Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics White City, Oregon

Report No. 03-02850-66

January 28, 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.

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Executive Summary

Introduction

During the week of October 20–24, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Southern Oregon Rehabilitation Center and Clinics (the center), which is part of Veterans Integrated Service Network (VISN) 20. The purpose of the review was to evaluate selected center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review we also provided fraud and integrity awareness training to 127 center employees.

Results of Review

Rehabilitation center management operated an effective QM program to monitor the quality of care provided to patients. Agent cashier operations and employee quarters were managed effectively. Reviews of several areas including the environment of care, patient transportation services, and part-time physician time and attendance found no significant deficiencies. To improve operations, the center needed to:

- Correct deficiencies and strengthen controls for pharmacy security.
- Reduce excess engineering and prosthetic supply inventories and implement procedures to prevent a build-up of medical supply inventory.
- Ensure that patient transportation drivers receive initial medical evaluations, periodic medical reevaluations, and safe driver training.
- Strengthen controls for automated information systems security.
- Improve procedures for performing unannounced inspections of controlled substances storage and dispensing locations.
- Improve documentation in contract files and ensure that contracting officials receive appropriate training.
- Ensure that bills for veterans' care are promptly sent to insurance companies.

VISN 20 Director and VA Southern Oregon Rehabilitation Center Director Comments

The VISN and Rehabilitation Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–18 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Mr. David Sumrall, Director, and Ms. Claire McDonald, CAP Review Coordinator, Seattle Audit Operations Division.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Rehabilitation Center Profile

Organization. Located in White City, the VA Southern Oregon Rehabilitation Center is VA's only freestanding rehabilitation center. The center provides residential treatment in psychiatry, addictions, medicine, and physical and vocational rehabilitation. Outpatient primary care and mental health services are also provided at the center and at a community-based outpatient clinic in Klamath Falls, OR. The center is part of VISN 20 and serves a population of approximately 45,000 veterans.

Workload. In Fiscal Year (FY) 2003, the rehabilitation center treated 10,569 unique veterans, a 10 percent increase from FY 2002. Center management attributed the increase in unique veterans treated to the continuing population growth in southern Oregon, the closure of several local health maintenance organizations, and the increasing number of veterans who are turning to VA for most or all of their medical care in order to use VA pharmacy benefits. The FY 2003 inpatient average daily census was 515. Outpatient workload totaled 83,177 patient visits in FY 2003 (an 8 percent increase from FY 2002).

Resources. As of December 2003, the center was operating on a continuing resolution. The center's FY 2003 medical care budget was $41 million, about an 8 percent increase over the FY 2002 budget of $38 million. FY 2003 staffing was 414.3 full-time equivalent employees (FTEE), including 17.0 physician and 32.3 nursing FTEE.

Programs. The center serves as a national and regional resource for underserved special populations, such as homeless and chronically mentally ill veterans and veterans with addictions. The center has 755 operating beds including 51 beds for the homeless veterans program and a 163-bed substance abuse unit.

Affiliations. The center has primary affiliations with the Oregon Health Sciences University, the Oregon Institute of Technology, Portland State University, and the University of Portland to provide training opportunities for students in nursing, social work, psychology, dentistry, dietetics, and pastoral care.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected 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 patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered center operations for FYs 2002–2003 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 15 activities:

- Agent Cashier
- Automated Information Systems Security
- Behavioral Health Care
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Employee Quarters
- Environment of Care
- Medical Care Collections Fund
- Part-Time Physician Time and Attendance
- Patient Transportation Services
- Pharmacy Security
- Primary Care Clinics
- Quality Management
- Service Contracts
- Supply Inventory Management

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–10). 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 center management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all employees, 123 of whom responded. We also interviewed 30 patients during the review. The questionnaire and interview results were discussed with the Center Director.

During the review, we also presented 3 fraud and integrity awareness briefings that were attended by 127 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

Organizational Strengths

The QM Program Was Comprehensive and Effective. Center management operated an effective QM program to monitor the quality of care provided to patients. All facility programs incorporated the applicable QM process steps by gathering data for analysis, applying evaluation criteria, and ensuring that identified improvements were implemented. Program managers established performance improvement teams to facilitate positive patient outcomes and used teams to conduct root cause analysis reviews to address complex incidents. The patient complaint program was comprehensive. Program employees analyzed complaints and provided individual managers and clinicians meaningful feedback in response to patient concerns. All program managers consistently documented evaluations, corrective actions, and implementation of proposed action plans.

