Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Wilkes-Barre, Pennsylvania

Report No. 03-01357-61 **January 12, 2004**

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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of May 19-23, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Wilkes-Barre Veterans Affairs Medical Center (VAMC), Wilkes-Barre, Pennsylvania, which is part of the Stars and Stripes Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected VAMC 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 108 employees.

Results of Review

Patients and employees generally expressed satisfaction with the quality of care provided at the VAMC. To improve operations, VISN 4 and VAMC Directors needed to:

- Provide greater management oversight to improve contracting practices.
- Strengthen controls over the Government Purchase Card Program.
- Implement controls over engineering supplies.
- Improve controls over delinquent accounts receivable.
- Strengthen accountability over controlled substances.
- Designate an alternate processing site to improve information technology (IT) security.
- Review and deobligate accrued services payable and undelivered orders in a timely manner.
- Strengthen the review of inactive Personal Funds of Patients (PFOP) accounts and transfer the funds appropriately.
- Establish contracts for recurring needs.
- Improve Community Residential Care (CRC) Program oversight.
- Strengthen two QM Controls.
- Improve environment of care (EOC) at the VAMC and the Allentown Community-Based Outpatient Clinic (CBOC).

VISN 4 and VAMC Directors' Comments

The VISN and VAMC Directors agreed with the CAP review findings and provided acceptable improvement plans (See Appendixes B and C, pages 17-31 for the full text of the Directors' comments). We will follow up on planned actions until they are completed. This report was prepared under the direction of Nelson Miranda, Director, Washington, D.C. Region Office of Healthcare Inspections; and Ms. Jacqueline Stumbris Audit Manager, Bedford Audit Operations Division.

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

Introduction

Medical Center Profile

Organization. Located in Wilkes-Barre, Pennsylvania, the VAMC provides a broad range of inpatient and outpatient health care services. Outpatient services are also provided at six CBOCs located in Allentown, Sayre, Williamsport, Tobyhanna, Schuylkill, and Columbia Counties. The VAMC is part of VISN 4 and serves a population of 206,758 veterans in 19 counties in Pennsylvania.

Programs. The VAMC is a teaching hospital, providing a full range of medical and allied health educational services. Comprehensive primary and tertiary health care is provided in medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, hematology, and nephrology. Additionally, long-term care services including geriatric care, extended care, hospice care, and transitional care are offered.

Affiliations and Research. The VAMC is affiliated with Drexel University's College of Medicine, the Lake Erie College of Osteopathic Medicine, and the Pennsylvania College of Optometry. The VAMC has 54 internal medicine residents, 2 ophthalmology residents, 1 optometry resident, and 1 dental resident. The facility also supports affiliations with 41 other colleges, universities, and schools of allied health. These affiliates provide training for students in such areas as occupational therapy, nutrition, nursing, pharmacy, physical therapy, biomedical engineering, physician assistants, psychology, and social work. The Institutional Review Board was deactivated January 2, 2002, and research was no longer being conducted.

Resources. The VAMC's fiscal year (FY) 2003 medical care budget was $130 million, a 9.2-percent increase over the FY 2002 expenditures of $119 million. FY 2002 staffing was 992 full-time equivalent employees (FTEE), including 65 physician and 270 nursing FTEE. The VAMC had 89 hospital operating beds and 105 nursing home beds.

Workload. In FY 2003, through March 31, 2003, the VAMC treated 36,676 unique patients, an 11.4-percent increase over the first 6 months of FY 2002. The VAMC Director attributed this increase to better access to care through the hiring of more clinical staff and expanded hours of services at several CBOCs. As of March 31, 2003, the inpatient care workload totaled 1,373 discharges, and the average daily census, including nursing home patients, was 141. The outpatient workload for the same period totaled 159,597 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 VAMC operations for FY 2002 and FY 2003 through May 23, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Accrued services payable and undelivered orders
Clinic appointment scheduling
Clinical contract administration
CRC Program
Controlled substances accountability
Delinquent accounts receivable
EOC inspections
Engineering supplies management
General Post Funds and PFOP
Government Purchase Card Program
IT security
Medical Care Collections Fund
Non-contract procurements
Pharmacy security
Prompt payment and interest payments
QM Program
Research laboratory security

An activity that was particularly effective or otherwise noteworthy is recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-15). 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 VAMC managers until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care.

During the review, we presented 2 fraud and integrity awareness briefings attended by 108 VAMC 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

Patients and Employees Generally Expressed Satisfaction with the Quality of Care. We interviewed 34 inpatients and 39 outpatients to obtain their perceptions about the quality and timeliness of services. Ninety-six percent of patients interviewed responded that their treatment needs were addressed to their satisfaction. All but one of the 73 patients indicated that they would recommend medical care at the facility to eligible family members or friends; and 97 percent rated the overall quality of care as good, very good, or excellent.

We distributed Employee Satisfaction Questionnaires to all employees, 141 of whom responded. Some employees did not respond to all of the questions, yielding different denominators for some of the questions. Seventy-eight percent of the employees (94 of 120) believed that high-quality patient care was the first priority at the medical center. Eighty-nine percent (40 of 45) responded that they were comfortable reporting errors, and ninety percent (35 of 39) felt security of information was maintained in accordance with VA policy. Ninety percent (124 of 138) of the employees also rated the quality of care provided to patients as good, very good, or excellent.

Opportunities for Improvement

Clinical Contract Administration – Managers Needed to Better Monitor Contract Practices and Ensure Compliance with VA Policies and Federal Acquisition Regulations

Conditions Needing Improvement. VAMC managers needed to ensure that clinical contracts were awarded in accordance with VA policies and the Federal Acquisition Regulation (FAR). Our review disclosed contract formation and management oversight deficiencies.

To determine the effectiveness of clinical contracting procedures, we reviewed all eight of the medical center's current clinical services contracts. These contracts had individual values exceeding $20,000 and a combined value of $9.7 million. FAR requires officials to establish contract files containing records of significant contractual actions. Listed below are documentation deficiencies found in these contract files.

