Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System

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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 healthcare 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

From June 23 - 27, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Greater Los Angeles Healthcare System (healthcare system). The purpose of the review was to evaluate selected healthcare system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness briefings to 266 employees.

Results of Review

Healthcare system managers reduced specialty clinic wait times, and developed an improved system for reporting incidents to the Patient Safety Coordinator. We also found that community nursing home contracts were properly managed. To improve operations, the healthcare system needed to:

- Strengthen management controls to ensure part-time physician accountability.
- Reduce excess medical supply inventory and strengthen inventory management controls.
- Improve the Patient Complaints Program and use of benchmarks, outcome criteria, and implementation and evaluation of action items in the QM program.
- Improve administrative and clinical oversight procedures for the Community Residential Care Program.
- Correct safety deficiencies in selected patient care units and the canteens.
- Improve unannounced agent cashier audits and security.
- Ensure the Controlled Substances Inspection Program operates properly.
- Strengthen equipment inventory procedures.
- Enhance information technology contingency plans.
- Correct physical security deficiencies in the pharmacy.
- Ensure required service contract award procedures are followed.

VISN 22 Director Comments

The Veterans Integrated Service Network (VISN) 22 Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 17-31, for the full text of the Director's comments.) We will follow up on the implementation of recommended improvement actions.

This report was prepared under the direction of Mr. Brian Linton, CAP Review Coordinator, Los Angeles Audit Operations Division and Ms. Janet Mah, Director, Los Angeles Audit Operations Division.

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

Introduction

Healthcare System Profile

Organization. The healthcare system provides a broad range of tertiary inpatient care and outpatient healthcare services at its West Los Angeles and Sepulveda campuses. Outpatient care is provided at 3 Ambulatory Care Centers in West Los Angeles, Sepulveda, and Downtown Los Angeles and 10 community-based outpatient clinics located in Bakersfield, East Los Angeles, Gardena, Lancaster, Lompoc, Pasadena, Oxnard, San Luis Obispo, Santa Barbara, and Ventura. The healthcare system is part of VISN 22 and serves a veteran population of about 625,000 in a primary service area that covers 6 counties in California.

Programs. The healthcare system provides tertiary, primary, and long-term care in the areas of medicine, surgery, mental health, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The healthcare system has 280 hospital beds; 673 nursing home and domiciliary beds; and operates several regional referral and treatment programs, including specialty imaging, medical, surgical, and mental health services.

Affiliations and Research. The healthcare system is affiliated with the University of California, Los Angeles and University of Southern California Schools of Medicine and supports 315 medical resident positions in 16 training programs. In Fiscal Year (FY) 2002, the healthcare system's research program had 638 projects with funding totaling about $41.5 million.

Resources. In FY 2003, the healthcare system's medical care budget totaled about $406.9 million, a 14 percent increase from the FY 2002 budget of $357.8 million. Staffing through March 2003 was 3,741 full-time equivalent employees (FTEE), including 270.3 physician and 965.2 nursing FTEE.

Workload. In FY 2002, the healthcare system treated 9,549 unique patients, an 8 percent decrease from FY 2001. The decline resulted from increased emphasis on outpatient treatment that made some inpatient admissions unnecessary, and changes in staffing and availability of alternative community programs. The FY 2002 average daily census was 244 inpatients and 460 nursing home and domiciliary patients. The outpatient workload totaled 938,316 visits in FY 2002 (a 3 percent increase from FY 2001) and 458,486 outpatient visits in FY 2003 through March 2003.

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 healthcare services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected healthcare facility operations, focusing on patient care administration, 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 patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered healthcare system operations for FY 2002 and FY 2003 through June 14, 2003, and was conducted 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 15 activities:

Accounts Receivable	Information Technology Security
Agent Cashier	Medical Supply Inventory
Clinical Research Compliance	Part-Time Physician Accountability
Community Nursing Home Contracts	Pharmacy Security
Community Residential Care Program	Quality Management
Controlled Substances Accountability	Service Contracts
Environment of Care	Wait Times and Enrollment
Equipment Inventory	

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 - 16). 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 healthcare system management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all healthcare system employees, and we received 338 responses. We also interviewed 30 patients during the review. The survey results were discussed with healthcare system management.

During the review, we also presented 6 fraud and integrity awareness briefings that were attended by 266 healthcare system employees. The briefings 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

Patient Safety Reporting Was Improved for Veterans in Community Residential Care Facilities. As a result of several incidents involving veterans residing in Community Residential Care (CRC) facilities, managers developed an improved system for reporting incidents to the Patient Safety Coordinator. Managers provided training to CRC team members about what to report and how to enter an electronic Patient Incident Report into the computer system. Managers have observed an increase in reported incidents since these interventions.

Specialty Clinic Wait Times Were Reduced. Healthcare system managers analyzed wait times in specialty clinics such as eye, urology, and cardiology and found that some clinics and sites had shorter wait times than others. The managers held discussions with providers, specialty chiefs, and patients and made changes, such as offering patients earlier appointment dates at other healthcare system sites, to reduce wait times.

Community Nursing Home Care Contracts Were Properly Managed. The evaluation, negotiation, and award processes for community nursing home care (CNHC) contracts were satisfactory. In addition, the contracts were properly administered and the CNHCs' quality of care evaluations were timely performed on a monthly basis. During these evaluations, the CNHC Coordinator visited the facilities to ensure veterans were provided acceptable levels of care.

Opportunities for Improvement

Part-Time Physician Accountability – Management Controls Needed to Be Strengthened

Conditions Needing Improvement. Healthcare system managers needed to account for work accomplished by part-time surgeons and ensure that part-time surgeons submitted required subsidiary timecards. Part-time physicians, including surgeons, with VA appointments work either fixed or adjustable tours of duty of less than 40 hours a week. The physicians record and certify their work hours, leave, and excused absences by completing a subsidiary timecard (VA Form 4-5631a). Healthcare system managers are responsible for ensuring that part-time surgical staff meet the employment obligations of their VA appointments. Effective management controls also reduce the risk and the appearance of improprieties, such as the payment of part-time physicians for services that have not been provided or for work at the affiliate or a private practice while on VA time. We identified two areas where healthcare system managers needed to strengthen management controls to ensure part-time surgical staff accountability.