Agent Cashier Operations Were Sound. The center had implemented effective controls to protect agent cashier funds from fraud, waste, and abuse. The physical security of the agent cashier's space and equipment afforded adequate protection for agent cashier activities. Safe combinations were under the proper custody of the Center Director. Agent cashier unannounced audits were generally performed every 90 days as required. The agent cashier turnover rate was properly monitored, and the cash advance was appropriately adjusted to satisfy the center's need.

Employee Quarters Were Effectively Managed. Facilities Management Service (FMS) effectively managed employee quarters. FMS staff used VA's Quarters Management Information Systems software to set rents, which FMS staff reviewed and adjusted annually. Correct rental amounts were appropriately deducted from tenant paychecks, and utilities such as telephone and cable television services were properly billed to tenants.

Tuberculosis Screening and Treatment Program Was a Best Practice. The center operated a Tuberculosis (TB) Program and Clinic, and clinicians provided comprehensive screenings, diagnoses, and treatments. Since 1991, more than 15,600 new patients had been screened for TB. According to workload reports, an average of 19 percent of all newly admitted patients had tested positive for TB and had received required treatment. Patients with lengths of stay longer than 1 year and all employees were tested annually. Program staff interacted with local and state Public Health Departments and other VA facilities to coordinate care and treatment of TB patients. The TB Program had been recognized as a best practice by the Centers for Disease Control and Prevention in Atlanta.

Opportunities for Improvement

Pharmacy Security – Deficiencies Should Be Corrected and Controls Strengthened

Conditions Needing Improvement. We reviewed pharmacy security to determine if controls were adequate to prevent the loss or diversion of controlled substances. To evaluate pharmacy security, we reviewed security policies and access control records, inspected pharmacy storage areas, and interviewed VA Police and pharmacy staff. Although the pharmacy had adequate access controls and an intrusion detection system, we identified four physical security deficiencies that required corrective action.

- The center's controlled substances vault did not comply with VA security requirements. The center had large quantities of Schedule II controlled substances (drugs with a high abuse potential and high diversion risk) that were stored in several locked wooden drawers located in a vault that was secured with only a single-lock wire mesh day gate. Federal law requires that Schedule II controlled substances be stored in safes or security containers that have burglary-resistant protections. In cases where a safe or security container is not practical, these controlled substances may be stored in a vault that has a steel, combination-lock door and a self-closing, self-locking day gate.

- The dispensing window was made of bulletproof glass to protect pharmacy staff. However, the wall in which the window was installed was constructed of drywall that would not provide protection from firearms, as required by VA policy.

- The windows in the pharmacy conference room, which is located near the controlled substances vault, had external locks that allowed for the screens and windows to be opened from outside the pharmacy.

- Mail-out controlled substances prescriptions awaiting pickup and delivery were placed in a bin in the open pharmacy area where all pharmacy staff routinely had access.

We also found that Pharmacy Service staff did not immediately report missing controlled substances to the VA Police as required by Veterans Health Administration (VHA) policy. On August 28, 2003, staff discovered that nine oxycodone tablets were missing from the infirmary, and on September 8, 2003, they discovered that nine methadone tablets were missing. However, they did not notify VA Police of the incidents until September 23, 2003. In addition, center management did not report these suspected thefts of controlled substances to the OIG.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Center Director takes action to require that: (a) controlled substances storage and dispensing areas meet security standards; (b) pharmacy employees secure all controlled substances, including mail-out prescriptions; and (c) any suspected theft, diversion, or suspicious loss of drugs are reported immediately to the VA Police and the OIG.