- Required database searches of the Federal Government's Excluded Parties Listing System (EPLS) were not documented for any of the eight contracts. Contracting officers are required to conduct EPLS searches to determine whether prospective contractors are ineligible for Federal contracts.

- Option years for seven contracts valued at $9.2 million were exercised. However, none of the contract files contained the required documentation to justify exercising the option years.

- Contract files for five contracts valued at $8.5 million did not contain documentation that required legal/technical reviews had been performed by the VA Office of Acquisition and Materiel Management.

- Three contracts valued at $5.6 million required background investigations of contractor personnel having access to VA computer systems. The contracting officer is responsible for initiating requests for background investigations. These investigations had not been requested or conducted at the time of our review, approximately 2 years after the contracts had been awarded.

- Contract files for three contracts valued at $5.6 million did not contain documentation that the required price analyses had been completed.

- The required Price Negotiation Memorandums (PNM) had not been prepared for five contracts valued at $4.7 million. After contract negotiations are completed, FAR requires the contracting officer to prepare PNMs to provide documentation of the most important elements of contract negotiations, including the purpose of the negotiations, descriptions of the services being procured, and explanations of how contract prices were determined.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director implements procedures and controls to: (a) improve contract administration and management oversight in accordance with VA policies and FAR, and (b) correct identified documentation deficiencies.

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

Government Purchase Card Program – Control Activities Needed To Be Effectively Implemented

Conditions Needing Improvement. VAMC managers needed to strengthen controls over the Government Purchase Card Program. Veterans Health Administration (VHA) policy requires that Government purchase cards be used for all purchases under the micro-purchase level of $2,500, and where practicable, for all purchases up to $100,000 where appropriate warranting has been completed. We determined that unneeded purchase cards were not deactivated and competitive bids were not sought for purchases exceeding $2,500.

We reviewed purchase card transactions that occurred from October 1, 2001 through March 31, 2003. As of March 31, 2003, the VAMC had 92 cardholders and 32 approving officials. During our review period, cardholders made 17,367 purchases totaling approximately $9 million. We focused our purchase card activities review on Engineering and Prosthetic Services purchases. During the review period, 22 Engineering and Prosthetic Services

cardholders made 7,453 purchases totaling approximately $2.5 million, and 4 approving officials certified that the payments were legal and proper. Our review identified the following areas needing management's attention:

Deactivation of Unnecessary Purchase Cards. An approving official did not adequately monitor cardholder purchase levels nor recommend that the Purchase Card Coordinator (PCC) deactivate unneeded purchase cards. VA policy states that approving officials are responsible for monitoring the use of the card by each cardholder and evaluating whether continued possession of cards by cardholders serves legitimate Government needs. Our review of Engineering and Prosthetic Services cardholder purchases showed that 4 of the 22 cardholders had not used their cards to purchase goods or services during the last 6 months of the review period. After reviewing the four cardholders' purchase histories, the PCC concluded that the purchase cards were no longer needed and deactivated these cards.

Competitive Procurements. Purchase cardholders did not seek competition or document sole source justifications for prosthetic purchases exceeding $2,500. FAR requires purchasing officials to promote competition to the maximum extent possible and to obtain supplies and services from the source whose offer is most advantageous to the Government. To promote competition, cardholders must consider three sources or document sole source justifications. In addition, the approving officials did not ensure sufficient documentation was maintained to demonstrate efforts to seek competition, as required by VA policy. As a result, VAMC managers did not have assurance that the most fair and reasonable prices were obtained or that procurements were made in VA's best interests.

We reviewed a judgment sample of 35 open market purchases totaling $232,523 from the universe of 7,453 engineering and prosthetic purchases. We found that 4 cardholders did not seek competition or document sole source justifications for 31 purchases totaling $165,891. The 31 non-competitive procurements included 16 hip implants totaling $115,867, 14 knee implants totaling $43,189, and 1 soft tissue implant purchase totaling $6,835.

To determine whether prices paid for implants were fair and reasonable, we contacted a regional supplier to obtain prices for comparable items. Information received from this competitor indicated that the VAMC had received competitive prices for knee and soft tissue implants but could have received lower prices for hip implants. Our comparison of prices paid by the VAMC to prices offered by the competitor indicated the facility could have paid 52 percent less for the hip implants. Based on that estimate, VA could have potentially saved $60,250 (52 percent of $115,867).

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director implements controls to: (a) monitor cardholder purchase levels to ensure that cards are needed and deactivate those that are unnecessary, and (b) seek competition for procurements exceeding $2,500 and document these efforts or document sole source justifications.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director

provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Engineering Supplies Management – Inventory Management Controls Needed To Be Implemented

Conditions Needing Improvement. Controls over engineering supplies needed to be implemented in order to effectively manage inventories. VHA mandated the use of the Generic Inventory Package (GIP) in October 2000. The GIP is an automated management tool used to establish proper inventory levels, set reorder quantities, and track usage of supplies. In addition, the GIP enables inventory managers to properly account for quantities on hand through periodic physical inventories. While the GIP was in use in other areas of the VAMC, it was not being utilized in the engineering section of Facilities Management Service (FMS). In FY 2002, the VAMC spent approximately $1,017,657 on expendable engineering supplies.

By not using the GIP for engineering supplies, FMS was not taking advantage of the inventory management functions of the system. In addition, the Chief, FMS, informed us that physical inventories had never been conducted for engineering supplies. As a result, we were unable to determine whether engineering supplies were overstocked, adequate to meet medical center needs, or misappropriated.

During our inspection of engineering supply storage areas, we found numerous unopened boxes of light bulbs, some of which were dated 1988. We also identified a box containing five mercury vapor bulbs and several other unopened boxes of germicidal lamps. Neither of these latter items had been used at the VAMC since the late 1980s. Furthermore, these items are considered hazardous materials, which needed to be disposed of by the facility's hazardous waste contractor.

