Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, Colorado

Report No. 03-02290-012

November 4, 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 August 4 – 8, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Grand Junction VA Medical Center, Grand Junction, CO (medical center), which is part of Veterans Integrated Service Network (VISN) 19. The purpose of the review was to evaluate selected medical center 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 training to 95 employees.

Results of Review

Review areas such as accounts receivable, supply inventory management, and environment of care were operating satisfactorily. These areas only had minor deficiencies or had corrective actions that were recently implemented or in process at the time of the CAP review. To improve operations, the medical center needed to:

- Ensure the consistent collection, trending, and analysis of resuscitation data.
- Strengthen controlled substances inventory control practices, safeguards, and inspection procedures.
- Improve information technology contingency planning and security controls.
- Document price negotiations for non-competitive contracts.

VISN 19 Director Comments

The VISN 19 Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 8 – 12 for the full text of the Director's comments.) We will follow up on the planned actions until they are completed.

/s/

RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. The medical center is a primary and secondary care facility that provides inpatient services as well as a full range of outpatient services. Outpatient care is also provided at a community-based outpatient clinic located in Montrose, CO. The medical center is part of VISN 19 and serves a veteran population of about 37,000 residing in western Colorado and southeastern Utah.

Programs. The medical center provides medical, surgical, and mental health services, and operates 23 hospital beds and 30 transitional care beds. The medical center benefits from scarce medical specialty agreements with community specialists who provide urology, ophthalmology, otorhinolaryngology, orthopedic, neurology, and podiatry services.

Affiliations and Research. The medical center is affiliated with the University of Colorado Medical School, but does not support a medical residency program. The medical center's affiliations with the University of Colorado, Brigham Young University, Mesa State College, San Juan College, and Trinidad State Junior College allows it to provide clinical training opportunities to students in nursing, pharmacy, social work, psychology, radiology, and physical therapy. The medical center does not operate a research program.

Resources. The Fiscal Year (FY) 2003 medical care budget is $34 million, a 3 percent increase over the FY 2002 budget of $33 million. In FY 2002, staffing was 291.5 full-time equivalent employees (FTEE), including 14 physician and 89 nursing FTEE.

Workload. In FY 2002, the medical center treated 10,107 unique patients, a 10 percent increase over FY 2001. Medical center management attributed the increase in unique patients treated to the continuing population growth in the Grand Junction area and the increasing number of veterans who are turning to VA for most or all of their medical care. The FY 2002 inpatient workload totaled 1,376 discharges, and the average daily census, including nursing home patients, was 47.5. The outpatient workload was 78,847 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered the medical center's operations for FY 2002 and FY 2003 through August 2003, and was done in accordance with OIG standard operating procedures.

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 12 activities.

Accounts Receivable	Laboratory Security
Community Nursing Home Contracts	Medical Supply Inventory Management
Community Residential Care Program	Pharmacy Security
Controlled Substances Accountability	Quality Management
Environment of Care	Service Contracts
Information Technology Security	Waiting Times and Enrollment

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3 – 7). For these activities, we have made recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities that were not discussed in the Opportunities for Improvement section did not have reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all medical center employees and we received 72 responses. We also interviewed 30 patients during the review. The survey and interview results were discussed with the Medical Center Director.

During the review, we also presented 4 fraud and integrity awareness briefings to 95 medical center employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Opportunities for Improvement

Quality Management – Resuscitation Data Needed To Be Collected, Trended, and Analyzed

Conditions Needing Improvement. The Special Care Unit Committee (SCUC) needed to improve the collection and evaluation of resuscitation data. Joint Commission on Accreditation of Healthcare Organizations standards require management to collect data and evaluate the effectiveness of resuscitations in preventing potentially serious patient complications and mortality. The collection, trending, and analysis of resuscitation information provide opportunities to benchmark outcomes and improve care.

