Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, Pennsylvania

Report No. 03-03208-76 **February 2, 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 November 17–21, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James E. Van Zandt VA Medical Center, which is part of Veterans Integrated Service Network (VISN) 4. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 127 medical center employees.

Results of Review

The environment of care, equipment accountability, and pharmacy security were managed effectively. Reviews of accounts receivable, controlled substances accountability, the Medical Care Collections Fund, and part-time physician time and attendance found no significant deficiencies. To improve operations, the medical center needed to:

- Develop and implement a comprehensive QM program and strengthen review processes.
- Improve administration of the fee basis program and consider contracting for some fee services.
- Ensure that service contracts are properly monitored and administered.
- Strengthen controls and correct security deficiencies for automated information systems resources.
- Reduce engineering supply inventory and strengthen inventory management controls.
- Review appointment scheduling procedures and reduce patient waiting times for primary care appointments.
- Ensure that patient transportation drivers receive initial medical evaluations, periodic medical reevaluations, and safe driver training.
- Ensure that new patient enrollment applications are processed within 7 days of receipt.

VISN 4 and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 13–25, 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

Medical Center Profile

Organization. Located in central Pennsylvania, the James E. Van Zandt VA Medical Center is a general medical and extended care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics (CBOCs) in Dubois, State College, and Johnstown, PA. The medical center serves a population of about 72,700 veterans.

Workload. In Fiscal Year (FY) 2003, the medical center treated 22,912 unique patients, a 6.8 percent increase from FY 2002. The FY 2003 inpatient average daily census was 18.8, and outpatient workload totaled 172,438 patient visits (a 6.5 percent increase from FY 2002).

Resources. The medical center's FY 2003 medical care budget was $57.1 million, a 19 percent increase over the FY 2002 budget of $48 million. As of November 2003, facility expansion was under way in central registration, pharmacy, primary care, and urgent care to accommodate increased workload. Staffing as of October 2003 was 449.9 full-time equivalent employees (FTEE), including 25.6 physician and 130.1 nursing FTEE.

Programs. The medical center provides comprehensive primary care and preventive health care services and limited specialty and long-term care services. Special programs include behavioral health services, ambulatory surgery, and physical medicine and rehabilitation. Specialty services not available at the medical center are provided by referral to the Pittsburgh VA Healthcare System, through local contracts, or on a fee basis.

Affiliations and Research. The medical center is affiliated with eight universities, colleges, and technical schools, including Pennsylvania State University, the University of Pittsburgh, and Duquesne University. Affiliated training programs include nursing, physician assistant, pharmacy technician, and recreation therapy. The medical center does not have a research program.

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 medical center 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 the requirement to refer suspected criminal activity 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 medical center operations for FY 2003 and FY 2004 through October 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 19 activities:

- Accounts Receivable
- Acute Medical Units
- Automated Information Systems Security
- Behavioral Health Care
- Community Nursing Home Contracts
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- Fee Basis Program
- Medical Care Collections Fund
- Nursing Home Care Unit
- Part-Time Physician Time and Attendance
- Patient Transportation Services
- Patient Waiting Times and Enrollment
- 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 4–12). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center 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, 67 of whom responded. We also interviewed 30 patients during the review. The survey and interview results were discussed with the Medical Center Director.

During the review, we also presented 5 fraud and integrity awareness briefings that were attended by 127 medical center employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, patient abuse, false claims, and bribery.

Results of Review

Organizational Strengths

Pharmacy Security Was Comprehensive. The medical center pharmacy met or exceeded all VA construction and security requirements. Access to the pharmacy was limited by solid, combination-lock doors and an intrusion detection security system. All controlled substances were stored either in a vault equipped with an electronic entry system that documented all access or in properly secured cabinets in patient care areas. The medical center also appropriately accounted for the receipt, storage, and disposition of controlled substances.

Equipment Accountability Controls Were Effective. As of October 31, 2003, the medical center's Material Management Section had 43 Equipment Inventory Lists (EILs) listing 370 equipment items with a total value of $9 million. We reviewed records for all 43 EILs and found that all equipment inventories had been properly scheduled and performed. To test the accuracy of the inventories, we reviewed a judgmental sample of 30 equipment items (value = $1.3 million) from 13 EILs and were able to account for all 30 items. Quarterly inventories, equipment adjustment vouchers, and reports of survey were completed as required.