As a result of our CAP review, the Chief, FMS, initiated a plan to implement the GIP for engineering supplies. During our on-site review, FMS personnel began the process of taking a physical inventory of all engineering supply items to be entered into the GIP. In addition, during our site visit, the facility's hazardous waste contractor disposed of the mercury vapor bulbs and germicidal lamps.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director implements controls and procedures to account for all engineering supplies in the GIP.

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

Delinquent Accounts Receivable – Controls Needed To Be Improved

Conditions Needing Improvement. VAMC managers needed to ensure active and timely follow-up on all debts owed to the medical center. This included debts owed by current and former employees as well as vendors. VA policy requires that aggressive efforts be utilized in pursuing collection of accounts receivable (AR). We identified the following debt collection deficiencies.

Delinquent Debts of Current Employees. The Veterans Health Information Systems and Technology Architecture (VistA) AR Profile module classifies bills into categories such as current employee, ex-employee, and vendor. A bill comment log is also provided in the system to document follow-up activity. As of March 31, 2003, VistA listed 12 current employee debts totaling $24,418; however, this category should have only included 7 ARs totaling $14,997. Five of the 12 debts were actually owed by ex-employees who had left the VAMC from 2 months to 21 months earlier. Fiscal staff did not know how to change the category of these debts or how to use the bill comment log. All seven current employee debts were established as a result of erroneous salary payments. We found problems with 5 of the 7 debts. Two of the five, totaling $7,166, involved erroneous referrals to the Treasury Offset Program (TOP). These current employee debts should be paid directly by the employee or by salary offset. In the three remaining debts totaling $4,740, waivers had been sought in two cases (one in August 1999, and the other in July 2002) but there had been no follow up to determine their status, and although the third debt originated in February 2000, a waiver was not applied for until May 13, 2003. Fiscal staff needed to follow up more aggressively on these debts.

Delinquent Debts of Former Employees. VistA listed 10 former employee ARs totaling $13,768; however, this category should have included 16 accounts totaling $27,660. This problem occurred because five ARs, totaling $9,421, had been incorrectly categorized as "current employees," and one AR valued at $4,471 had been incorrectly categorized as a vendor's debt.

Two of the former employee debts, totaling $6,871, were not referred to the TOP in a timely manner. One of the former employee debts valued at $127 was incorrectly submitted to the TOP without the individual's Social Security Number. One former employee debt, valued at $1,780, was referred to the Committee on Waivers and Compromises in October 2002. At the time of our review, there had been no follow-up by fiscal staff to determine the status of the waiver request.

Delinquent Vendor Accounts Receivable. As of April 8, 2003, the VAMC had 18 vendor ARs totaling $10,430. We reviewed each of the 18 accounts through the facility's VistA AR Profile module. Fifteen of these ARs, totaling $2,637, resulted from the failure to use FY 2001 credit memos for items returned to five prosthetics vendors. According to the Chief, Fiscal Service, these credit memos had been overlooked and were not used to offset purchases from these vendors after purchase cards became the method of choice for payment. The Chief, Fiscal Service stated that these credit memos would be used to offset future purchases.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director establishes procedures to: (a) provide a training program for Fiscal Service staff on the VistA AR Profile module in order that all options may be utilized appropriately and omissions and errors are corrected as necessary, (b) notify current employees of their delinquent debts and initiate offsets of their disposable pay, (c) refer former employee debts to TOP as required, (d) follow up on debts submitted for waivers, and (e) use existing credit memos to offset future purchases for applicable vendor ARs.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Controlled Substances Accountability – Inspector Training and Pharmacy Employee Access to Controlled Substances Needed To Be Strengthened

Conditions Needing Improvement. VAMC managers needed to ensure that all controlled substances inspectors were properly trained, training documentation was maintained, the number of pharmacy employees with access to controlled substances in a 24-hour period did not exceed the mandated limit, and blank prescription pads are adequately secured.

To evaluate controlled substances accountability, we reviewed monthly controlled substances inspection reports for the VAMC and the Allentown and Sayre CBOCs for the 12-month period ending March 2003. We also reviewed documentation of controlled substances inspectors' training for the three sites, and VHA and local policy related to controlled substances. We observed an unannounced controlled substances inspection and conducted interviews with Pharmacy personnel, controlled substances inspectors, and the Controlled Substances Inspection Coordinator.

Inspector Training Deficiency. VHA policy requires that a program for training controlled substances inspectors be established, followed, and documented. VAMC inspectors did not have the required formal training. Training documentation was not properly maintained for four VAMC controlled substances inspectors, two of the Sayre CBOC inspectors, and one Allentown CBOC inspector.

Access to Controlled Substances. VHA policy limits access to controlled substances in the pharmacy to a maximum of 10 pharmacy employees within a 24-hour period. We found that 28 pharmacy employees were allowed access to controlled substances in the pharmacy each day.

Access to Blank Prescription Pads. During our EOC inspection, we found blank prescription pads in unlocked office desks in the Allentown CBOC. Leaving blank prescription pads in unlocked office desks increases facility risk for drug diversion.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the VAMC Director improves controlled substances accountability by requiring that: (a) a formal training program for controlled substances inspectors is established, followed, and documented, (b) the number of pharmacy employees with access to the pharmacy controlled substances area, in a 24-hour period, is limited to 10, (c) the issue of leaving blank prescription pads in unlocked office desks is discussed with clinical managers at the VAMC and surrounding CBOCs to prevent this from reoccurring, and (d) all areas of the CBOCs and VAMC are checked to ensure that blank prescription pads are secured.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Information Technology Security – An Alternate Processing Site Needed To Be Designated

Condition Needing Improvement. We reviewed VAMC IT security controls to determine if they were adequate to protect automated information system (AIS) resources from unauthorized access, disclosure, modification, destruction, or misuse. We found that physical security for the computer room was adequate. However, the VAMC contingency plan did not include a designated alternate processing facility. VHA policy requires facilities to develop and implement AIS contingency and recovery plans. One key element of an effective contingency plan is the designation of an alternate processing facility that can be used in case of a disaster. An alternate processing facility can provide backup AIS services in the event that the primary facilities are severely damaged or cannot be accessed.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the VAMC Director takes action to select an alternate processing facility that could be used during disaster recovery and includes this in the contingency plan.