We interviewed clinical staff and reviewed minutes of the SCUC and the Clinical Executive Board (CEB) for the 12-month period that ended June 30, 2003, to evaluate the adequacy of the medical center's monitoring of resuscitation outcomes. The medical center's local policy designates the CEB as the oversight committee for QM activities and prescribes that the CEB receive quarterly minutes from the SCUC on resuscitation data and issues. During the period reviewed, the SCUC submitted only one quarterly report to the CEB. We reviewed the SCUC's minutes for the one quarter and found no evidence that the resuscitation outcomes had been trended by ward, time of day, provider, and patient response. The quarterly minutes from the SCUC only showed the number of resuscitations that had occurred, and one problem regarding the availability of certain medications. Although appropriate action on the medication issue had been taken, there was no documentation of follow-up in SCUC minutes. Senior managers agreed that this area of QM could be strengthened to enhance monitoring and follow-up practices and to identify opportunities to improve care.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director improves QM for resuscitative care by requiring:

(a) The SCUC to collect, trend, and analyze resuscitation data to evaluate outcomes and identify opportunities to improve care.
(b) The CEB to review and evaluate SCUC minutes quarterly.
(c) The SCUC to document appropriate corrective actions for reported problems.

The VISN Director agreed with the findings and recommendation. The VISN Director reported that a new electronic data collection instrument has been implemented to allow the SCUC to evaluate resuscitation outcomes and identify opportunities to improve care. The SCUC will document the trending and analysis of the resuscitation data in its meeting minutes and has received oversight and guidance from the CEB on improving meeting minute documentation for areas such as the follow up of corrective actions. In addition, the CEB will review SCUC minutes quarterly and ensure that SCUC recommendations are implemented, documented, and followed up appropriately. The medical center plans full implementation of the corrective

actions by November 28, 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Conditions Needing Improvement. Medical center and Pharmacy Section management needed to strengthen inventory control practices, prescription safeguards, and unannounced inspection procedures for controlled substances. VHA policy requires Pharmacy Section staff to safeguard controlled substances and establish a comprehensive inventory system to ensure patient safety and adequate control of controlled substances stock. In addition, the Medical Center Director is responsible for establishing a monthly unannounced inspection program to certify the accuracy of controlled substances records and inventory.

To assess controlled substances inventory controls, safeguards, and inspection procedures, we interviewed Pharmacy Section staff, inspected controlled substances storage areas, and reviewed pharmacy procedures. We also interviewed the Controlled Substances Inspection Coordinator and inspectors, observed an unannounced inspection conducted in the pharmacy and on one ward, and reviewed inspection reports for the 12-month period that ended June 30, 2003. We identified seven weaknesses: one related to pharmacy inventory control practices; one related to prescription safeguards; and five related to unannounced controlled substances inspection procedures.

Inventory Control Practices. The disposition and resolution of controlled substances quantity discrepancies identified during each 72-hour inventory were not sufficiently documented in the inventory control records. The 72-hour inventory control records had annotations indicating that there were discrepancies between the quantities in the inventory records and quantities found during the physical counts. For example, the inventory control record for April 20, 2003, had annotations indicating that there were 1,592 Onezepam tablets in stock even though inventory records showed that there should have been 1,597 tablets, a 5 tablet discrepancy. The Pharmacy Section supervisor believed that the discrepancies in the inventory quantities were only temporary differences caused by the time lapse between when the prescriptions were filled and picked up by the patients. However, we could not validate the Pharmacy Section supervisor's explanation because Pharmacy Section staff had not documented the disposition and resolution of the discrepancy.

Prescription Safeguards. The Pharmacy Section did not have established procedures to verify or pre-certify the legitimacy of agents claiming to represent patients. As a result, the dispensing pharmacist only requested that agents provide sufficient proof of their identities before releasing patients' prescriptions, including controlled substances, to the agents.