The Environment of Care Was Effectively Maintained. The medical center had well maintained buildings. Patient care and public areas were clean, well organized, and in good repair. Hallways were clean and uncluttered. Signs posted throughout the facility provided good directions to patient care and administrative areas. Employees surveyed told us that the facility was clean and had good housekeeping support to ensure a safe and clean patient environment.

Opportunities for Improvement

Quality Management – Program Management and Review Processes Should Be Improved

Conditions Needing Improvement. Medical center management needed to implement a comprehensive, systematic QM program and to significantly strengthen program area review processes. To evaluate the QM program, we reviewed 18 program areas, including performance improvement teams, root-cause analyses, and patient complaints. For each area, we assessed various review processes such as data analysis, benchmarking, and the evaluation of the effectiveness of corrective actions. We interviewed pertinent employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files.

QM Program Structure. The QM program was fragmented and did not have a unifying structure to ensure effective oversight. Managers in some clinical services were performing QM activities, but there was no coordinated, facility-wide QM program. Although medical center management had designated the Leadership Staff Conference (LSC) as the QM oversight committee, the LSC was not effective in accomplishing the oversight role. As a result, there was minimal interdisciplinary collaboration and sharing of information among clinical services and programs. In addition, communication of important QM issues was inconsistent, and the identification and resolution of QM problems was not timely. For example, a death review took 5 months to be completed. After a subsequent VISN review, an additional 9 months passed before senior managers communicated the review results to the medical center's Medical Staff Executive Committee for discussion and action.

Medical center management acknowledged the need to improve the structure of the QM program and had initiated several corrective actions, including review of the medical center's committee structure and revision of the QM policy. However, as of November 2003 these corrective actions were still in the early stages of development, and QM review processes in several areas still needed significant improvement.

QM Review Processes. Required QM review processes were not in place or were inadequate for 14 of the 18 program areas reviewed. Medical center management needed to ensure that important review processes such as data trending, benchmarking, and identification of corrective actions and relevant outcome criteria were completed for all QM program areas.

- Although program managers collected various types of data, they did not adequately organize and analyze the data to identify trends. For example, managers did not analyze data on patient complaints, medical records reviews, and outcomes from resuscitations to identify trends related to staffing, location, or other important factors.

- Program managers did not consistently compare the results of QM reviews with relevant benchmarks as required by Joint Commission on Accreditation of Healthcare Organizations standards. For example, benchmarks had not been used in reviews of medication management, blood products usage, and operative procedures.

- When QM reviews identified problems, program managers did not consistently identify corrective actions. For example, the Utilization Review Committee reviewed the appropriateness of admissions and lengths of stay and determined that the acute care ward was not meeting VISN goals. However, the committee did not initiate any specific actions to correct this problem.

- Program managers did not consistently identify criteria to use in determining whether corrective actions were effective. For example, outcome criteria had not been defined for reviews of operative procedures and outcomes from resuscitations.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to develop and implement a comprehensive QM program that will ensure: (a) effective oversight, (b) appropriate communication channels, (c) thorough data analysis and benchmarking in all QM program areas, (d) consistent identification of corrective actions for identified problems and relevant outcome criteria, and (e) timely follow-up on identified problems.

The VISN and Medical Center Directors agreed with the recommendation and reported that plans had been implemented to redefine the structure and purpose of the LSC. To improve communication and interdisciplinary collaboration, medical center committees will report performance measures and performance improvement data directly to the LSC, and the position of Associate Director for Patient/Nursing Services will be organizationally aligned under the Director. In addition, medical center management implemented procedures to ensure thorough data analysis and benchmarking in all QM program areas, consistent identification of corrective actions for identified problems, and timely follow-up on identified problems. The target date for full implementation of the recommendation is September 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Fee Basis Program – Program Administration Should Be Strengthened and Contracting Considered for Some Fee Services

Conditions Needing Improvement. Under the fee basis program, the medical center may authorize veterans to obtain health care at VA expense from non-VA providers. We reviewed the program to determine if controls were adequate to ensure that fee payments for outpatient and inpatient care were appropriate and to determine whether fee care was the medical center's best alternative for providing services. For the 10-month period October 2002–July 2003, the medical center spent about $2.4 million on fee services. Medical center management needed to strengthen controls over four program administration areas and consider contracting as an alternative to obtaining some fee services.