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

Accrued Services Payable and Undelivered Orders – Unnecessary Obligations Needed To Be Promptly Cancelled

Conditions Needing Improvement. VAMC managers needed to ensure that reviews of delinquent accrued services payable (ASPs) and undelivered orders (UDOs) were conducted in accordance with VA policy. VA policy requires that Fiscal Service employees review ASPs and UDOs monthly, follow up with the initiating services on obligations that are inactive for more than 90 days, and determine if they are still needed. In addition, as part of the fiscal year-end closing procedure, all documents supporting ASPs and UDOs are required to be reviewed with

the initiating services to determine whether the services or goods are likely to be received. For those obligations that will not be filled, prompt action should be taken to cancel the orders and make the funds available for other VAMC needs. As of March 31, 2003, the VAMC had 864 obligations totaling $8.5 million. Of these obligations, 210 totaling $1.8 million were inactive for more than 90 days.

We reviewed a judgment sample of 50 obligations valued at $60,072 that were inactive for more than 90 days. This sample consisted of 25 ASPs valued at $32,417 and 25 UDOs valued at $27,655. These obligations were established during or prior to FY 2002. The Chief, Fiscal Service, performed the required monthly reviews. However, Fiscal Service employees needed to improve the fiscal year-end review. Six obligations valued at $8,349, consisting of two ASPs for $174 and four UDOs for $8,175, were no longer needed and could have been cancelled prior to September 30, 2002. The Chief, Fiscal Service, had not contacted the initiating services at the end of the fiscal year to determine if these obligations were still needed. He acknowledged that the six obligations should have been cancelled prior to the end of FY 2002 and the funds used for other purposes.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the VAMC Director implements controls to: (a) review all obligations and verify the need for these obligations with the initiating services as part of the fiscal year-end review, and (b) cancel unneeded obligations before the end of the fiscal year so that funds can be made available for other uses.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Personal Funds of Patients – Reviews of Inactive Accounts Needed To Be Strengthened to Ensure Appropriate Transfers of Funds

Conditions Needing Improvement. VAMC managers needed to improve controls for reviewing inactive PFOP accounts. VA policy requires that PFOP accounts that are inactive for a period of 3 months be reviewed to verify the patients' status. Determinations must be made as to whether the patients' funds should be transferred out of the PFOP fund to the patients, guardians, or the patients' next of kin. As of March 31, 2003, there were 162 PFOP accounts with balances totaling $846,374. We found that 129 of these PFOP accounts valued at $224,067, had been inactive for more than 3 months.

We tested a sample of 23 inactive accounts valued at $53,389. The dates of last activity for these accounts ranged from May 1993 to December 2002. Our review revealed that 13 of the 23 accounts valued at $7,395 belonged to patients who had been discharged from the facility and 10 of the 23 valued at $45,994 belonged to deceased patients. The Chief, Fiscal Service, had verified the status of these accounts but had not attempted to locate the patients, guardians, or next of kin to transfer the funds appropriately.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the VAMC Director implements controls and procedures to ensure that the status of inactive accounts be determined and patients' funds be appropriately transferred when necessary.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Community Residential Care – Critical Areas of the Program Needed Improvement

Conditions Needing Improvement. VAMC managers had developed an effective CRC Program but oversight needed improvement. CRC home inspections needed to be completed at the required intervals; written agreements needed to be established with CRC home operators; visits to veterans in the CRC Program needed to be completed monthly; and annual reviews between Veterans Benefits Administration (VBA) field examiners and VHA clinicians needed to be conducted as required by VHA policy M-5, Part III, Chapters 1-9, Geriatrics and Extended Care, Community Residential Care Program.

CRC Home Inspections. Inspections are required every 2 years with a fire and life-safety inspection required annually. Program officials explained that regular inspections were not completed annually because of state oversight responsibilities. However, inspections by VA officials are also required. The Director agreed that inspections by VAMC employees are necessary and assured us they will be conducted annually as required by VHA policy.

Written Agreements. There were no written agreements between the VAMC and CRC Program operators regarding the type of services provided in CRC homes. CRC Program managers were unable to explain the variance in costs to veterans based on services provided to them at the CRC homes. Also, there was no process in place to verify that VA employees were not owners, operators, or employees of the CRC homes.

Medical Record Documentation. We reviewed 10 medical records of patients enrolled in the CRC Program. Only 3 patient medical records had documentation that CRC providers were given instructions for care when patients were initially placed in their homes. CRC Program guidelines require monthly follow-up visits by VHA health care employees to evaluate patients' conditions and adjustments to CRC homes environment.

Protection of VA Funds. VBA field examiners are required to communicate annually with VHA clinicians regarding patients who have fiduciaries and are receiving VA funds. There was no evidence that this had been conducted.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the VAMC Director establishes procedures to: (a) perform CRC home inspections, (b) establish written agreements with CRC home operators, (c) ensure that CRC homes are not owned and

operated by VA employees, (d) conduct monthly patient visits and ensure that care instructions are updated in the medical records, and (e) ensure that program managers communicate annually with VBA field examiners regarding patient finances.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director agreed with the VAMC Director's corrective action plans to improve the management and oversight of the CRC Program. In addition, the Facility Director provided a copy of a newly developed agreement with CRC home operators to establish services provided in the homes, and a copy of CRC quarterly meeting minutes as evidence that VBA Field Examiners attend meetings to discuss veterans' finances. We will follow up on the planned actions until they are completed.

Non-Contract Procurements – Contracts Needed To Be Established for Recurring Needs

Conditions Needing Improvement. VAMC managers should consider establishing contracts for services procured on a recurring basis. Services purchased on a recurring basis by the VAMC included: fee-basis services, transcription services, and patient mobility equipment repair services. Establishing contracts for recurring services would allow for a more efficient procurement process, provide a potential for cost savings, and would likely improve management oversight of vendor activities. Details on the non-contract procurements follow.