Inspection Procedures. Controlled substances inspections were not conducted in accordance with VHA policy and were not timely completed. Of the 11 inspections we reviewed, only 4 were completed in 1 day. The other seven inspections took from 9 to 24 days to complete. We also observed an unannounced controlled substances inspection in which the inspector did not

review records of the Pharmacy Section's 72-hour inventories; verify transfers of controlled substances from one area to another; or compare controlled substances dispensing entries to patient drug administration records to ensure patients received dispensed medications. In addition, the Controlled Substances Inspection Coordinator, who was responsible for overseeing the controlled substances inspection program, did not analyze inspection results to identify potential problem areas.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director improves controlled substances accountability by requiring:

(a) Pharmacy Section staff to document the disposition and resolution of any controlled substances quantity discrepancies identified during the 72-hour inventories.
(b) Pharmacy Section managers to develop policies and procedures to verify the legitimacy of agents picking up controlled substances and other medications for patients.
(c) The controlled substances inspection program to conform to VHA policy.

The VISN Director agreed with the findings and recommendation. The VISN Director reported that local medical center policies have been revised or are in the process of being revised to ensure documentation of the disposition and resolution of inventory discrepancies; the legitimacy of agents who claim to represent patients when picking up patients' prescriptions; and the controlled substances inspection program's conformance to VHA policy. The medical center plans full implementation of the corrective actions by November 28, 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Information Technology Security – Contingency Planning and Security Controls Needed To Be Improved

Conditions Needing Improvement. Medical center management and Information Technology Service (ITS) managers needed to enhance information technology (IT) contingency planning and security controls. We reviewed the medical center's IT security to determine if controls were adequate to protect automated information system (AIS) resources from unauthorized access, disclosure, modification, destruction, and misuse. We found that staff with access to the medical center's computer systems had attended annual AIS and computer security awareness training. In addition, environmental safeguards had been installed and implemented to protect the main computer room. However, we found two areas where medical center management and ITS managers needed to enhance IT security.

Contingency Planning. ITS managers needed to ensure that the contingency planning process was effective and that the contingency plan was adequately tested to identify weaknesses. ITS managers had performed a procedural test to assess the accuracy of the contingency plan documentation. However, ITS managers had not tested the contingency plan under conditions simulating a disaster and therefore, did not identify the plan's weaknesses. Improved testing would have disclosed that the plan did not have an alternative data processing facility and off-site storage for backup files - two elements that are essential to continuity of medical center

operations and the prevention of major disruptions in patient care activities during an unexpected system failure or disaster.

Security Controls. ITS managers needed to strengthen security controls used to limit and monitor AIS access. ITS managers had established basic policies and procedures to authorize the use of the medical center's AIS resources. However, the policies and procedures did not ensure adequate segregation of duties or include a process for reinstating or reactivating access for suspended AIS users. For example, the Alternate Information Security Officer (ISO) was also the Veterans Health Information System and Technology Architecture (VistA) Coordinator. As a result, the Alternate ISO had programmer level access to AIS resources as the VistA Coordinator and could both monitor and control her own use of the medical center's computer systems. In addition, we found that ITS did not have a policy or procedure for reinstating or reactivating suspended access for AIS users and suspended users simply called ITS whenever they needed their access reactivated.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director improves IT security by requiring:

(a) ITS managers to test the medical center's AIS contingency plan under conditions that simulate a disaster.
(b) ITS managers to identify an alternative processing facility and establish off-site storage for backup system data.
(c) ITS managers to re-assign the Alternate ISO's duties to a staff person who does not have programmer level access to the medical center AIS.
(d) ITS managers to establish a policy and procedure to reinstate or reactivate VistA access for authorized users.

The VISN Director agreed with the findings and recommendation. The VISN Director has taken actions to ensure the AIS contingency plan has been tested under conditions simulating a disaster; an alternative processing facility and off-site storage have been identified; the Alternate ISO's duties have been properly reassigned; and the development of a policy and procedure to reinstate or reactivate authorized VistA users. The medical center plans full implementation of the corrective actions by October 31, 2003. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Service Contracts – Contract Price Negotiations Needed To Be Documented

Condition Needing Improvement. The contracting officer did not adequately document negotiations of contract pricing in 5 of the 10 non-competitive contracts we reviewed. The Federal Acquisition Regulations (FAR) requires that the contracting officer prepare a price negotiation memorandum (PNM**)** that contains, among other explanations, the most significant facts and considerations controlling the negotiated agreement, including any significant differences between the contractor's and contracting officer's positions.