Accountability for Accomplished Work. Healthcare system managers could not adequately account for work accomplished during substantial portions of the part-time surgeons' tours of duty and therefore, could not ensure that the surgical staff's appointments were consistent with workload. To evaluate part-time surgical staff appointment levels and workload, we reviewed March 2003 healthcare system workload data for 29 part-time surgeons and attempted to account for work completed during their scheduled duty hours. Of the 29 part-time surgeons, 10 did not perform any surgeries and 4 of the 10 did not have any recorded clinical patient encounters. Overall, we found that 23 of the 29 (79 percent) part-time surgeons spent less than 50 percent of their time in documented patient encounters and the operating room. When we increased each part-time surgeon's workload by an additional 20 percent in an effort to account for other possible clinical and administrative work, 22 part-time surgeons were still below the 50 percent threshold.

Based on our review, healthcare system managers initiated their own workload review and identified instances where part-time surgeons who treated patients or supervised residents in clinics did not receive credit for clinical patient encounters. The healthcare system managers identified at least nine cases where part-time surgeons did not receive credit because they had not properly documented medical care provided or resident supervision in the patients' electronic medical records. Healthcare system managers believed the accountability issues raised by our review were attributable to medical record documentation deficiencies that caused patient encounter workload to be understated.

Time and Attendance Records. The timekeeper and responsible supervisor did not obtain all of the part-time surgeons' timecards before they prepared and certified the surgeons' official time and attendance records. For Pay Period 11, starting June 1 and ending June 14, 2003, two part-time surgeons were recorded and certified as present during their scheduled duty hours even though they had not submitted the required subsidiary timecards.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Acting Healthcare System Director establish controls to:

(a) correct medical care documentation problems and improve the accuracy of part-time surgical staff workload data;
(b) ensure the appointments of part-time surgical staff are periodically evaluated and adjusted, as needed, to be consistent with workload; and
(c) ensure that part-time surgical staff timecards are submitted and certified by responsible supervisors before timekeepers prepare official time and attendance records.

The VISN and Acting Healthcare System Directors agreed with the findings and recommendations. The Directors reported that as of October 2003, all providers had been instructed on the correct process for completing patient encounter forms in the Computerized Patient Record System. In addition, physician workload, and clinical and academic assignments had been reviewed and an analysis to identify needed appointment changes was initiated. The healthcare system also verified designations of Department Chairs, Section Chiefs, and clinical supervisors as certifying officials for time and attendance and planned to provide the above-mentioned staff appropriate time and attendance certification training. The healthcare system plans full implementation of the corrective actions by July 2, 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medical Supply Inventory Management – Excess Inventory Should Be Reduced and Inventory Management Controls Strengthened

Conditions Needing Improvement. The healthcare system needed to reduce excess medical supply inventory and use automated controls to manage inventory more effectively. The Veterans Health Administration (VHA) established a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage supply inventory. Materiel Management staff can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Materiel Management staff used GIP to manage medical supply inventory but did not use GIP inventory control tools such as the Inactive Item Report to meet the 30-day supply goal. As of April 2003, the 2 GIP primary inventory points included 736 line items with a reported value of about $459,006. To determine the accuracy of the quantities and value of stock reported in GIP and test the reasonableness of inventory levels, we reviewed inventory data and a judgmental sample of 10 medical supply items. We found two inventory management deficiencies.

Reported Stock Quantities and Value. Information in GIP did not accurately report the quantities of stock on hand and overstated the value of the medical supply inventory because Materiel Management staff did not properly record transactions or monitor supply usage rates. According to GIP, there were 7,851 units of the 10 medical supply items in our judgmental sample in stock with a value of about $112,722. However, a physical inventory disclosed that 7 of 10 items did not have accurate quantities recorded in GIP, and that there were 1,465 units of the 10 items in

stock with a value of about $44,239. Therefore, GIP overstated the quantity of the sampled items on hand by about 6,386 units and their inventory value by about $68,483 (155 percent).

Excess Stock. Materiel Management staff needed to improve medical supply inventory operations to achieve the 30-day supply goal. GIP data indicated that 107 of the 736 line items (14 percent) in the healthcare system's medical supply inventory had no demand during the 12-month period prior to our review. Of the 10 sampled items, 5 items had inventory levels ranging from about 35.8 days to 8.5 years. The value of the physical inventory that exceeded 30 days was $42,787, or 96.7 percent of the stock on hand for the 10 items.

The inaccuracies in GIP and excess stock occurred because Materiel Management staff were not properly recording transactions, monitoring supply usage rates, and adjusting GIP stock levels to meet the 30-day supply goal. Because GIP data were inaccurate, we could not readily determine the value of stock on hand or the value of excess stock for the entire inventory. Materiel Management staff stated that they had not fully implemented automated inventory management tools available in GIP and that they needed to reduce inventory levels, monitor supply usage, and adjust stock levels accordingly.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Acting Healthcare System Director implement procedures to:

(a) require the use of GIP automated tools;
(b) monitor supply usage rates;
(c) reduce medical supply inventory levels to the 30-day supply goal; and
(d) improve the accuracy of GIP data.

The VISN and Acting Healthcare System Directors agreed with the findings and recommendations. The Directors reported that specific stock quantity and value discrepancies identified during the CAP review had been corrected and periodic inventories had been scheduled through December 2003 to address any additional discrepancies. In addition, Materiel Management staff had begun reviewing GIP reports, including days of stock on hand, to adjust inventory levels where needed, and Supply Processing and Distribution technicians responsible for inventory have been scheduled for GIP training. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Quality Management – Patient Complaints, Benchmarking, Outcome Criteria, and Implementation and Evaluation Needed Improvement

Conditions Needing Improvement. To evaluate the QM program, we reviewed 16 specific program areas, such as performance improvement teams, root cause analyses (RCA), and patient complaints. We also assessed a range of 3 to 8 process steps, such as data analysis, use of benchmarks, and use of evaluation criteria in all 16 program areas, as applicable. We found that basic QM review processes were in place for 15 of 16 program areas reviewed. The Patient Complaints Program needed improvement in most of the process steps. Also, in the other 15 program areas, managers and program coordinators did not consistently compare facility results

with available benchmarks in data analyses, identify criteria to evaluate the effectiveness of all corrective actions, or implement and evaluate all actions. We interviewed relevant employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files.

Patient Complaints. We found that the Patient Complaints Program needed improvement in all three of the applicable process steps. While we found graphs of complaints by category, such as patient care or access, these data were not compared with past data or benchmarks. Program coordinators did not present the data analyses in any forum for discussion by clinicians who could benefit from the information. No conclusions or recommendations were made to address problem areas. VHA policies require that patient complaints be gathered, critically analyzed, and improvements acted upon as appropriate.

Benchmarking. Service chiefs and program coordinators had used benchmarks in data analyses in several monitoring functions, including medication usage evaluations and operative procedure reviews. However, they needed to compare facility results with available benchmarks, goals, or thresholds for all monitoring functions, as required by accreditation standards. The use of benchmarks was not documented in blood usage review, outcomes from resuscitation, or medical record quality.