Fee Basis. During the 18-month period ending April 30, 2003, VAMC managers made payments of $2.1 million for 48 fee-basis physicians and surgeons. Additional fee-basis payments totaling $375,000 were made to four hospitals/clinics.

According to a report by the VISN 4 Acquisition Task Force dated September 21, 2000, "…fee-basis arrangements are usually for non-recurring needs and are not intended to be long-term solutions. With a contract, there is a contractual obligation to provide the services, thus ensuring availability of services when needed. The fee-basis arrangement however, does not necessarily guarantee physician availability." We believe that managers need to determine whether replacing these fee-basis arrangements with competitive contracts could result in lower procurement costs.

Transcription Services. During the 18-month period ending on April 30, 2003, the VAMC made repetitive non-contract purchases of transcription services from two vendors totaling $1,054,000. We believe the use of contracts for these services could improve market leverage and lower Government expenditures.

Contracts would have improved management oversight in several respects:

- The contracting officer would have been required to conduct a search of the EPLS database to determine if the prospective transcription services contractors were ineligible to be awarded Federal contracts because of ethical violations. The database search was not conducted for the non-contractual transcription services vendors.

- Transcription service vendors are given access to VA computer systems. The contracting officer would have been required to initiate a request for the required background investigations of contractor personnel. The required background investigations were not requested or performed for transcription services personnel.

- The contracting officer's appointment of a contracting officer technical representative would have ensured that an individual was assigned the responsibility of ensuring that services were being provided in accordance with the contract terms, and that invoices were validated for accuracy before payment. This would also reduce the risk of over billing. The individual charged with certifying invoices received from one of these vendors for payment was unable to validate the accuracy of the invoices. Nevertheless, these invoices were certified for payment.

Repairs to Patient Mobility Equipment. Prosthetic Service, without benefit of a contract, transacted business with a vendor for repairs of wheelchairs, scooters, lift chairs, and other patient mobility equipment. These repetitive expenditures totaled $80,000 over the 18-month period ending April 30, 2003. We believe that contracting for these repair services would better protect the Government's interests.

Suggested Improvement Action 1. We suggested that the VISN Director ensure that the VAMC Director considers establishing contracts for the above recurring procurements.

The VISN and VAMC Directors agreed with the findings and suggestion, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Quality Management Program – Two QM/PI Controls Needed To Be Strengthened

Conditions Needing Improvement. The VAMC Performance Improvement (PI)/QM program was generally effective. However, we found that the following areas needed improvement.

Written Scope and Operations. The written scope of the VAMC PI/QM program did not specifically address the community nursing home (CNH) or outpatient spinal cord injury (SCI) programs. VAMC managers and employees had documented in the Medical Executive Committee minutes and PI Steering Committee minutes that they had continuously aggregated PI/QM monitoring results from most of the clinical programs located on and off the VAMC campus. VAMC managers and employees analyzed the results to detect trends and had taken actions to address system issues, but not for the outpatient SCI program and the CNH program.

Benchmarking trended results of CPR outcomes. We did not find comparison data with goals or benchmarks set by the VAMC or VISN 4 to improve the cardiopulmonary resuscitation monitoring program.

Suggested Improvement Action 2. We suggested that the VISN Director ensure that the VAMC Director establishes procedures to: (a) revise the PI/QM program to improve its scope and operations regarding the outpatient SCI and CNH programs, and (b) improve the CPR monitoring program by including benchmarks for comparing the VAMC's findings.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Environment of Care – Minor Cleanliness, Security, and Repair Issues Needed To Be Addressed at the VAMC and the Allentown CBOC

Conditions Needing Improvement. We inspected all clinical and administrative areas of the VAMC, including the Allentown CBOC and found the EOC to be generally acceptable. However, we discovered minor problem areas that could be improved.

During our EOC inspection rounds we found dirt build-up around the walls and behind the equipment in the Outpatient Pharmacy, and dirty or damaged gaskets on all refrigerators throughout both facilities. Managers took immediate steps to either correct or complete work orders on the EOC deficiencies. While on site we suggested that the Director develop a plan of action to address the unresolved minor EOC issues. The Director concurred with our suggestion and submitted an action plan to resolve the issues.

Suggested Improvement Action 3. We suggested that the VISN Director ensure that the VAMC Director establishes procedures to implement and evaluate the action plan for correcting minor EOC unresolved problems.

The VISN and VAMC Directors agreed with the findings and suggestion, and the VISN Director agreed with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania

Report Number: [XX–XXXX–XX]

Recommendation	Explanation of Benefit	Better Use of Funds
2	Better use of funds by seeking competition for prosthetic implant purchases.	$60,250
7	Better use of funds by deobligating unneeded accrued services payable and undelivered orders.	$8,349
	Total	$68,599

Appendix B

VISN 4 Director Comments

VISN Director Comments
Draft Report of Combined Assessment Program Review
VA Medical Center, Wilkes-Barre, PA
(Project Number 2003-01357-HI-0172)

The VISN 4 Director concurs with the draft report of the Combined Assessment Review of the VA Medical Center, Wilkes-Barre, PA, and the comments and action plans provided by the Medical Center Director.

The Medical Center has demonstrated significant effort in improving and correcting recommendations cited in the report, evidenced by the effectiveness of the facility's corrective action plans and subsequent outcomes.

The network office will monitor continued implementation and improvement in the outstanding items in the report. This will be accomplished through routine updates to and/or site visits by the VISN's leadership team and program managers, to include the Chief Medical Officer, Chief Financial Officer, Compliance Officer and Compliance Auditors, Pharmacy Benefits Manager, QM Manager, Senior Acquisitions Manager, Information Security Officer, and Safety & Fire Protection Engineers. Status of corrective actions will also be discussed during performance appraisal meetings between the VISN Director and VAMC Director.

VAMC Director Comments

Medical Center Director Comments
Draft Report of Combined Assessment Program Review
VA Medical Center, Wilkes-Barre, PA
(Project Number 2003-01357-HI-0172)

Clinical Contract Administration – Managers Needed to Better Monitor Contract Practices and Ensure Compliance with VA Policies and the Federal Acquisition Regulation

Recommended Improvement Action 1. We recommend that the VISN Director ensures that the VAMC Director implements procedures and controls to (a) improve contract administration and management oversight in accordance with VA policies and FAR, and (b) correct identified documentation deficiencies.