Program Administration. Management needed to correct weaknesses in fee basis program administration by ensuring that more utilization reviews (URs) are performed, provider invoices are properly supported, VA timeliness standards for paying invoices are met, and fee basis authorization and payment duties are separated.

- Medical center management needed to ensure that more URs of fee services were performed. URs should be performed to ensure that fee services are medically necessary and that the services cannot be provided by VA. Although the medical center did not have a policy for determining the necessity of URs, fee basis staff agreed that at a minimum, URs should be required for all medically complex cases, surgical procedures, observation stays, and home health services. The medical center had one nurse responsible for fee service URs in addition to her other responsibilities. The UR nurse estimated that with her other responsibilities, she could only perform about 25 percent of the necessary fee service reviews. The Manager of Resources estimated that if all URs were performed as required, the medical center would achieve significant cost savings.

- Fee basis clerks did not consistently ensure that fee services invoices had adequate documentation to support payments. We reviewed 15 paid invoices and found that 5 (33 percent) had no supporting documentation. The fee basis staff had not enforced VA policy requiring that service providers include supporting documentation with their invoices.

- The medical center was not timely in paying fee basis providers. As of November 2003, the medical center had approximately 1,720 unpaid fee basis invoices (value = $1.3 million) over 30 days old. VA and medical center policies require that invoices be paid within 30 days of receipt.

- Fee basis clerks were responsible for both authorization and payment of invoices. VA policy requires that these duties be assigned to different employees.

Evaluation of Contracting. Medical center management had pursued alternatives to fee basis services, such as hiring staff and purchasing specialized equipment so that services could be provided onsite, but they generally did not consider contracting as an alternative. Contract staff stated that before contracts could be pursued, they would need more information about the type and volume of fee basis services being obtained. They had not requested or received fee basis program cost information in recent years.

The Manager of Resources cited mammography as one fee service that had been transitioned to a clinical services contract, resulting in significant cost savings. Under the contract, the medical center pays only 55 percent of the applicable Medicare rates for mammograms. Based on our discussions with the Manager of Resources, a similar savings might be achieved for other services such as magnetic resonance imaging (MRI). As of November 2003, the medical center obtained MRI services on a fee basis and paid full Medicare rates. For FY 2003, MRI fee services costs totaled $88,000. If the medical center contracted for MRI services at 55 percent of the Medicare rate, it would save about $48,400 per year (55 percent x $88,000). Medical center management acknowledged that using contracts instead of fee basis services could result in significant cost savings and that contracts should be considered.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director require that: (a) criteria is established for performing URs, (b) all necessary URs are performed for fee services, (c) invoices for fee services are properly

supported and reviewed before being paid, (d) supported fee basis invoices are paid within 30 days of receipt, (e) authorization and payment duties are separated, and (f) contracts are considered as an alternative to fee services.

The VISN and Medical Center Directors agreed with the recommendation and reported that as of January 2004 plans had been implemented to establish criteria for performing URs and ensuring that all necessary URs are performed. The target date for full implementation is March 31, 2004. In addition, by March 31, 2004, the Fee Basis Section will notify all fee providers that invoices must include supporting documentation or payment will be denied and will revise its procedures to ensure separation of payment and authorization duties. By February 29, 2004, the backlog of unpaid fee services invoices will be eliminated. Medical center management has also implemented plans to identify services that are appropriate for contracting and to perform market analyses for those services. The target date for completing this action is September 30, 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Service Contracts – Contract Monitoring and Administration Should Be Strengthened

Conditions Needing Improvement. To determine if contracts were properly awarded and administered, we reviewed 23 service contracts (value = $8.4 million), including 5 clinical, 5 non-clinical, and all 13 of the medical center's nursing home contracts. The medical center needed to significantly strengthen its monitoring of contractor performance and improve documentation of the contract price negotiation process and insurance verification.

Contract Monitoring. For each contract, a contracting officer's technical representative (COTR) should be designated and properly trained to monitor contractor performance and ensure that services are provided in accordance with contract terms. Specifically, COTRs should review contractor invoices and certify that charges are appropriate. COTRs may not redelegate their authority, and if they can no longer perform their duties, the contracting officer should appoint new COTRs. We found two significant deficiencies with contract monitoring procedures at the medical center.