The VISN and Center Directors agreed with the recommendations and reported that plans had been implemented to ensure that controlled substances storage and dispensing areas meet VA security requirements by July 17, 2004. In addition, during the CAP review, center staff took action to properly secure mail-out prescriptions and to ensure that suspected drug thefts, diversions, or suspicious losses are promptly reported to the VA Police and the OIG. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Conditions Needing Improvement. Center management needed to reduce excess inventories of engineering, prosthetic, and medical supplies and make better use of automated controls to more effectively manage supply inventories. In FY 2003, the center spent $594,846 on engineering, prosthetic, and medical supplies. The VHA Inventory Management Handbook establishes a 30-day supply goal and requires that facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories.

Engineering Supplies. FMS staff did not use GIP or any other formal method to manage engineering supply inventory. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgmental sample of 10 high-use engineering supply items (value = $5,394). Because FMS did not use GIP, we asked service staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day supply goal for 5 of the 10 items, with inventory levels ranging from 57 to 800 days of supply (excess value = $2,519). Without sufficient inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded current needs. The Chief of FMS acknowledged the need to reduce the inventory and to develop a comprehensive plan for controlling supplies with GIP.

Prosthetic Supplies. Prosthetic and Sensory Aids Service (PSAS) used VA's Prosthetics Inventory Package (PIP) automated system to control inventory. However, they were not fully using PIP features to meet the inventory goal of 30 days. The PSAS maintained a supply inventory of 110 items valued at $11,990. To determine the accuracy of PIP-reported information and the reasonableness of inventory levels, we reviewed a judgmental sample of 10 items (value = $2,675). All 10 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 62 to 800 days of supply. The estimated value of stock exceeding 30 days was $2,083, or 78 percent of the total value for the 10 items. Excess inventory occurred because the PSAS staff were not properly monitoring PIP and adjusting stock levels to reflect actual usage rates. By applying the 78 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of excess stock was $9,352 (78 percent x $11,990 estimated PIP value of stock).

Medical Supplies. Although Acquisition and Material Management Service (A&MMS) staff used GIP to manage medical supplies, inventory levels exceeded the 30-day supply goal. As of

October 2003, the medical supply inventory consisted of 139 items with a stated value of $6,587. To test the reasonableness of inventory levels, we reviewed a judgmental sample of 20 medical supply items (value = $1,578). Nineteen of the 20 items had stock on hand that exceeded a 30-day supply, with inventory levels ranging from 49 to 7,500 days of supply. The estimated value of the stock exceeding 30 days for these 19 items was $1,177, or 75 percent of the total value of the 20 items. By applying the 75 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of excess stock was $4,940 (75 percent x $6,587 estimated GIP value of stock).

For 17 of the 19 items with excess stock, the excess occurred because the center was unable to purchase the items in smaller quantities to meet the 30-day supply goal. All of the items had minimum purchase requirements because they were either mandatory standardized items, Federal Supply Schedule contract items, or items that were available from a limited number of vendors. As of October 2003, the Chief of A&MMS was working with other VISN 20 facilities to establish procedures for consolidating purchases to prevent a build-up of medical supply inventory.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Center Director requires: (a) FMS to reduce excess inventory and develop a comprehensive plan for controlling engineering supplies with GIP, (b) PSAS to reduce excess inventory and monitor supply usage, and (c) A&MMS to continue working with other VA facilities in VISN 20 to consolidate purchases to avoid a build-up of medical supply inventory.

The VISN and Center Directors agreed with the recommendations and reported that the center had developed procedures to reduce excess engineering inventory and implement GIP for controlling these supplies. The target date for full implementation is June 30, 2004. The center had also taken actions to monitor prosthetic supply inventory levels and reduce excess inventory by February 28, 2004. In addition, as of November 2003, the center had established a program to consolidate medical supply purchases with other VA facilities in the VISN to avoid excess medical supply inventory. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Patient Transportation Services – Medical Evaluations and Training of Drivers Should Be Improved

Conditions Needing Improvement. The center used 3 employee and 77 volunteer drivers to provide patient transportation services. Center management needed to ensure that these drivers received initial medical evaluations, periodic medical reevaluations, and annual safe driver training. In addition, local policies needed to be consistent with VHA policies and procedures.