- **EPLS**

Concur. Wilkes-Barre VAMC is documenting the EPLS search. It has been added to our facility checklist. **Completed**

- **Option years**

Concur

- **Legal/technical reviews**

Concur

VAMC Director Comments

Background investigations of contractor personnel having access to VA computer systems

Concur. Security Background Checks have been initiated for all contractors having computer access.

- **Price analysis completed**

Concur

- **Price Negotiation Memorandums (PNM)**

Concur. Action Plan: Recognizing past contracts cannot be retroactively corrected, in the future, contract folders will include evidence that the contracting officer entered into negotiations with offers in the form of PNM. The current contracting officer has developed and reorganized the contract documentation format. This will serve as a better control and management tool for the contracting department and maintain a consistency for all acquisition related actions. Per the new format each tab (based on the standard file division) will list the required information for each of the six tabs from contract formation to closeout. **Completed**

VAMC Director Comments

Government Purchase Card Program – Control Activities Needed To Be Effectively Implemented

Recommended Improvement Action 2. We recommend that the VISN Director ensures that the VAMC Director implements controls to: (a) monitor cardholder purchase levels to ensure that cards are needed and deactivate those that are unnecessary, and (b) seek competition for procurements exceeding $2,500 and document these efforts or document sole source justifications.

- **Deactivate unnecessary purchase cards**

  Concur. All unneeded purchase cards had been deactivated at the time of the OIG's visit.

  Action Plan: Credit card usage is being monitored on a monthly basis to ensure legitimacy and continued need. **Completed**

- **Competitive procurements**

  Concur. Wilkes-Barre VAMC contacted one of the OIG's suggested sources, Johnson and Johnson, in early July regarding hip and knee pricing. Contractor indicated that "courtesy pricing" (a.k.a. discount pricing) to the government was to expire at the end of July (2003), at which time pricing would revert to "open market" (a.k.a. no discount). Contractor also indicated that courtesy pricing only extended to knees and did not apply to hips. Facility also contacted the VA National Acquisition Center to inquire about the award date for the new knee and hip national contract. NAC Contracting Officer indicated that offers are in, source selection was to begin in October, and an award date of late November (2003) is anticipated.

VAMC Director Comments

Action Plan: Local contracting officer has circulated the NAC's Statement of Work for Hip and Knee replacement to determine if it would meet our needs. If it does, Wilkes-Barre will wait for award of the NAC contract. If it doesn't, we will issue our own RFP prior to October 1st and award a station contract by January 1, 2004. Wilkes-Barre is currently sole sourcing, with justification, soft tissue and knee replacement purchases in the interim.

Engineering Supplies Management – Inventory Management Controls Needed To Be Implemented

Recommended Improvement Action 3. We recommend that the VISN Director ensures that the VAMC Director implements controls and procedures to account for all engineering supplies in the GIP.

Concur. Implementation of the GIP for engineering supplies was in process at the time of the survey.

Action Plan: We have detailed numerous people into positions in order to ensure all data input. **Target date for completion is September 30, 2003.** All Primaries are **complete**. Secondaries to be completed by **December 31, 2003.**

Delinquent Accounts Receivable – Controls Needed To Be Improved

Recommended Improvement Action 4. We recommend that the VISN Director ensures that the VAMC Director establishes procedures to: (a) provide a training program for Fiscal Service staff on the VistA AR Profile module in order that all options may be utilized appropriately and omissions and errors are corrected as necessary, (b) notify current employees of their delinquent debts and initiate offset of their disposable pay, (c) refer former employee debts to TOP as required, (d) follow up on debts submitted for waivers, and (e) use existing credit memos to offset future purchases for applicable vendor ARs.

VAMC Director Comments

- **Training program for Fiscal Service staff**

Concur. Training class for Fiscal employees on using VistA AR profile was conducted.

Action Plan: Fiscal's new employee orientation plan has incorporated training on the VistA AR profile. **Completed**

- **Current employees**

Concur. All current employees were notified of their debts.

Action Plan: Computer generated letters are issued every 30 days (maximum 3 letters). If the debts are not paid after the 3rd letter then 15% of the employees disposable pay is deducted each pay period until the debt is satisfied**. Completed**

- **Former employees**

Concur. All former employee debts have been referred to TOP.

Action Plan: Debts are automatically forwarded to TOP after 120 days of inactivity. **Completed**

- **Waivers**

Concur. WBVAMC has followed up on all waiver requests**.**

Action Plan: Waiver requests will be followed up when the monthly reconciliation of accounts receivable is conducted. **Completed**

- **Credit memos**

Concur. All outstanding credit memos are cleared.

VAMC Director Comments

Action Plan: Outstanding credit memos will be reviewed on a monthly basis when the accounts receivables are reconciled. **Completed**

Controlled Substances Accountability – Inspector Training and Pharmacy Employee Access to Controlled Substances Needed To Be Addressed

Recommended Improvement Action 5. We recommend that the VISN Director ensures that the VAMC Director improves controlled substances accountability by requiring that: (a) a formal training program for controlled substances inspectors is established, followed, and documented, (b) the number of pharmacy employees with access to controlled substances in a 24-hour period is limited to 10, (c) the issue of leaving blank prescription pads in unlocked office desks is discussed with clinical managers at the VAMC and surrounding CBOCs to prevent this from reoccurring and, (d) all areas of the CBOCs and VAMC are checked to ensure that blank prescription pads are secured.