Outcome Criteria. Service chiefs and program coordinators had identified criteria to use in determining whether corrective actions were effective in RCAs. However, they needed to identify criteria to evaluate the effectiveness of actions for all QM monitoring functions, as required by accreditation standards. Outcome criteria were not consistently defined for corrective actions identified in several review areas, including medication usage evaluations and outcomes from resuscitation.

Implementing and Evaluating QM Actions. We did not find evidence that service chiefs and program coordinators consistently implemented recommended QM actions in several review areas, including RCAs, administrative investigations, and medication usage evaluations, as required by accreditation standards. To provide reasonable assurances that responsible employees provide appropriate follow through, healthcare system managers need a strong system for ensuring that implementation and evaluation of all recommendations is completed.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director implement procedures to consistently:

(a) critically analyze, discuss, and act on patient complaints data;
(b) document use of available benchmarks;
(c) define outcome criteria for all identified corrective actions; and
(d) implement and evaluate all corrective actions until the problems are resolved or the desired improvements are accomplished.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that as of October 2003 the Patient Advocate Office had presented an analysis of the patient contacts to the Executive Leadership to identify issues for improvement, and provided the analysis to the appropriate service chiefs for action.

The healthcare system planned to research and include benchmarks for all QM review items as appropriate, and review all future documented corrective actions to assure associated outcome criteria. The Patient Safety Committee planned to review all corrective actions on a weekly basis to determine the status of recommendations and implementation along with the outcomes. In addition, the Executive Leadership planned to review and act on incomplete recommendations and unsatisfactory outcomes. The improvement actions are acceptable, and we consider the issues resolved.

Community Residential Care Program – Administrative and Clinical Oversight Procedures Needed Improvement

Conditions Needing Improvement. We found that Community Residential Care (CRC) Program managers generally provided an appropriate level of oversight to CRC patients in residential care facilities (RCFs). However, managers did not consistently ensure that the frequency of inspections complied with VHA policy, patients received annual physical examinations (PEs), clinicians routinely visited the patients, or that an annual meeting with Veterans Benefits Affairs (VBA) Fiduciary and Field Examination (F&FE) supervisors occurred. To evaluate compliance with VHA policies, we reviewed local policies and procedures, medical records, and RCF inspection files, and interviewed the Program Coordinator and QM personnel.

Clinical Oversight Inspections. VHA policy requires CRC managers to ensure that an interdisciplinary team consisting of a social worker, nurse, dietitian, and fire safety specialist conducts inspections of RCFs at least every 2 years. Of the 10 RCF inspection files we reviewed, we found that the CRC team did not inspect 2 RCFs over the last 24 months. The Program Coordinator told us that these RCFs were in the process of being phased out of the program due to poor compliance with inspection requirements. Three patients were residing at these facilities, and managers should have offered the patients alternate RCFs. If the patients chose to stay by signing a waiver, managers should have placed the RCFs in a hold status and stopped referring patients to them until the facility operators complied with inspection requirements.

Annual Fire and Safety Evaluations. In addition to the clinical team inspection, VHA policy requires that healthcare system fire safety inspectors annually evaluate RCFs for compliance with fire and safety standards. Of the 10 RCF files that we reviewed, only 2 had received the required annual evaluations. The Program Coordinator agreed that they needed to improve this process and told us that the RCF fire and safety evaluation would be standardized at the VISN level to ensure timeliness of inspections at all RCFs in their area of jurisdiction.

Annual Physical Examinations. Healthcare system clinicians are required to ensure that patients in RCFs received PEs annually. We reviewed 10 medical records and found that only 8 had documented evidence that clinicians had performed annual PEs. The Program Coordinator agreed that this area was problematic, especially for patients who elect to use their private physicians for some aspects of their health care. The Program Coordinator told us of several planned electronic enhancements to the CRC computer program, including an electronic alert reminding clinicians when PEs were due.

Monthly Visits. VHA policy prescribes that healthcare system clinicians visit patients in RCFs at least monthly. We reviewed 10 medical records and found that 3 did not contain evidence of the clinicians' visits every month. The Program Coordinator told us that visits were missed when clinicians were on extended leave or vacations.

Meeting With VBA. VA policies require F&FE supervisors to meet annually with appropriate VHA staff to discuss joint responsibilities and concerns involving incompetent veterans who have assigned fiduciaries. Such meetings provide opportunities to share information concerning the changing needs of veterans residing in RCFs and the observed conditions of the RCFs. The Program Coordinator was unaware of this requirement and told us he would incorporate the annual meeting into the CRC Program policy.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director require:

(a) the CRC team to conduct RCF inspections at least every 2 years;
(b) fire safety inspectors to conduct annual evaluations of RCFs;
(c) clinicians to perform and document annual PEs of patients in RCFs;
(d) clinicians to make and document monthly visits to patients in RCFs;
(e) the CRC Program Coordinator to arrange an annual meeting with VBA F&FE supervisors to discuss issues involving incompetent veterans with assigned fiduciaries; and
(f) Social Work managers to set up monitors to ensure ongoing compliance with these requirements.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that a new inspection program had been implemented, and plans and procedures had been developed to ensure that safety inspections were conducted every 12 months. The healthcare system was also coordinating resources to perform and document annual patient PEs, and had established monitors to ensure that clinicians make and document monthly visits to patients in RCFs. In addition, the healthcare system had initiated contact with VA Regional Office field examiners to discuss issues involving incompetent veterans, and had established monitors to ensure compliance. The improvement actions are acceptable, and we consider the issues resolved.

Environment of Care – Safety Deficiencies in Patient Care Units and Canteens Needed to be Corrected

Conditions Needing Improvement. Healthcare system managers maintained a generally clean and safe environment of care. However, we found that managers needed to address safety deficiencies in the chemical storage areas and canteens. To evaluate the environment of care, we inspected selected clinical areas for general cleanliness and safety. We also inspected food preparation, service, storage, and disposal areas in the Canteen Service and Nutrition and Food Service. In addition, we interviewed managers and reviewed policies and procedures, committee minutes, and pest control logs.

Chemical Storage. Potentially hazardous chemicals, such as craft paints, cleaning supplies, and disinfectants were found unsecured in several patient care areas, including the day treatment room at the Los Angeles Ambulatory Care Center and in the intensive care units and dialysis room on the West Los Angeles campus.

Canteen. Temperatures in all refrigerators at the West Los Angeles canteen were too high. The manager was aware of the problem, and new seals had been ordered. In addition, no emergency eyewash stations were available for staff. A recent inspection of all three healthcare system canteens by the Director, National Canteen Service (NCS) identified several additional items warranting corrective actions.