Medical Evaluations. VHA policy requires that employee and volunteer drivers receive initial medical evaluations and follow-up evaluations at least every 4 years. We reviewed personnel folders for the three employee drivers and found that they had received pre-employment medical evaluations but had not received periodic reevaluations. We also reviewed records for three volunteer drivers and found no evidence of either initial or follow-up medical evaluations.

Driver Training. Center management needed to ensure that drivers received safe driver training as required by VHA policy. We reviewed training records for the three employee drivers and three volunteer drivers and found no documentation to show that any of the drivers had received training. According to the Voluntary Services manager, volunteer drivers had been trained on various aspects of patient transportation and safe driving methods but the training had not been documented.

These problems occurred because the center's local policy was not consistent with VHA policies and procedures. For example, local policy did not require initial medical evaluations, medical reevaluations every 4 years, or annual safe driver training.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Center Director takes action to: (a) provide and document initial medical clearances for drivers, (b) periodically reevaluate all drivers, (c) provide and document annual safe driver training for all drivers, and (d) ensure that center policies are revised and implemented to follow VHA policy.

The VISN and Center Directors agreed with the suggestions and reported that plans had been implemented to ensure that all patient transportation drivers receive medical evaluations and safe driver training by April 30, 2004. In addition, by January 15, 2004, the center will revise its local policy to be in compliance with VHA policy. The improvement plans are acceptable, and we consider the issues resolved.

Automated Information Systems Security – Controls Should Be Strengthened

Conditions Needing Improvement. We reviewed automated information systems (AIS) security to determine if controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that Information Management Service (IMS) staff had implemented virus detection procedures and established effective controls for assigning passwords. However, we identified four AIS security issues that required corrective action.

System Access. VHA policy requires that facilities review Veterans Health Information Systems and Technology Architecture (VISTA) user access and privileges at least every 90 days for appropriate levels of access or continued need. Working with the Information Security Officer (ISO), we reviewed a judgmental sample of 55 accounts and concluded that user access should have been removed for 25 accounts (45 percent). When the inappropriate access was identified, the ISO immediately removed the access.

Physical Security. The window in the office where computer system backup files were stored did not have a wire mesh screen as required by VA computer security policy. During our review, the Chief of IMS ordered the installation of the required screen.

Training. In FY 2003, 13 employees and 12 volunteers who had access to VA computer systems did not receive mandatory computer security training. According to the ISO and Chief of IMS,

the lack of training occurred because they did not sufficiently remind employees and volunteers of the training requirement.

Segregation of Duties. VHA policy requires that each facility establish a policy to ensure that AIS duties are separated so that a single employee cannot bypass system controls. While we did not identify inappropriately shared functions, we found that the center had not established the required local policy.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Center Director requires that: (a) VISTA access is reviewed and removed promptly for all individuals who do not have a continued need for access, (b) backup files are stored in a secured location, (c) mandatory computer security training is completed by all employees and volunteers with system access, and (d) a local policy is established to ensure continued segregation of AIS duties.

The VISN and Center Directors agreed with the suggestions and reported that as of October 2003, the center had implemented procedures to review VISTA access. As of November 2003, the center had installed a wire mesh window screen in the room where backup files are located and had begun tracking computer security training for employees and volunteers. In addition, the center had developed a local policy addressing the segregation of AIS duties. The target date for implementing this policy is January 31, 2004. The improvement plans are acceptable, and we consider the issues resolved.

Controlled Substances Accountability – Unannounced Inspection Procedures Should Be Improved

Conditions Needing Improvement. Center management needed to ensure that controlled substances inspectors followed all required procedures when conducting unannounced inspections. VHA policy requires medical facilities to conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate the controlled substances inspection program, we reviewed inspection reports for the 12-month period October 2002–September 2003, interviewed inspectors, and observed unannounced inspections in the three locations where controlled substances were stored and dispensed. We identified five inspection deficiencies.

- Inspection procedures did not ensure that all controlled substances storage locations were inspected every month. During the 12-month review period, 9 of the 36 required inspections (25 percent) were not performed.

- Inspectors did not sign and date the Controlled Substance Administration Records (also known as green sheets) to verify that the physical count of controlled substances on hand agreed with inventory records.