We reviewed 10 non-competitive contracts with a total value in excess of $1.1 million to determine whether the contracting officer complied with the FAR, including documentation of the negotiations with the contractors. Of the 10 non-competitive contracts, 5 contracts valued at about $600,000 did not have adequate price negotiation documentation. The contracting officer had not prepared PNMs for four contracts and the PNM for one contract did not include the basis for determining the fairness and reasonableness of the contract price. The contracting officer agreed that PNMs should have been prepared in accordance with the FAR.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires the contracting officer to prepare PNMs for all non-competitive contracts in accordance with the FAR.

The VISN Director agreed with the finding and recommendation and has taken action to ensure the contracting officer prepares PNMs for all non-competitive contracts. The improvement plan is acceptable, and the planned action has been completed.

Appendix A

VISN 19 Director Comments

DEPARTMENT OF VETERANS AFFAIRS

MEMORANDUM

Date: October 14, 2003

From: Network Director, VISN 19 (10N19)

Subj: Draft Report – CAP Review of Grand Junction VAMC
Inspection Number: 2003-02290-R7-0124

To: Assistant Inspector General for Auditing (52)

Attached is the VISN 19 response on the recommendations for improvement contained in the draft Combined Assessment Program review report at Grand Junction VAMC. If there are any questions or concerns, please contact Craig Calvert, VISN 19, at 303-756-9279.

Charles K. Maffet, M.D.

Appendix A

VISN 19 Director Comments

Grand Junction VA Medical Center
Combined Assessment Program Review
Comments and Implementation Plan

1. Quality Management – Resuscitation Data Needed To Be Collected, Trended, and Analyzed

a. The SCUC to collect, trend, and analyze resuscitation data to evaluate outcomes and identify opportunities to improve care.

Concur with suggested improvement actions.

A new electronic data collection instrument was developed and implemented in August to capture pertinent information relative to the conduct of each resuscitation code. Data is being tracked and trended by ward, time of day, provider, patient response, etc. for analysis by the Special Care Unit Committee to evaluate outcomes and identify opportunities to improve care. The next quarterly meeting of the SCUC in October will have meeting minutes that document trending and analysis of resuscitation data.

Target: October 31, 2003

b. The CEB to review and evaluate SCUC minutes quarterly.

Concur with suggested improvement actions.

The Clinical Executive Board met on September 30, 2003 and reviewed the SCUC minutes for the 4th Quarter. CEB is providing SCUC with guidance and oversight on improving meeting minute documentation. This includes improved documentation of follow-up to corrective actions. Review of SCUC minutes is a quarterly agenda item for CEB. CEB will ensure that SCUC recommendations are implemented, documented, and followed-up appropriately.

Target: November 28, 2003

c. The SCUC to document appropriate corrective actions for reported problems.

Concur with suggested improvement action.

The reported medication problem had been corrected but there was no documentation in meeting minutes to demonstrate that the problem had been resolved. As stated in above responses, future meeting minutes will reflect completion of follow-up items.

Target: October 31, 2003

2. Controlled Substances Accountability – Controls, Safeguards, and Inspection Procedures Needed To Be Strengthened

a. Pharmacy Section staff to document the disposition and resolution of any controlled substances quantity discrepancies identified during the 72-hour inventories.

Concur with suggested improvement action.

Pharmacy policy has been revised to require that any discrepancies and resolution of discrepancies will be pursued and documented on the inventory sheet. Any unresolved discrepancies are to be reported immediately to the Pharmacy supervisor for further investigation and action. New policy has been provided to the Pharmacy staff.