Pest Control. Although we received several written comments about pest problems from employees who responded to our survey, we found minimal evidence of pests in the patient care areas inspected. We observed small flying insects on two patient care units, which were possibly fruit flies or gnats. Managers explained that this is a recurring seasonal problem.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director take action to:

(a) properly secure all potentially hazardous chemicals;
(b) follow up on identified canteen deficiencies from our inspection, as well as from the recent NCS inspection; and
(c) monitor and treat patient care areas for reported pests, particularly on the two patient care units where we observed small flying insects.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that as of October 2003, all unsecured chemicals had been secured and/or placed in protective flammable lockers. In addition, all refrigerator door seals at the West Los Angeles canteen had been replaced, and all other deficiencies noted by the NCS Director had been corrected. The healthcare system also planned to treat patient wards for pests, and had implemented new Nursing and Environmental Management procedures for the handling and disposal of trash and waste. The healthcare system plans full implementation of the corrective actions by October 31, 2003. The improvement actions are acceptable, and we consider the issues resolved.

Agent Cashier – Unannounced Audits and Physical Security Should Be Improved

Conditions Needing Improvement. Fiscal Service managers needed to improve agent cashier controls in the areas of unannounced audits and physical security. VA policy requires that at least two staff skilled in fiscal or audit techniques perform an unannounced audit of cash assets at least every 90 days. Supplemental security equipment such as security surveillance television (SSTV) cameras may be installed to provide active detection of intrusion or illegal activity. To test agent cashier internal controls and ascertain potential weaknesses, we observed an

unannounced audit and evaluated the physical security of the agent cashier's office space. We also reviewed the results of the last three unannounced audits. We found that Fiscal Service staff conducted unannounced audits at least every 90 days; the agent cashier advance was adequate; and the cash box keys and safe combinations were properly safeguarded. We identified two areas where Fiscal Service managers could improve agent cashier controls.

Unannounced Audit. One of the two fiscal auditors who conducted the unannounced audit of the agent cashier's cash assets did not properly verify the cash balance. During the audit, the auditor mistakenly concluded that approximately $5,980 was missing. However, a follow-up review of agent cashier records indicated that the funds were accounted for and had been disbursed in the form of checks.

Physical Security. Although the agent cashier maintains a significant cash advance, the SSTV camera was not operational during the unannounced audit. The Chief of Police agreed to address the deficiency and stated that the camera was not operational because of problems with the contractor who installed the camera.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director:

(a) provide agent cashier auditors refresher training on conducting audits, and
(b) have the SSTV camera in the agent cashier office space repaired.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that the fiscal auditor was given updated instructions on how to verify the cash balance and that the healthcare system was in the process of recruiting for the vacant internal auditor position. Also, the SSTV camera was repaired in October 2003. The improvement actions are acceptable, and we consider the issues resolved.

Controlled Substances Accountability – Inspection Procedures Needed To Be Improved

Conditions Needing Improvement. The healthcare system needed to improve the management of its Controlled Substances Inspection Program. VHA policy requires that the healthcare system managers maintain an adequate and comprehensive system for controlled substances to ensure safety and control stock levels. It also requires the rotation of controlled substances inspectors to ensure that no single inspector will conduct more than six monthly inspections in a 12-month period, and that a portion of the inspectors rotates out of the inspection team each year. To evaluate controlled substances accountability, we reviewed selected documentation pertaining to the Controlled Substances Inspection Program, observed an unannounced monthly inspection, and interviewed Pharmacy Service staff. Inspection procedures need to be improved in the following areas.

Documentation of Training. The healthcare system did not maintain documentation on all orientation and training provided and all inspectors were not appointed in writing as required. The appointment and training for 1 of the 24 inspectors (4 percent) was not documented.

Location of Inspections. Inspection procedures did not ensure that all controlled substances storage locations were inspected every month. We found that 152 of the 977 locations (16 percent) were not inspected for the 12-month period ending April 2003.

Rotation of Inspection Assignments. Inspection assignments were not rotated as required. We found that 9 of the 24 inspectors (38 percent) completed more than 6 inspections for the 12-month period ending April 2003. Also, a portion of the inspectors did not rotate out of the inspection team each year.

Completeness of Inspections. The monthly unannounced controlled substances inspection that we observed did not include all outdated stock and records. We found that excess, outdated, and unusable controlled substances were not inspected, and that the inspection did not include Security Prescription Form pads (VA Form 10-2577F).

The deficiencies occurred because healthcare system managers did not follow VHA Controlled Substances Inspection Program policies and ensure that the inspectors received refresher training on conducting inspections.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director:

(a) operate the Controlled Substances Inspection Program in accordance with VHA policy;
(b) establish controls to ensure the inspection program is operating effectively; and
(c) provide refresher training to all inspectors in the Controlled Substances Inspection Program.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that the healthcare system provided one FTEE for a full-time Controlled Substances Inspection Coordinator in Police and Security Service to ensure effectiveness and program compliance in the Controlled Substances Inspection Program. Written procedures to inspect outdated stock and prescription pads were developed and implemented as of August 2003. Additional training has been scheduled each month when procedural errors have been identified, when new procedures have been instituted, and when requested by the inspector. The improvement actions are acceptable, and we consider the issues resolved.

Equipment Inventory – Accountability Deficiencies Should Be Corrected

Conditions Needing Improvement. The healthcare system needed to improve its procedures for requesting and performing physical inventories of nonexpendable equipment. VA policy requires physical inventories of items costing more than $5,000 with an expected life of more

than 2 years to be scheduled at least every 24 months, and performed again in 6 months if the inventory accuracy rate falls below 95 percent. When a physical inventory is due, the responsible official is notified and provided a copy of the Equipment Inventory List (EIL). As of May 2003, the EIL Status Report showed that there were 570 lists for the 7 areas in the healthcare system. To evaluate the inventory frequency for nonexpendable equipment, we reviewed the inventory accuracy rates shown on the status report. We also met with Materiel Management staff to discuss inventory notification procedures for requesting and performing physical inventories of equipment. There were two areas where the healthcare system could improve its management of equipment inventory accountability.

Frequency of Inventory. Of the seven healthcare system areas shown on the EIL Status Report, three areas with accuracy rates below 95 percent did not have physical inventories performed again within the required 6-month timeframe. The four remaining areas with accuracy rates of 100 percent had physical inventories scheduled annually.