- Contracting officers did not designate COTRs for 3 of the 23 contracts and did not replace COTRs for 7 other contracts when the designated COTRs were reassigned to positions that did not permit them to readily monitor contractor performance. One contracting officer stated that she had not been notified that the COTRs had been reassigned.

- For 14 of the 23 contracts, COTRs did not review invoices and certify acceptance of contractor charges. Instead, other medical center staff, such as a claims clerk and a program assistant who had not been designated as COTRs and did not have the appropriate clinical or technical expertise, performed these duties.

These monitoring problems occurred because the COTRs had not been provided adequate initial or annual refresher training on their roles and responsibilities.

Contract Documentation. For each noncompetitive contract, the Federal Acquisition Regulation requires that the contracting officer prepare a price negotiation memorandum (PNM) that contains the most significant facts and considerations controlling the negotiated agreement. The PNM should include any significant differences between the contractor's and contracting officer's positions. Four of the 23 contracts reviewed were noncompetitive. We found that the contracting officers had not prepared PNMs for three of these contracts. The contracting officers agreed that PNMs should be prepared.

Insurance Verification. Clinicians contracted by VA are required to maintain their own liability insurance. We reviewed files for five clinical service contracts to determine if the contracting officers had obtained documentation that contract clinicians had the required insurance. Four of the five files did not have this documentation. The contracting officers agreed to obtain the required documentation.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires contracting officers to: (a) designate COTRs for all contracts and monitor COTR appointments to verify that they are current and appropriate, (b) ensure that COTRs thoroughly review and certify acceptance of contractor invoices, (c) provide COTRs initial and annual refresher training on their roles and responsibilities, (d) prepare PNMs for all negotiated contracts, and (e) verify contractor liability insurance for all clinical service contracts.

The VISN and Medical Center Directors agreed with the recommendation and reported that by January 30, 2004, all contracts will be reviewed and COTR designations added or deleted as required. In addition, by June 30, 2004, COTR training will be provided, PNMs will be prepared for all negotiated contracts, and contractor liability insurance will be verified for all clinical service contracts. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Automated Information Systems Security – Controls Need To Be Strengthened

Conditions Needing Improvement. We reviewed automated information systems (AIS) policies and procedures to determine if controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. The medical center had established effective procedures for the removal of sensitive information from excess computer equipment. However, we identified four AIS security issues that required corrective action.

Contingency Plan. Veterans Health Administration (VHA) policy requires annual testing of the medical center's AIS contingency plan. The medical center's three CBOCs were not included in contingency plan tests. These tests generally occurred on weekends when the CBOCs were closed. In addition, the Information Security Officer (ISO) had not implemented procedures to ensure that AIS contingency plan training was consistently provided for all medical center departments.

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 ISO, we reviewed a judgmental sample of 45 accounts and concluded that user access should have been removed for 20 accounts (7 former employees and 13 former contract personnel).

Physical Security. The computer room did not have adequate entry controls to restrict and monitor access. VHA policy requires that all access to the room be logged and reviewed. The ISO is responsible for reviewing this log to determine if the individuals logging in still have an official need for access. Access to the computer room was logged occasionally but not consistently.

Backup Data Storage. AIS staff stored computer system backup files in a building adjacent to the computer room building. VHA policy requires that essential data be backed up and stored in a location physically separate from the computer room and that this location must be determined by local risk analysis. While the VHA policy does not provide a specific distance requirement for the backup storage location, the ISO agreed that storage adjacent to the computer room building did not satisfy local risk considerations.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires that: (a) CBOCs are routinely included in contingency plan training and testing, (b) VISTA access be promptly terminated for all individuals who do not have a continued need for access, (c) computer room access is consistently monitored, and (d) backup storage files are stored at a location that meets local risk considerations.

The VISN and Medical Center Directors agreed with the suggestion and reported that testing of the contingency plan for each CBOC will be completed by March 30, 2004. By January 30, 2004, the ISO will be trained to conduct monthly VISTA access monitoring to ensure the continued need for user access and privileges. In addition, as of January 5, 2004, all employees who enter the computer room are required to sign-in, and the sign-in log will be monitored by the ISO. As of November 2003, the ISO had implemented plans to store backup files at a location that meets local risk considerations. The improvement plans are acceptable, and we consider the issues resolved.