- **Training program for controlled substances inspectors**

Concur. A formal controlled substances inspector training program has been implemented and was given to all current inspectors. This includes all Community Based Outpatient Clinics, where controlled substances are kept and maintained. All training is documented and sent to the medical center education department and entered into the employee-training folder. A copy of the training is also kept on file with the medical center controlled substance coordinator. Letters have been issued from the Medical Center Director, to all selected controlled substance inspectors, informing them of the training and the role of the inspector. Training is given to all new inspectors upon being selected and refresher training is given once a year to the current list of inspectors. All training is documented according to VHA policy. **Completed**

VAMC Director Comments

- **Access to controlled substances**

Concur. The controlled substance area at the VAMC Wilkes-Barre is secured by a dual locking system. One is electronic, which records who enters that area at any given time, and the other is manual, which is controlled by one key. There is only one key available at any given time. In order to enter this area, both systems must be activated together. Therefore, even though more people have electronic access, which is needed to cover various rotational responsibilities and shifts at the medical center, in reality, only the person who has the key in their possession actually has access to the vault area. This key is issued to the person assigned to process controlled substances on a daily basis. If this person has to leave, the key is then in the possession of their replacement or the pharmacist assigned to the checking station. Therefore, at any time, only one person has access to the controlled substance area. A daily log including persons/times is kept outlining initial possession and changes in possession of the key. **Completed**

- **Blank prescription pads in unlocked office desks**

Concur. Clinical Managers at all sites were requested to ensure that all prescriptions pads be secured and accessible only to those who are authorized. **Completed**

Action Plan: Service Chiefs developed and implemented a formal monitoring process to ensure that prescription pads are secured. Monitor results are reported to the Chief of Staff on a monthly basis. In addition, this topic has been added to the checklist for Environment of Care Safety & Sanitation Inspection Team rounds. **Completed**

Information Technology Security – An Alternate Processing Site Needed To Be Designated

Recommended Improvement Action 6. We recommend that the VISN Director ensures that the VAMC Director takes action to select an alternate processing facility that could be used during disaster recovery and includes this in the contingency plan.

VAMC Director Comments

Concur. Wilkes-Barre VAMC's contingency plans are in compliance with the VHA requirement to develop and implement an information system contingency and recovery plan. The recommendation to name an alternate processing facility is being addressed by the VISN 4 ISO and CIO. **Completed locally; awaiting VISN-wide resolution.**

Action Plan: VAMC will work with appropriate VISN staff and councils to seek resolution.

Accrued Services Payable and Undelivered Orders – Unnecessary Obligations Needed To Be Promptly Cancelled

Recommended Improvement Action 7. We recommend that the VISN Director ensures that the VAMC Director implements controls to: (a) review all obligations and verify the need for these obligations with the initiating service as part of the year-end review, and (b) cancel unneeded obligations before the end of the fiscal year so that funds can be made available for other uses.

- **Review and verify the need for these obligations**

Concur. Unnecessary obligations were cancelled prior to the close of the fiscal year. All obligations have been reviewed in accordance with MP 4 Part V, 1b.04j. This is documented on the F851 and F850 FMS reports that are dated 8/31/03.

Action Plan: In the future (on a monthly basis) the review will be conducted and documented on the F851 and F850 FMS reports. **Completed**

- **Cancel unneeded obligations before the end of the fiscal year**

VAMC Director Comments

Concur. All obligations for FY 2002 that were noted in the OIG audit have been cancelled or adjusted as appropriated. It needs to be noted that this review is conducted each and every fiscal year, but we did not aggressively follow-up on documents after the prior fiscal year closed. This is part of the monthly review of undelivered orders and accrued services payables.

Action Plan: This monthly review (of prior year obligations) will be documented on the F851 and F850 reports. **Completed**

Personal Funds of Patients – Review of Inactive Accounts Needed To Be Strengthened to Ensure Appropriate Transfer of Funds

Recommended Improvement Action 8. We recommend that the VISN Director ensures that the VAMC Director implements controls and procedures to require that the status of inactive accounts be determined and patients' funds be appropriately transferred when necessary.

Concur. All inactive accounts have been transferred appropriately. VistA menu option exists (dormant accounts) and is part of the monthly reconciliation. Beginning with the August 2003 reconciliation, it is reviewed and necessary action taken. It is signed by the Fiscal Officer and becomes part of the reconciliation file (this is also attached to the reconciliation that is forwarded to both the Medical Center Director and Associate Director). **Completed**

VAMC Director Comments

Community Residential Care – Critical Areas of the Program Needed Improvement

Recommended Improvement Action 9. We recommend that the VISN Director ensures that the VAMC Director establish procedures to: (a) perform CRC home inspections, (b) establish written agreements with CRC home inspectors, (c) ensure that CRC homes are not owned and operated by VA employees, (d) conduct monthly patient visits and ensure that care instructions are updated in the medical records, and (e) ensure that program managers communicate annually with VBA field examiners regarding patient finances.

- **CRC home inspections**

Concur. All of the annual fire and safety inspections of the CRC homes were completed as of June 4, 2003. Appropriate follow-up letters were sent regarding compliance.

Action Plan: CRC Coordinator in Social Work contacted the Safety Specialist from Facilities Management to schedule Fire & Safety Inspections for 2004 with the following seven VA-approved CRC Homes; Getz; Januzzi; My Home, Inc,; Orangeville Manor; Smith; Weitz and Wyoming Valley Manor. These inspections with the respective homes will be scheduled prior to the expiration of the current inspections. **Completed**

- **Written agreements with CRC home operators**

Concur. A written agreement with the CRC home operators was completed and sent along with a cover letter.

VAMC Director Comments

Action Plan: A written agreement will be mailed out to the seven CRC home operators in the 3rd Quarter of FY 2004 for their signature and return. The signed, written agreement will be mailed & return requested prior to the expiration of the current agreement. **Completed**

- **CRC homes are not owned and operated by VA employees**

Concur. Acting Supervisor, Social Work Service, contacted all seven VA-approved Community Residential Care Homes. All seven administrators verified that the home was not owned, operated or staffed by VA employees.