Timeliness of Notification. Responsible officials were not sent timely delinquent notices when inventories of the EIL areas were not performed as scheduled. Healthcare system managers were aware of the deficiency and corrective actions were implemented during the CAP review.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director:

(a) conduct follow-up physical inventories of areas with accuracy rates below 95 percent within the required 6-month timeframe, and
(b) send timely delinquent inventory notices to responsible officials when scheduled inventories are not performed.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that as of October 2003, Materiel Management staff had reviewed annual EIL inventories conducted during the last year, identified EILs with accuracy rates below 95 percent, and begun notifications of the need to re-inventory these EILs. In addition, the Acting Healthcare System Director's notification letter now states that if the EIL accuracy rate falls below 95 percent, the EIL will be re-inventoried in 6 months and monthly delinquent letters will be sent to departments that do not return their EILs on time. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Contingency Plans Needed To Be Enhanced

Conditions Needing Improvement. The healthcare system needed to reassess the adequacy of information technology (IT) security controls in ensuring continuity of service. VHA policy and Health Information Security Service guidelines require the development of contingency plans, the backup of data files and applications, and the designation of alternate sites in the event of a disaster. To evaluate IT security controls, we reviewed security plans, risk assessments, and security awareness training for employees. We also interviewed Information Resource

Management (IRM) staff, reviewed contingency/disaster recovery plans, evaluated data backup methods, and toured the IRM building and computer rooms. We found that IT security controls were adequate in the areas of security awareness training, access controls, virus protection, password controls, and computer room security. In addition, contingency plans outlining disaster recovery and contingency procedures had been developed, and essential staff and functions had been identified. We found two areas where IRM managers could enhance IT security.

Computer Equipment Identification. The healthcare system's contingency plans did not include lists of computer equipment based on critical need or set priorities for the restoration of this equipment in the event of a disaster. These elements are essential to IT contingency plans because they facilitate continuity in healthcare system operations and prevent major disruptions in patient care during an unexpected system failure or disaster.

Alternate Site Selection. The healthcare system did not identify an alternate automated information processing site as part of its contingency plans. A designated alternate processing site is key to maintaining healthcare system operations during an unexpected system failure or disaster at the West Los Angeles campus.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director update IT contingency plans to include the identification of critical computer equipment, priorities for restoring equipment in the event of a disaster, and an alternate processing facility.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that the IT Disaster Plan had been modified to include a list of all critical computer equipment and the priorities for the restoration of the equipment. In addition as of October 2003, the Sepulveda campus alternate processing site had received funding and orders had been placed for Veterans Health Information Systems and Technology Architecture hardware upgrades. The healthcare system plans full implementation of the corrective actions by April 1, 2004. The improvement actions are acceptable, and we consider the issues resolved.

Pharmacy Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. The healthcare system needed to improve pharmacy security to protect Pharmacy Service staff and safeguard controlled substances. VHA policy requires that pharmacies have adequate electronic entry systems to control access and secure all controlled substances. The Chief of the Police and Security Service is responsible for planning all security systems and ensuring their operation and monthly inspection. To evaluate pharmacy security controls, we inspected pharmacy dispensing and storage areas, reviewed security policies and procedures, and interviewed Pharmacy Service staff. We identified two security weaknesses that needed to be addressed.

Electronic Entry Systems. The West Los Angeles campus pharmacy's electronic entry system requires Pharmacy Service staff to use a key card and an access code to enter the pharmacy. The use of keypad shields would improve security by preventing passersby and unauthorized staff from observing the access codes of Pharmacy Service staff.

Panic Buttons. During the test we requested, the inpatient pharmacy vault and the outpatient pharmacy window panic buttons were not operational and we could not evaluate the responsiveness of VA Police to possible incidents in the pharmacy. The panic buttons were not operational because a telephone line had been cut during construction in the inpatient vault area and the outpatient window buttons had not been reset after an earlier test. During the CAP review, Pharmacy Service managers submitted a work order to have the vault panic button repaired and instructed Pharmacy Service staff on the proper operation and testing of the outpatient panic buttons.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Acting Healthcare System Director:

(a) install keypad shields to prevent observation of access codes, and
(b) schedule monthly inspections for testing panic buttons to ensure pharmacy security systems are operational.

The VISN and Acting Healthcare System Directors agreed with the findings and suggested improvement actions. The Directors reported that funds had been approved to install shields around the keypads by October 31, 2003, to prevent outside observation of card codes. In addition, during the first week of each month, the inpatient and outpatient pharmacies are now scheduled for panic button tests. The improvement actions are acceptable, and we consider the issues resolved.

Service Contracts – Contract Award Procedures Needed To Be Improved

Conditions Needing Improvement. VISN Network Business Center (NBC) managers needed to improve contract award procedures. The Federal Acquisition Regulation states contracting officers must at a minimum, use price analysis to determine whether the price is fair and reasonable when a commercial item is acquired, and document the principle elements of the negotiated agreement in the contract file. To determine the effectiveness of contract award procedures and contract administration, we reviewed a judgmental sample of 10 current service contracts valued at an estimated cost of about $9.8 million. The 10 service contracts included 4 competitive contracts and 6 noncompetitive contracts. Of the 10 contract files reviewed, 6 contracts did not have contract price analysis documentation and 5 files did not document that a fair and reasonable price was obtained. The NBC supervisory contract specialist agreed that price analyses were needed and that statements of price reasonableness should have been prepared to ensure fair and reasonable contract prices were obtained and supported.

Suggested Improvement Actions. We suggested that the VISN Director ensure that NBC contracting staff:

(a) prepare price analyses for negotiated acquisitions, and
(b) prepare and maintain statements of price reasonableness in the contract files.

The VISN Director agreed and reported that refresher training was provided to all staff and a contract file checklist was developed and implemented to assure the completeness of processes and files. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

VISN 22 Director Comments

VA DESERT PACIFIC HEALTHCARE NETWORK

VA Greater Los Angeles Healthcare System
Los Angeles, CA

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VA Loma Linda Healthcare System
Loma Linda, CA

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VA Long Beach Healthcare System
Long Beach, CA

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VA San Diego Healthcare System
San Diego, CA

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VA Southern Nevada Healthcare System
Las Vegas, NV

~

Kenneth J. Clark
Network Director
5901 E 7th St
Long Beach, CA
90822

Memorandum

Date: October 8, 2003

From: Network Director, VA Desert Pacific Healthcare Network (10N/22)

Subj: Response to OIG CAP Survey at VA Greater Los Angeles Healthcare System (Project Number 2003-01948-R7-0102)

To: Assistant Inspector General for Auditing (52)
Thru: Margaret Seleski, Management and Program Analyst, (10B5)

