deficiency Needed To Be Corrected

Suggested Improvement Action 1. We suggest that the VISN Director ensure that the medical center Director takes action to designate an alternate processing facility that could be used during disaster recovery.

Concur with suggested improvement action:

The VISN is working to establish a hot site for VISN facilities to use in the event of a disaster. In the mean time Coatesville VAMC is working on a Memorandum of Understanding with Wilmington VAMC.

Target Date: October 15, 2003

7. Physician Conflict of Interest – Controls Needed To Be Implemented

Suggested Improvement Action 2. We suggest that the VISN Director ensure that the medical center Director require the COS and each medical center manager physician to receive a copy of VHA Handbook 1660.3 and sign the acknowledgement form regarding conflict of interest.

Concur with suggested improvement action:

All physicians have received a copy of VHA Handbook 1660.3 and signed the acknowledgement form regarding Conflict of Interest. Process is in place to have all future hires receive the Handbook during the credentialing and privileging process. They will sign the acknowledgement form and it will be filed in their OPF at time of appointment.

Completed August 1, 2003

8. Non-Contract Procurements – Contracts Should Be Established for Recurring Needs

Suggested Improvement Action 3. We suggest that the VISN Director ensure that the medical center Director:

(a) consider establishing contracts for the above recurring procurements; and
(b) conduct quarterly reviews of prosthetic purchasing activities.

a. Establishing Contracts

Concur with suggested improvement action:

A&MMS has reviewed and identified the recurring procurements. A Blanket Purchase Agreement has been signed with W.W. Grainger covering the engineering supplies. Environmental products were reviewed and converted to Mashua's Blanket Purchase

Agreement. Prosthetics recurring procurements were reviewed. Open market procurements were changed to Federal Supply Schedule contracts. Consideration will be given to computer supply products.

Completed September 8, 2003

b. Quarterly Reviews

Concur with suggested improvement action:

A&MMS has developed a spreadsheet identifying criteria for the quarterly audits. Audits have been scheduled and are being conducted.

Completed August 4, 2003

9. Environment of Care – Minor Cleanliness, Security, and Repair Issues Needed To Be Addressed

Suggested Improvement Action: We suggest that the VISN Director should ensure that the medical center Director implements planned corrective actions.

Concur with suggested improvement action:

Sterile processing room paint peeling around walls and broken tiles have been repaired and walls repainted. Splashguards for storage shelving were purchased by A&MMS and installed on all shelving units. Prescription pads are kept locked or secured on the person of the provider.

Completed August 31, 2003

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by reducing excess engineering supply inventory.	$110,196
2a	Better use of funds by promoting competition to the maximum extent practicable.	52,002
	Total	$162,198

Appendix D

Report Distribution

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This report will be available in the near future on the VA OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.