Supply Inventory Management – Engineering Inventory Should Be Reduced and Controls Improved

Condition Needing Improvement. The medical center needed to reduce excess inventory of engineering supplies and make better use of automated controls to manage engineering supply inventory. VHA policy establishes a 30-day stock level goal for engineering supplies and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage this inventory. GIP assists inventory managers in monitoring inventory levels, analyzing usage patterns, and ordering supply quantities necessary to meet current demand.

Facilities Service had substantial quantities of engineering supplies on hand. The service did not have a formal inventory control system for most engineering supplies, although it had begun

using GIP to manage a few supply items in September 2003. To reduce the frequency of purchases, engineering technicians routinely bought supplies in quantities that would last up to 1 year.

To test the reasonableness of stock levels, we reviewed a judgmental sample of 10 engineering supply items (value = $5,561). For one sample item that was managed using GIP (value = $31), a 30-day stock level was maintained. For the other nine items (value = $5,530), engineering staff estimated that the stock would last between 45 days and 2 years. Stock levels for these items could have been reduced to 30 days if appropriate controls such as reorder points, normal stock levels, and written inventory records had been established. For engineering supply items with recurring use, GIP can be an effective inventory management tool and its implementation should continue in accordance with VHA requirements. Because Facilities Service employees did not fully utilize GIP or any other formal inventory systems, we could not determine the value of stock on hand or the value of excess stock for the entire inventory.

Suggested Improvement Actions. We suggested that the VISN Director ensure that the Medical Center Director requires Facilities Service to fully implement GIP and reduce excess engineering supply inventory.

The VISN and Medical Center Directors agreed with the suggestion and reported that Facilities Service would continue implementing GIP to monitor engineering supply inventory and reduce excess stock by December 31, 2004. The improvement plans are acceptable, and we consider the issues resolved.

Patient Waiting Times – Waiting Times for Initial Primary Care Appointments Should Be Reduced

Condition Needing Improvement. VHA policy requires newly enrolled veterans to be given initial appointments within 30 days from the dates that appointments were initially requested. For the 6-month period May 2003–October 2003, the average waiting time for initial appointments at the medical center's primary care clinic was 44 days.

According to the Medical Director of Primary Care, the delays resulted primarily from a shortage of patient examination rooms in the primary care clinic. The medical center is increasing the number of examination rooms, which will improve clinic efficiency by enabling medical staff to see additional patients. This project is scheduled to be completed in April 2004.

In our opinion, the medical center's method of scheduling follow-up appointments also contributed to these delays. Follow-up appointments are made up to 1 year in advance. As a result, most appointment slots were allocated to currently enrolled veterans, and there were not enough slots to ensure that all new enrollees were seen within 30 days. The Medical Director of Primary Care agreed that the medical center should review appointment scheduling procedures to increase the number of initial appointment slots available.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director takes action to review appointment scheduling procedures to increase the number of initial appointment slots available to newly enrolled veterans.

The VISN and Medical Center Directors agreed with the suggestion and reported that as of January 2004 medical center staff had reviewed appointment scheduling procedures for primary care and implemented new procedures to open additional appointment slots. The improvement plans are acceptable, and we consider the issue resolved.

Patient Transportation Program – Driver Medical Evaluations and Training Should Be Improved

Conditions Needing Improvement. The medical center used 7 employee and 87 volunteer drivers to provide patient transportation services. 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 records for three employee and three volunteer drivers. All of the employees had received the initial medical evaluations and periodic reevaluations. One of the volunteers had received an initial medical evaluation but had not been reevaluated. The other two volunteers had received no medical evaluations before transporting patients. Medical center managers stated that all volunteer drivers would be scheduled for medical evaluations.

Driver Training. Medical center management needed to ensure that drivers received annual safe driver training as required by VHA policy. The three employee drivers had received the annual training. However, we found no documentation that the three volunteer drivers received annual refresher training, although they had received initial training.

These problems occurred because the medical center's local policy was not consistent with VHA policies and procedures and 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 Medical Center Director takes action to: (a) provide and document initial medical evaluations for drivers, (b) periodically reevaluate all drivers, (c) provide and document annual safe driver training for all drivers, and (d) ensure that medical center policies are revised and implemented to follow VHA policy.