1. Please find below my comments as well as an action plan for addressing the two recommendations and nine suggestions resulting from the CAP Survey.

a. The CAP survey of the VA Greater Los Angeles Healthcare System was conducted in a thorough and effective manner providing a positive and productive process that offered meaningful and useful suggestions that will lead to improved performance and effectiveness of our business and clinical systems and processes. I applaud the CAP Survey Team for conducting a careful, comprehensive survey and, in particular, the Health Care Inspection and Audit Team Leaders for their professionalism in collaborating with facility and Network leadership in setting a tone for an informative and helpful process.

b. Realizing that the CAP survey team was required to utilize a national "boilerplate" template for drafting their report, the following comments are directed only at the overall tone of the draft survey report. It is indeed unfortunate that required formatting configurations create a general negative tone to the report when the survey itself, as demonstrated in the exit interview, indicated many positive aspects of facility operations and, given the size and complexity of the facility and the scope and depth of the survey process, yielded remarkably few findings for corrective action.

c. Comments made by members of the survey team and the information presented in the exit survey were very balanced and constructive; however, the generally negative tone of the report and lack of perspective as to findings gives the reader the impression that many serious deficiencies were found during the CAP Survey. In reality, a careful reading of the report, which recounts a thorough and comprehensive review of most key administrative and operational elements, conducted at VA's largest and most complex medical center, records only **two** recommendations identified as a result of the survey. Also, due to the formatting of the report, which highlights and even underscores the negative aspects of the survey without providing sufficient perspective and balance in terms of complimentary and positive comments,

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Response to OIG CAP Survey at VA Greater Los Angeles Healthcare System (Project Number 2003-01948-R7-0102)
Page 2

the reader is led to an overall negative impression of the medical center's operations. Again, the issue of the formatting and negative tone for CAP reports is recognized throughout the system and is not reflective of the survey team's very balanced approach in identifying organizational strengths and weaknesses.

d. In summary, while I concur in the findings and recommendations that resulted from a thorough and professionally conducted survey process, it is unfortunate that the balanced presentation and perspective readily apparent in the Team's comments throughout the survey process and contained in the exit summation, are not reflected in the final report. This is a shortcoming in the reporting process that should be addressed between VHA and the OIG.

3. We very much appreciate the professional manner that the survey was conducted and the interactions that occurred between OIG surveyors, GLA, and Network Staff.

4. Should you have questions regarding our response, please contact me or Ronald Norby, Deputy Network Director at (562) 826-5963.

Kenneth J. Clark, FACHE

cc: Janet Mah, Office of OIG, Los Angeles, CA
Brian Linton, Office of OIG, Los Angeles, CA
Juilio Arias, Office of OIG, Los Angeles, CA

Appendix A

VA Department of Veterans Affairs **Memorandum**

Date: October 6, 2003

From: Network Director, VA Desert Pacific Healthcare Network (10N/22)

Subj: Action Plan Associated with Combined Assessment Program Review, VA Greater Los Angeles Healthcare System (Project No. 2003-01948-R7-0102)

To: Assistant Inspector General for Auditing (52)

1. I concur with the two recommendations and nine suggestions and am attaching an action plan that includes specific activities, target dates, and/or identification of the current status for each recommendation/suggestion.

RECOMMENDATION #1

Strengthen management controls to ensure part-time physician accountability. – **Dean Norman/Linda Surapruik/Sandi Riley**

Subject/Issue	Action Plan	Date Due	Comments
a. Correct medical care documentation problems and improve the accuracy of part-time surgical staff workload data	1. All providers were instructed regarding the correct process for completing patient encounter forms in CPRS 2. Department reports of monitoring activities ongoing 3. Compliance audits of documented workload conducted and ongoing	1. Complete 2. Quarterly reports to OEI 3. Quarterly audits by staff from Office of COS	None
b. Ensure the appointments of part-time surgical staff are periodically evaluated and adjusted, as needed, to be consistent with workload	1. Review of workload, clinical and academic assignments and other factors of all physicians is complete 2. Analysis of required appointment changes in progress 3. Plans to be developed and implemented for each position that include continuous review schedule. 4. Contracting for specialty	1. Complete 2. 10/31/03 3. 12/31/03 4. 11/15/03 5. 12/31/03 6 7/2/04	None

	medical services with the affiliate(s) being considered. Plans being developed for each specialty 5. Specialty plans for contracting with affiliates to be implemented 6. Contracts finalized		
c. Ensure that part-time surgical staff timecards are submitted and certified by responsible supervisors before timekeepers prepare official time and attendance records	1. Verified that Department Chairs, Section Chiefs, and clinical supervisors are designated as certifying officials for time and leave approval 2. Training provided to above-mentioned staff regarding policies and procedures in progress	1. Complete 2. 10/15/03	None

RECOMMENDATION #2

Reduce excess medical supply inventory and strengthen inventory management controls. – **John Fitzgerald/Brian Happy**

Subject/Issue	Action/Plan	Date Due	Comments
1. Medical Supply Inventory Management - Excess Inventory Should Be Reduced and Inventory Management Controls Strengthened: Recommended Action: That the VISN Director ensure that the Acting Healthcare System Director implement procedures requiring Materiel Management staff to use GIP automated tools, monitor supply usage rates, reduce medical supply inventory levels to the 30-day supply goal, and improved the accuracy of GIP data.	1. Stock Quantities and value discrepancies discovered during the audit have been corrected. 2. Excess stock: The items that had no history within the last twelve months have been reviewed removed from inventory or have been validated as a valid need. It was also noted that of the ten items sampled, five items exceeded the 30-day level with an inventory value of $42,787. SPD has corrected this by reviewing the levels, and made corrections to the inventories by properly recording transactions to the inventory. In addition to these corrections we have scheduled periodic		None

	inventories beginning this month through the end of December 2003. This will correct the stock quantity and value discrepancies. We are also reviewing the GIP reports including the days stock on hand report to take corrective action where needed. Training has been scheduled for the SPD techs are responsible for this inventory. The Materiel Mgmt Tech responsible for the SPD inventory has monthly training and meets with the Chief of Material Management to review the GIP reports.		