Completed.

b. Pharmacy Section managers to develop policies and procedures to verify the legitimacy of agents picking up controlled substances and other medications for patients.

Concur with suggested improvement action.

Pharmacy policy has been revised regarding picking up of prescriptions. Patients are required to have a photo ID to pick up controlled substances. If a patient's family member or agent is picking up the prescription, they should have the patient's ID and their own ID. In all cases the pharmacy staff handing over the prescription will make every effort to validate the legitimacy of the agent's claim to represent the patient (such as telephone call with the patient at time of pick-up, telephone call from patient when patient is requesting pick-up of the medication and who the agent will be, etc.). New policy has been provided to the Pharmacy staff.

Completed.

c. The controlled substances inspection program to conform to VHA policy.

Concur with suggested improvement action.

Controlled substances inspection program was revised to conform to VHA policy in mid-August. Controlled substances inspection findings have been addressed, revised procedures incorporated into MCM 002-4 (Controlled Substances Inspection, 8/12/03), and all current inspectors duly trained. Monthly inspections are now conducted by two inspectors versus one to expedite completion. Inspectors have been instructed to complete the inspection in one day, working continuously rather than piecemeal over several days. Plans call for appointment of three more inspectors for a total of eight. Validation of Pharmacy Section 72-hour inventories was added to the inspection procedures in June 2003 and reemphasized to the inspectors. Regarding transfers between areas, steps now include verification that all controlled substances returned from the wards to Pharmacy are added to the Pharmacy Inventory or to the Destruction Holding Report. Inspectors have been retrained on use of CPRS and BCMA to verify orders for and administration of controlled substances. The Controlled Substances Inspection Coordinator, effective with the October 2003 report, will discuss monthly inspection reports more closely with top management to include trending of findings to identify problem areas.

Handbook 1108.2 has recently been revised (dated August 29, 2003). On the 9/26/03 VHA Directors' Conference Call, VACO Pharmacy Service announced creation of a nationally mandated training program for inspectors, scheduled for release in November. We are working on revisions to local policy/procedures and will be in full compliance with the new handbook by the end of November. Everyone involved with controlled substance inspections will participate in the new training program and current policy requirements.

Target: November 28, 2003

Appendix A

3. Information Technology Security – Contingency Planning and Security Controls Needed To Be Improved

a. ITS managers to test the medical center's AIS contingency plans under conditions that simulate a disaster.

Concur with suggested improvement action.

Our AIS contingency plan was tested September 29, 2003, under conditions similar to a disaster.

Completed.

b. ITS managers to identify an alternative processing facility and establish an off-site storage for backup system data.

Concur with suggested improvement actions.

The Cheyenne VA Medical Center is now designated as our alternate processing site.

Completed.

The Medical Center is pursuing an arrangement for off-site storage of daily backup system data via Records Master, a private business records storage company. Backup media will be available 24/7 in this secure, temperature and humidity controlled off-campus location. This has been reviewed with the VISN 19 CIO and determined to be an appropriate solution for "off-site storage."

Target: October 31, 2003

c. ITS managers to re-assign the Alternate ISO's duties to a staff person who does not have programmer level access to the medical center AIS.

Concur with suggested improvement actions.

The Alternate ISO is now the Chief of Police and he has completed Certified Security Professional training. He does not have programmer level access to AIS resources.

Completed.

d. ITS managers to establish a policy and procedure to reinstate or reactivate VistA access for authorized users.

Concur with suggested improvement actions.

Our ISO is writing a policy and procedure for reinstating VISTA access for individuals who have not used the system within time parameters and have thus been inactivated.

Target: October 31, 2003

4. Service Contracts – Contract Price Negotiations Should Be Documented

a The Medical Center Director require the contracting officer to prepare PNMs for all non-competitive contracts in accordance with the FAR.

Concur with suggested improvement actions.

The contracting officer has prepared price negotiation memoranda (PNMs) for all non-competitive contracts that have been in process since the OIG CAP visit and will continue to do so in the future.

Completed.

Appendix B

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