- Inspectors did not measure all liquids in pharmacy stock using a volumetric cylinder as required by VHA policy. In addition, the center's controlled substances inspection policy did not require inspectors to measure liquids or weigh powders.

- Inspectors did not compare receiving reports and vendor invoices with pharmacy stock inventory records to verify the quantities of controlled substances received into stock.

- Inspectors did not randomly select ward dispensing entries and compare them with patient records to verify that controlled substances removed from inventory were properly supported by medication orders and administration records.

These problems occurred because the center did not have a formal orientation and training program for controlled substances inspectors. Instead inspectors received a 1 hour overview of VHA inspection policies and procedures. The Controlled Substances Inspection Coordinator acknowledged that training was not sufficient and reported that a new in-depth training program was being developed which would incorporate new requirements outlined in the VHA policy.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Center Director takes action to require that: (a) unannounced inspections are conducted in accordance with VHA policy, (b) the center's local policy complies with VHA policy, and (c) all inspectors receive training on current VHA inspection policies and procedures.

The VISN and Center Directors agreed with the suggestions and reported that prior to the CAP review, the center had identified problems with the inspection program and had begun implementing corrective actions. However, as of October 2003, these actions had not been fully implemented and inspectors had not been fully trained on the new policies and procedures. The target date for training all inspectors is May 31, 2004. The improvement plans are acceptable, and we consider the issues resolved.

Service Contracts – Contract Files and Training Records Should Be Improved

Conditions Needing Improvement. Center management needed to improve documentation in contract files and ensure that contract staff receive appropriate training. To evaluate contract administration procedures, we reviewed 15 contract files (11 service contracts and 4 nursing home contracts) and interviewed the Chief of A&MMS, contracting officers, and contracting officers' technical representatives (COTRs). We identified two issues that required corrective action.

Designation and Training of COTRs. For each contract, a COTR should be designated and properly trained to monitor contractor performance and ensure that services are provided in accordance with contract terms. We found that 11 of the 15 contract files did not contain letters designating COTRs, although center employees were fulfilling COTR performance duties. These employees were aware that they were the designated COTRs, despite the absence of appointment letters in the files. In addition, we found that none of the COTRs had received training on their roles and responsibilities as required by VA policy.

Training of Contracting Officers. The Chief of A&MMS did not ensure that two contracting officers received simplified acquisition training as required by VA policy before granting them warrant authority.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Center Director establish procedures to: (a) designate all COTRs in writing, (b) provide training to COTRs on their roles and responsibilities, and (c) provide appropriate training to contracting officers before granting warrants.

The VISN and Center Directors agreed with the suggestions and reported that the center had implemented procedures to ensure that COTRs are properly designated and trained by April 15, 2004. In addition, the two contracting officers will complete required training by January 30, 2004. The improvement plans are acceptable, and we consider the issues resolved.

Medical Care Collections Fund – Billing Days Should Be Reduced

Condition Needing Improvement. Center management needed to improve the timeliness of sending bills to insurance companies. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain veterans who have insurance. Successful cost recovery requires that center staff accurately identify veterans with insurance, promptly bill insurance companies, and aggressively follow up on insurance receivables. Although staff were identifying veterans with insurance and following up on outstanding receivables, they were not promptly billing insurance companies.

For the month of September 2003, the center took an average of 108 days from the date of care to bill insurance companies. In October 2003, MCCF staff were preparing bills for care provided in June 2003 and had a backlog of 2,057 claims. The FY 2003 VHA goal for billing insurance companies was 65 days. According to the MCCF Supervisor, the billing backlog occurred because in the past 5 years, the center added seven new primary care clinics, which led to an increase of about 5,200 patients. Although MCCF staffing was increased by two FTEE during the same period, the staff could not keep up with the increased volume of bills.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Center Director implement actions to improve the timeliness of sending bills to insurance companies in accordance with VHA goals.

The VISN and Center Directors agreed with the suggestions and reported that plans had been implemented to authorize an additional MCCF staff position by December 2003. The improvement plans are acceptable, and we consider the issues resolved.