Action Plan: A letter, along with an agreement was sent to the homes, requesting that this be verified in writing and asking each administrator to submit a list of all owners. Each administrator will be asked to submit a list of all owners & employees. **Completed**

- **Monthly patient visits**

Concur. Regular, monthly patient visits are made to each CRC Home by Social Workers. These are documented in the electronic medical record of each patient, included is an assessment of the patient's adjustment to the home and the community and instructions for care. A random sample of three homes was conducted by the CRC Coordinator from Social Work. Monthly visits are monitored in this manner. **Completed**

- **Communicate annually with VBA field examiners regarding patient finances**

Concur. Rick Reiser, VBA Field Examiner, met with Community Residential Care Social Workers on June 6, 2003.

VAMC Director Comments

Action Plan: CRC Coordinator in Social Work will schedule Rick Reiser, VBA Field Examiner, to attend all future quarterly meetings of the CRC staff. **Completed**

Non-Contract Procurements – Contracts Needed To Be Established for Recurring Needs

Suggested Improvement Action 1. We suggest that the VISN Director ensures that the VAMC Director considers establishing contracts for the above recurring procurements.

- **Fee Basis**

  Concur. A list of fee based medical professionals has been compiled and is being divided into categories of recurring vs. non-recurring. Next, the requiring units will follow the established process: "Fee Basis vs. Contract" to make a determination whether to stay fee basis or pursue a contract. As of this date, 3 fee based service professionals have been formally contracted out. **Target date for completion is December 1, 2003.**

- **Transcription Services**

  Concur. VAMC is currently evaluating proposals from vendors. Award decision expected on or before November 7, 2003. **Target date for completion is November 7, 2003.**

- **Repairs to Patient Mobility Equipment**

  Concur. Repairs on prosthetic items are provided through one vendor primarily without benefit control.

VAMC Director Comments

Included in the current Durable Medical Equipment (DME) contract for bid is a repair component. Proposals due September 22, 2003; award to follow bid selection. **Target date for completion is November 1, 2003**

Concur. Ensure that the final DME contract has the repair services necessary to meet the needs of our veteran population in 19 counties. Due to solicitation concerns this target date is October 1, 2003. Bids to be returned by September 25, 2003. **Target date for completion is November 1, 2003**

Action Plan: The process to ensure future compliance for this particular issue will be to contract maintenance through the COTR who will bring all non-conformance issues to the attention of the CO to resolve. Contract maintenance is done through random survey of patients receiving service, visitation to vendor site to ensure compliance, home visits, and reporting as performance improvement activities to PI Steering Committee.

Quality Management Program – Two QM/PI Controls Needed To Be Strengthened

Suggested Improvement Action 2. We suggest that the VISN Director ensures that the VAMC Director establish procedures to: (a) review the PI/QM program to improve its scope and operations regarding the outpatient SCI and CNH programs, and (b) improve the CPR monitoring program by including benchmarks for comparing the VAMC's findings.

- **PI/QM program scope and operations**

Concur. The scope of activities of the PI Program, Medical Center Policy 00Q-03-380, (4.b), is revised to include: the outpatient SCI program (VHA Handbook 1176.1, May 21, 2002), and the CNH program (VHA Handbook 1143.1, June 24, 2002; VISN policy is pending on Oversight of Community Contract Nursing Homes. Monitoring indicators are in place for both programs and are being reported to the PI Steering Committee. **Completed**

VAMC Director Comments

- **CPR monitoring program**

Concur. CPR outcome review will include benchmarks for comparing medical center CPR outcomes. Will research goals and benchmarks for CPR outcomes with VISN. **Completed locally; awaiting VISN-wide resolution.**

Action Plan: VAMC will work with appropriate VISN staff and councils to seek resolution.

Environment of Care – Minor Cleanliness, Security, and Repair Issues Needed To Be Addressed at VAMC and Allentown CBOC

Suggested Improvement Action 3. We suggest that the VISN Director ensures that the VAMC Director establish procedures to implement and evaluate the action plan for correcting minor EOC unresolved problems.

Concur. Access to the outpatient pharmacy has been resolved. Gaskets have been replaced on the refrigerators.

Action Plan: Housekeeping service in the Outpatient Pharmacy area has been improved by scheduling the cleaning work during the day shift rather than the evening shift eliminating the access difficulty. Also, a housekeeping scrub team now performs a more comprehensive cleaning of the Outpatient Pharmacy twice annually. All dirty and damaged refrigerator gaskets have been replaced. Visual inspection of refrigerator gaskets in clinical areas is included in the semi-annual preventive maintenance inspections performed by the air conditioning maintenance shop. Also, inspection of refrigerator gaskets has been added to the checklist used by the Environment of Care Safety & Sanitation Inspection Team for their semi-annual inspections of the Wilkes-Barre facility and the outpatient clinics. **Completed**

Appendix D

OIG Contact and Staff Acknowledgements

OIG Contact	Nelson Miranda, Director Washington Office of Healthcare Inspections Washington, DC Region
Acknowledgements	Jacqueline Stumbris, Audit Manager Bedford Audit Operations Division John Cintolo James Lothrop Patricia McGauley Rayda Nadal Steven Rosenthal Marion Slachta Raymond Tuenge Joseph Vivolo

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Deputy Chief of Staff (00A1)
Executive Secretariat (001B)
Under Secretary for Health (10B5)
Chief of Staff to the Under Secretary for Health (10B)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Acting Assistant Secretary for Information and Technology (005)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Operations (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Management and Financial Reports Service (047GB2)
Medical Inspector (10MI)
VHA Chief Information Officer (19)
Director, National Center for Patient Safety (10X)
Veterans Integrated Service Network Director (10N4)
Director, Wilkes-Barre VA Medical Center (693/00)

Non-VA Distribution

Office of Management and Budget
General Accounting Office
Senator Arlen Specter
Senator Rick Santorum
Congressman Kevin Blaum
Congressman Todd A. Eachus
Congressman George Hasay
Congressman Thomas Tigue
Congressman John Yudichak
Congressman Donald Sherwood
Congressman Paul E. Kanjorski
Congressman Patrick Toomey
Congressman Tim Holden

Congressional Committees (Chairmen and Ranking Members):
Committee on Governmental Affairs, U.S. Senate
Committee on Veterans' Affairs, U.S. Senate
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives
Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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 at least 2 fiscal years after it is issued.