SUGGESTION #3

Improve the Patient Complaints Program and use of benchmarks, outcome criteria, and implementation and evaluation of action items in the QM program. – **Mike Mahler/Joan Lopes**

Subject/Issues	Action Plan	Date Due	Comments
a. Improve Patient Complaints Program	1) The Patient Advocate Office was recently reorganized and is now a part of the Executive Office 2) Additional customer liaison staff members at all major GLA locations were trained to enter patient contacts into the database. 3) Starting in September, the Patient Advocate Office will present an analysis of the patient contacts broken down by category and location to Executive Leadership. This will identify issues for improvement. This analysis will also be forwarded to appropriate service chiefs for action. 4) Additional Patient Advocates are approved for hiring.	Ongoing	

b. Document use of available benchmarks	Benchmarks will be researched and included for all QM review items, as appropriate.	Ongoing	
c. Define outcome criteria for all identified corrective actions	Minutes are currently being reviewed to provide guidance on actions items versus discussion items. All future documented corrective actions will be reviewed to assure that there is an associated outcome criterion/a.	Ongoing	
d. Implement and evaluate all corrective actions until the problems are resolved of the desired improvements are accomplished	1) The Patient Safety Committee reviews all corrective actions recommended by RCAs and AIs on a weekly basis. The review is to determine the status of recommendations and implementation along with the outcomes. 2) Incomplete recommendations and unsatisfactory outcomes are reviewed and acted on by Executive Leadership on an as needed basis as well as quarterly.	Ongoing Ongoing	

SUGGESTION #4

Improve administrative and clinical oversight procedures for the Community Residential Care Program. – **Dean Norman/Steve Berman**

Subject/Issues	Action Plan	Date Due	Comments
a. VISN Director ensures that the Acting Healthcare System Director requires the CRC team to conduct RCF inspections at least every 2 years.	A new inspection scheduling tracking and following procedure program has been implemented. This program will ensure that all disciplines complete inspections and follow up within time frames in keeping with VA Policies. Facilities are being inspected using the new system. The Community Residential Care Director is	Ongoing	

	personally scheduling inspections, tracking the team member's reports, etc.		
b. VISN Director ensures that the Acting Healthcare System Director requires fire safety inspections to conduct annual evaluations of RCFs	A planning session between CRC staff and Safety staff developed a plan and procedure to ensure that Safety inspections are conducted every 12 months.	Ongoing	In compliance

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c. VISN Director ensures that the Acting Healthcare System Director requires clinicians to perform and document annual PEs of patients in RCFs	More CRC patients are receiving their physicals in Bldg. 206. Ongoing planning with Primary Care, Ambulatory Care and private sector physicians is in process. Veterans in residential care receive physical exams from many different providers. We plan to coordinate all resources in order to comply with this policy.	Next report due10/30/03	Open
d. VISN Director ensures that the Acting Healthcare System Director requires clinicians to make and document monthly visits to patients in RCFs	This item is being reviewed monthly as part of Community Care Quality Management program, with a monitor constructed in conjunction with the Data Warehouse. For the past two months, June & July, compliance was 99 and 97 percent respectively. We have added another clinical staff member to the CRC program to enable us to be in full compliance with the 30-day requirements.	Ongoing	
e. VISN Director ensures that the Acting Healthcare System Director requires the CRC Program Coordinator to arrange an annual meeting with VBA F&FE supervisors to discuss issues involving incompetent veterans with fiduciaries	Contact with VARO field examiners has been initiated. Date for meeting not yet set.		Open
f. VISN Director ensures that the	The monitors were added and are in place.		Completed

Acting Healthcare System Director requires Social Work managers to set up monitors to ensure ongoing compliance with these requirements.			

SUGGESTION #5

Correct safety deficiencies in selected patient care units and the canteens. – **John Fitzgerald/Bob Benkeser**

Subject/Issues	Action Plan	Date Due	Comments
a. Properly secure all potentially hazardous chemicals in patient care areas.	All unsecured chemicals found during OIG visit have been secured and/or placed in protective flammable lockers. The area has a service specific hazard program with annual updated inventory plans.	**Completed**	All GLA employees will again be reminded to follow their Service Specific Programs relative to selecting, handling, storing, transporting, using and disposing of hazardous materials and waste from receipt or generation through final disposal.
b. Follow-up on identified canteen deficiencies from our inspection, as well as from the recent NCS inspection.	The door seals were replaced in all refrigerators at the West Los Angeles canteen and all other deficiencies noted by the Director, NCS were corrected prior to the OIG inspection team leaving the station.	Completed	
c. Monitor and treat patient care areas for pests, particularly on two patient care units where we observed small flying insects.	Patient care wards will be treated for pests. Also, new Nursing and Environmental Management procedures for handling and disposing of trash and waste are being implemented.	October 31, 2003	

SUGGESTION #6

Improve unannounced agent cashier audits and security. – **John Fitzgerald/Ann Marie Wilk**

Subject/Issues	Action Plan	Date Due	Comments
a. One of the two fiscal auditors who conducted the unannounced audit of the agent cashier's cash assets did not properly verify the cash balance. Refresher training is suggested.	The internal auditor position was vacated in 2002 and the unannounced audits were temporarily assigned to a Fiscal employee as a collateral duty. This employee has been given updated instructions on how to verify the cash balance. We are also in the process of recruiting for the position of Internal Auditor.		The position will be announced 9/9/03
b. The security camera in the Agent Cashier's office is not operational.	Lee Hayes, Chief, Maintenance & Operations has arranged to have the camera connected/repaired on Oct. 10th.	10/10/03	

SUGGESTION #7

(1) Ensure the controlled substances accountability inspection program operates properly.

Donna Beiter/Jeff Sayers/Rick Brisard

An updated policy governing the Controlled Substance Inspection Program was recently published by VAHQ. VHA Handbook 1108.2, dated August 29, 2003, replaced VHA Handbook 1108.2, dated July 23, 2003. The IG used the older handbook as reference during the survey. As a result, several areas previously identified as non-compliant are no longer valid.

The attached responses will address the OIG/CAP survey findings as they now relate to the requirements contained in the newly published handbook.

Subject/Issues	Action Plan	Date Due	Comments
Documentation of Training. The healthcare system did not maintain documentation on all orientation and training provided and all inspectors were not appointed in writing as required. The appointment and	Training records are now on file for all 24 inspectors. Individualized training records have been created, and all training is now documented and verified immediately upon completion. Each month, additional training is scheduled when procedural errors are identified, when new	None	This has been completed for all inspectors