Appendix A

VISN 20 Director Comments

Department of Veterans Affairs

Memorandum

Date: December 17, 2003

From: Network Director, VISN 20 (10N20)

Subj: CAP Review of VA Southern Oregon Rehabilitation Center and Clinics

To: Director, Seattle Audit Operations Division (52SE)

1. Attached is the status report for the Office of Inspector General Combined Assessment Program survey recommendations from the VA Southern Oregon Rehabilitation Center and Clinics.

2. If you have any questions regarding the report, please contact Carol Bogedain Quality Management Coordinator, at (541) 826-2111, extension 3346.

//signed//
Leslie M. Burger, MD, FACP

Attachment

cc: Director, Management Review Office (10B5)

Appendix B

Rehabilitation Center Director Comments

Department of Veterans Affairs

Memorandum

Date: December 16, 2003

From: Acting Director, VA Southern Oregon Rehabilitation Center and Clinics (648/00)

Subj: CAP Review of VA Southern Oregon Rehabilitation Center and Clinics

To: Claire McDonald, VA Office of Inspector General (52SE)
Thru: Director, Northwest Veterans Integrated Service Network 20 (10N20)

1. Attached is the response to the OIG CAP Site Review and comments from the Network Director, VISN 20.

2. We appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

//signed//
MAX E. McINTOSH, PhD, MBA

Attachment

cc: Director, Management Review Office (10B5)

VA Southern Oregon Rehabilitation Center & Clinics
Director's Comments to
Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations and suggestions in the Office of Inspector General Report:

OIG Recommendations

1. Pharmacy Security – Deficiencies Should Be Corrected and Controls Strengthened

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Center Director takes action to require that: (a) controlled substances storage and dispensing areas meet security standards; (b) pharmacy employees secure all controlled substances, including mail-out prescriptions; and (c) any suspected theft, diversion, or suspicious loss of drugs are reported immediately to the VA Police and the OIG.

Concur with recommended improvement actions

a. Controlled substances storage and dispensing areas meet security standards

Planned Action: 1) The existing controlled substances vault will be renovated to meet Type 1 requirements as outlined in VA Handbook 0730, Appendix B. All enclosure walls and ceiling will be constructed of steel security mesh and dry wall, with the addition of steel bulk drug storage cabinets, firmly anchored in place, for the storage of Schedule II (open containers only) and all Schedule III through V controlled substances. Unopened bulk containers, classified as Schedule II, will be stored in the existing GSA class 5 safe. 2) Walls around dispensing windows will be upgraded to meet U.L. Standard 752 Class III Ballistic Levels. 3) All accessible window screens will be replaced with stainless steel woven mesh, meeting Physical Security Requirements as outlined in VA Handbook 0730 with the addition of internal key locking slide bolts.

All planning, design and construction will be completed by July 17, 2004.

b. Pharmacy employees secure all controlled substances, including mail-out prescriptions

Planned Action:

All packages of controlled substances to be mailed are now stored in a locked cabinet pending mailroom pick up. A log of these packages is maintained daily. This process was initiated on October 23, 2003, at the time of the OIG visit.

c. Any suspected theft, diversion, or suspicious loss of drugs are reported immediately to the VA Police and the OIG

Planned Action: This issue was identified prior to the IG visit, and the following corrective actions were taken on September 22, 2003 including: 1) Nursing Service leaders and Pharmacy staff were reminded of Medical Center Memorandum 119-007,

which states, "Any suspected theft, diversion, or suspicious loss of drugs, will immediately be reported to the VA Police;" 2) end of shift drug counts were initiated; and 3) Nursing staff were provided training on rectifying and reporting discrepancies. On October 20, 2003, at the request of the Deputy Director, the Chief of Police submitted recommendations for consideration by management to help prevent such incidents in the future.

2. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Strengthened

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Center Director requires: (a) FMS to reduce excess inventory and develop a comprehensive plan for controlling engineering supplies with GIP, (b) PSAS to reduce excess inventory and monitor supply usage, and (c) A&MMS to continue working with other VA facilities in VISN 20 to consolidate purchases to avoid a build-up of medical supply inventory.

Concur with recommended improvement actions

a. FMS to reduce excess inventory and develop a comprehensive plan for controlling engineering supplies with GIP

Planned Action: A Performance Improvement Team was established on September 3, 2003 to develop an implementation schedule and rollout plan for each individual operational entity within FMS utilizing the Generic Inventory Package (GIP) module. A target date of June 30, 2004 has been identified for implementation of GIP for engineering supplies. Excess engineering supplies has and will continue to be identified and excessed via Federal Property Management Regulations (FPMR) through A&MMS.

b. PSAS to reduce excess inventory and monitor supply usage

Planned Action: PSAS is taking the following actions to resolve excess inventory and to improve monitoring of inventory levels: 1) VISN Prosthetics Representative to provide Prosthetics Inventory Package (PIP) training to the Chief, PSAS to fully utilize PIP Report features by January 31, 2004; 2) Excess all equipment over 30 days supply by 2/28/2004; 3) Initiate quarterly monitor of PIP stock levels beginning January 31, 2004; and 4) Implement inventory bar-coding system to upgrade inventory tracking by June 30, 2004.

c. A&MMS to continue working with other VA facilities in VISN 20 to consolidate purchases to avoid a build-up of medical supply inventory

Planned Action: White City VA SORCC has obtained automated access to inventories maintained by Portland and Puget Sound VAMC's. This has allowed for transfers of inventories in quantities that will circumvent vendor minimum order limitations and avoid excess inventories of greater than 30 days stock on hand. This program was completed November 1, 2003.

OIG Suggestions

3. Patient Transportation Services – Medical Evaluations and Training of Drivers Should Be Improved

Suggested Improvement Actions. We suggest that the VISN Director ensure that the Center Director takes action to: (a) provide and document initial medical clearances for drivers, (b) periodically reevaluate all drivers, (c) provide and document annual safe driver training for all drivers, and (d) ensure that center policies are revised and implemented to follow VHA policy.

Concur with suggested improvement actions

a. Provide and document initial medical clearances for drivers

Planned Action: We will provide and document initial medical clearances for Motor Vehicle Operators and volunteers who transport patients beginning in January 2004 and completed by April 30, 2004.

b. Periodically reevaluate all drivers

Planned Action: Revise Medical Center Memorandum #138-004 to incorporate the requirement that all Motor Vehicle Operators and volunteer drivers who transport patients will be reevaluated for medical clearance at least every four years by January 15, 2004.

c. Provide and document annual safe driver training for all drivers

Planned Action: We will provide annual safe driver training to all Motor Vehicle Operators and volunteer drivers who transport patients by April 30, 2004. Training will be documented and maintained according to local policy.

d. Ensure that center policies are revised and implemented to follow VHA policy

Planned Action: Medical Center Memorandum #138-004, Government Vehicles, will be revised by January 15, 2004 to reflect VHA policy, requiring initial medical clearances, periodic reevaluations, and mandatory annual driver safety training for all Motor Vehicle Operators and volunteer drivers who transport patients. Full implementation of the revised policy will occur by April 30, 2004.

4. Automated Information Systems Security – Controls Should Be Strengthened

Suggested Improvement Actions. We suggest that the VISN Director ensure that the Center Director requires that: (a) VISTA access is reviewed and removed promptly for all individuals who do not have a continued need for access, (b) backup files are stored in a secured location, (c) mandatory computer security training is completed by all employees and volunteers with system access, and (d) a local policy is established to ensure continued segregation of AIS duties.

Concur with suggested improvement actions

a. VISTA access is reviewed and removed promptly for all individuals who do not have a continued need for access.

Planned Action: Beginning on October 24, 2003, the ISO, or Alternate ISO, initiated daily reviews and terminates or disables user accounts that do not have a continued need for access.

b. Backup files are stored in a secured location

Planned Action: A wire mesh window screen, which is compliant with the current security policy was installed on November 3, 2003 where the backup media is stored making this area a secure location.

c. Mandatory computer security training is completed by all employees and volunteers with system access

Planned Action: As of November 24, 2003, we have established a monitor to track employee and volunteer completion of mandatory computer training. The ISO will monitor to ensure all employees and volunteers complete the mandatory computer security training within the timeframe allowed.

d. A local policy is established to ensure continued segregation of AIS duties

Planned Action: A facility level policy has been written to ensure continued segregation of AIS duties for the ISO (IMS-21); and is in the concurrence process with completion expected by January 31, 2004.