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training for 1 of the 24 inspectors (4 percent) was not documented.	procedures are instituted, and when requested by the Inspector. All inspectors received a formal appointment letter in August 03, which is documented in the inspector's individual record.		
Location of Inspections. Inspection procedures did not ensure that all controlled substances storage locations were inspected every month. We found that 152 of the 977 locations (16 percent) were not inspected for the 12-month period ending April 2003.	Most areas not inspected were located in research areas. Pharmacy is placing a Pyxis unit in research areas, which will eliminate this particular problem. Beginning October 1, all inspectors will be required to verify via email to the CSI Coordinator, by the 25th of the month, that they have completed their assignment. Those not providing verification will be immediately referred to the appropriate Associate Director for immediate remedial action so that the inspection is completed by the end of the month.	Jan 1, 2004	Due date is for proposed installation of Pyxis units in research areas. All other components of this action have been completed.
Rotation of Inspection Assignments. Inspection assignments were not rotated as required. We found that 9 of the 24 inspectors (38 percent) completed more than 6 inspections for the 12-month period ending April 2003. Also, a portion of the inspectors did not rotate out of the inspection team each	The newly published VHA Handbook, dated August 29, 2003, has dropped these requirements. We are compliant with the new requirements. Beginning with the schedule published for the inspection year Aug. 03 through July 04, each inspector does an inspection every other month, and never does the same area consecutively, also in accordance with the new requirements	None	We are already compliant with new regulations.

year.			
Completeness of Inspections. The monthly-unannounced controlled substances inspection that we observed did not include all outdated stock and records. We found that excess, outdated, and unusable controlled substances were not inspected, and that the inspection did not include Security Prescription Form pads (VA Form 10-2577F).	Written procedures to inspect outdated stock and prescription pads were developed and implemented on August 1 , 2003. All inspections since that time have met the requirement. The CSI Coordinator accompanies each inspector during a vault inspection to provide orientation and training on the new procedures. Documentation is on file in the inspector's training record. This additional training will continue until all inspectors are fully oriented	Ongoing	Training is accomplished during actual inspections as inspectors are assigned to inspect pharmacy vaults.
Suggested Improvement Actions. We suggest that the VISN Director ensure that the Acting Healthcare System Director: a) Operates the controlled substances inspection program in accordance with VHA policy; b) Establishes controls to ensure the inspection program is operating effectively; and provides refresher training to all inspectors in the controlled substances inspection program.	Response: GLAHS recognizes that the scope, complexity and time involved with conducting a comprehensive controlled substance inspection (CSI) program in a multi-campus environment such as ours poses unique difficulties. We have provided 1.00 FTEE to Police & Security Service, to be assigned as a full time CSI Coordinator. Because this will no longer be a collateral assignment, the incumbent will be able to provide the necessary degree of program oversight to assure effectiveness and program compliance. Further, Mr. Brisard will continue his relationship with the program in a collateral role, providing independent reviews of the CSI program to assure compliance	Feb. 1	Approval to recruit new full time coordinator position has been granted. Commitment is expected by Nov. 1, pending action by HR. Once on board, Mr. Brisard will spend the next two months with the new Coordinator to assist in the transition. Afterwards he will set up and administer a QA program to evaluate monthly the quality and compliance of the inspection program.

	with national policy, and conduct assessments of procedural quality and effectiveness at all levels.		

SUGGESTION #8

Strengthen equipment inventory procedures. . – **John Fitzgerald/Brian Happy**

Subject/Issue	Action Plan	Date Due	Comments
1. Suggested Improvement Actions: That the VISN Director ensure that the Acting Healthcare system Director: (a) Conducts follow-up physical inventories of areas with accuracy rates below 95% within the required 6-month timeframe, and (b) Sends timely delinquent inventory notices to responsible officials when scheduled inventories are not performed.	(a) Material Management reviewed the annual inventories that were conducted during the last year and 33 EIL's out of 512 were identified as having accuracy rates below 95%. A&MM is currently in the process of notifying the EIL officials of requirement to re-inventory their EILs. In addition, the Director's notification letter now states that if the EIL accuracy rate falls below 95% their EIL will be re-inventoried in six months. (b) Material Management prepared letters for the Director of GLA to send on the 50 EILs that were identified as delinquent. Material Management now sends out the delinquent letters monthly for those Departments that do not return their EILs on time.		None

SUGGESTION #9

Enhance information technology contingency plans. . – **John Fitzgerald/Karl Syndulko**

Subject/Issues	Action Plan	Date Due	Comments
1. Update IT contingency plans to include identification of	Modifications have been made to the IT Disaster Plan to list all critical computer equipment, and to set priorities		GREATER LOS ANGELES HEALTHCARE SYSTEM

critical computer equipment and priorities for restoring equipment in the event of a disaster.	for restoring. Critical IT equipment is listed in detail on the GLA IRM technical Intranet site.		CONTINGENCY PLAN VISTA/DHCP SYSTEM, NT/NETWORK
2. A designated alternate processing site is key to maintaining healthcare system operations during an unexpected system failure or disaster.	GLA maintains a specially designed computer room at the Sepulveda campus, approximately 15 miles north of the main WLA campus. GLA has received funding for and placed on order upgrades to the Vista Hardware that will enable us to place a mirror Vista system at Sepulveda. A new SANs is also being installed at Sepulveda to provide primary and back-up non-Vista server support. Daily back-up tapes from the Vista system are also kept at the Sepulveda campus computer room.		The new ES80 hardware at WLA and ES40 mirror system at Sepulveda will be installed by April 1, 2004.

SUGGESTION #10

Correct physical security deficiencies in the pharmacy. - **Donna Beiter/Jeff Sayers**

Subject/Issues	Action Plan	Date Due	Comments
Correct physical security deficiencies in the pharmacy	Funds have been approved for the upgrade of the electronic entry system which will provide the following: • Installation of shields around the number pads to prevent outside observation of card codes • Enhanced monitoring of access to better secure pharmacy areas Replacement of the DOS-	This upgrade is expected to be completed by October 31, 2003	Panic buttons were repaired in both the inpatient and outpatient pharmacies at West Los Angeles. During the first week of each month, both the inpatient and outpatient pharmacies are scheduled to do a panic button test. In

	based system with a window-based program with improved event monitoring and reporting • Increased communication speed between access points • Greater flexibility to limit access to employees for specific doors and areas.		addition, on a quarterly basis, a response time test will be conducted in both the inpatient and outpatient pharmacies to determine the length of time it takes for security to respond to a panic button that has been activated.

SUGGESTION #11

Improve NBC Contracting Award Procedures

Subject/Issues	Action Plan	Date Due	Comments
a. Prepare price analyses for negotiated acquisitions b. Prepare and maintain statements of price reasonableness in contract files	Existing NBC policy requires that price analyses be negotiated and maintained in the contract files. The Director of the NBC has met with all staff to re-educate them to the importance of keeping documentation in the files and assuring full price analyses for all contracts. He has also developed and implemented a check-list for use by all staff to assure the completeness of processes and files.	Completed	

Appendix B

Report Distribution

VA Distribution

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Deputy Chief of Staff (00A1)
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- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
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- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
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This report will be available in the near future on the VA OIG Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.