5. Controlled Substances Accountability – Unannounced Inspection Procedures Should Be Improved

Suggested Improvement Actions. We suggest that the VISN Director ensure that the Center Director takes action to require that: (a) unannounced inspections are conducted in accordance with VHA policy, (b) the center's local policy complies with VHA policy, and (c) all inspectors receive training on current VHA inspection policies and procedures.

Concur with suggested improvement actions.

a. Unannounced inspections are conducted in accordance with VHA policy

Planned Action: Although we did not have 12 months of unannounced inspections, the Controlled Substance Inspection Coordinator recognized that the quality of the unannounced inspection reports was inadequate and developed corrective actions prior to the IG visit. Numerous changes had been implemented prior to the OIG audit to assure that all inspections were unannounced and that they met the requirements of the new VHA Handbook 1108.2, which was published in August 2003. These changes were incorporated into Medical Center Memorandum 11-002 in September 2003.

b. The center's local policy complies with VHA policy

Planned Action: The medical center memorandum was initially rewritten in September 2003 to reflect the mandates and guidelines contained in VA Handbook 1108.2, published in August 2003. The medical center memorandum has been revised again to reflect new web-based training; and will be signed prior to December 31, 2003.

c. All inspectors receive training on current VHA inspection policies and procedures

Planned Action: All inspectors have received basic training on how to conduct the controlled substance inspections. In addition, each inspector is now required to complete the Controlled Substance Inspection Certification Program, a web based training program developed by the Employee Education System, Birmingham Resource Center, and present a copy of their successful completion of the training program prior to them doing their next scheduled inspection. This training is documented, recorded and tracked in TEMPO. Training Certificates are monitored and maintained in the Controlled Substance Inspection Program file in the Chief of Staff office. Certification of all inspectors will be completed by May 31, 2004.

6. Service Contracts – Contract Files and Training Records Should Be Improved

Suggested Improvement Actions. We suggest that the VISN Director ensure that the Center Director establish procedures to: (a) designate all COTRs in writing, (b) provide training to COTRs on their roles and responsibilities, and (c) provide appropriate training to contracting officers before granting warrants.

Concur with suggested improvement actions

a. Designate all COTRs in writing

Planned Action: A&MMS will review the facility "Contract Log" and determine appropriate individual COTR designations, by January 30, 2004. Upon completion of the COTR training as stated in paragraph (b) below, a written designation as Contracting Officer's Technical Representative will be issued by name and cite their specific roles and responsibilities, by April 15, 2004.

b. Provide training to COTRs on their roles and responsibilities

Planned Action: Once the appropriate individuals are identified as COTRs, A&MMS will provide the subject training using the VHA COTR handbook and record each course completion in the individual's employee education report of training (TEMPO), by March 30, 2004.

c. Provide appropriate training to contracting officers before granting warrants

Planned Action: Two individual contracting officers are in the process of completing the 40 hours of basic acquisition training required every two years. Subject training will be completed January 30, 2004.

7. Medical Care Collections Fund – Billing Days Should Be Reduced

Suggested Improvement Action. We suggest that the VISN Director ensure that the Center Director implement actions to improve the timeliness of sending bills to insurance companies in accordance with VHA goals.

Concur with suggested improvement actions

Planned Action: It is recognized that the VA SORCC has been unable to meet current performance standards related to timeliness of submitting bills to insurance companies, although improvement was achieved from FY2000 to FY2003 reducing the billing lag time from approximately 180 days to 108 days. The national performance standard for this billing requirement has been reduced from 65 days to 45 days for FY2004, which magnifies the problem in achieving this standard. This has been identified as a resource (staffing) issue and subsequent to the OIG/CAP review; the Clinic Administrator/Health Administration Service has submitted a request to the Resource Committee for an additional Billing Clerk. It is anticipated that this position will be approved at their next scheduled meeting (December 17, 2003) and progress will be made to improve billing lag time when this person is hired and trained.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2 b, c	Better use of funds by reducing excess prosthetic supply inventory and preventing build-up of medical supply inventory.	$14,292

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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