The VISN and Medical Center Directors agreed with the suggestion and reported that plans had been implemented to ensure that all patient transportation drivers will receive initial medical evaluations, periodic reevaluations, and annual safe driver training. The target date for full implementation is March 2004. In addition, by June 30, 2004, a patient transportation policy that

complies with VHA policies and procedures will be written and implemented. The improvement plans are acceptable, and we consider the issues resolved.

Enrollment Applications – Processing Time Should Be Improved

Condition Needing Improvement. The medical center was not meeting the VHA timeliness goal for processing veteran enrollment applications within 7 days of receipt. We reviewed enrollment data for the 6-month period June 2003–November 2003 and found that 359 enrollment applications had not been processed within 7 days. A major cause for these delays was insufficient staff dedicated to processing enrollment applications. The Eligibility and Enrollment Section was authorized 4.5 FTEE Health Benefits Advisors (HBAs), who were also responsible for assigning new enrollees to a primary care team, reviewing and updating eligibility at time of patient check-in, processing inpatient admissions, and other administrative duties associated with centralized registration. During FY 2003, the medical center used 893 hours of overtime (approximately 0.5 FTEE) for HBAs to process enrollment applications.

Suggested Improvement Action. We suggested that the VISN Director require that the Medical Center Director review and adjust HBA staffing and individual workloads to ensure enrollment applications are processed within 7 days of receipt.

The VISN and Medical Center Directors agreed with the suggestion and reported that as of January 2004 a vacant HBA position was being evaluated for prioritization and funding and that in the interim, overtime and compensatory time were being used to reduce processing times and the backlog of applications. The target date for completing corrective action is June 30, 2004. The improvement plans are acceptable, and we consider the issue resolved.

Appendix A

VISN Director Comments

Department of Veterans Affairs **MEMORANDUM**

Date: January 14, 2004

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

Subj: CAP Review of the James E. Van Zandt VA Medical Center, Altoona, PA

To: Claire McDonald, VA Office of Inspector General (52SE)

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

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

/s/

CHARLEEN R. SZABO, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **MEMORANDUM**

Date: January 9, 2004

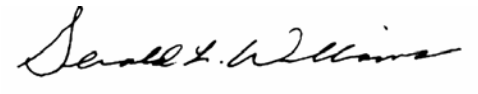
From: Director, James E. Van Zandt VA Medical Center, Altoona, PA (00/503)

Subj: CAP Review of the James E. Van Zandt VA Medical Center, Altoona, PA

To: Claire McDonald, VA Office of Inspector General (52SE)

1. I have reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the James E. Van Zandt VA Medical Center. I concur with the findings and am attaching action plans for each finding.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.



GERALD L. WILLIAMS

JAMES E. VAN ZANDT VA MEDICAL CENTER

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

OIG Recommendations:

1. Quality Management – Program Management and Review Processes Should Be Improved

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to develop and implement a comprehensive QM program that will ensure: (a) effective oversight, (b) appropriate communication channels, (c) thorough data analysis and benchmarking in all QM program areas, (d) consistent identification of corrective actions for identified problems and relevant outcome criteria, and (e) timely follow-up on identified problems.

Concur with recommended improvement action

a. Effective oversight:

Planned Action: The Leadership Staff Conference (LSC) structure and purpose will be redefined. The committee will be renamed Leadership Staff Council (LSC). The LSC will provide oversight of the Quality and Performance Improvement Program, serve as a central forum for communication of performance measures and improvements, and will be the unifying structure to ensure an effective quality management program.

The LSC will establish an annual performance plan based upon the goals of the organization and expectations of stakeholders, monitor implementation of improvement plans and progress towards goals, analyze information from across the organization and identify areas requiring improvement, and assure that achieved improvements are maintained. In addition, the LSC will be responsible for establishing the procedures and oversight of the monitoring, analysis, and improvement activities for the following functions:

- mortality/morbidity trend reports
- patient complaints trend reports
- HCFMEA reports
- adverse event trend data and reports
- RCAs
- sentinel events
- administrative investigations
- tort claims

- utilization management trend data and reports
- medication usage trend data and reports
- blood products usage trend data and reports
- operative and other procedure trend data and reports
- outcomes from resuscitation trend data and reports
- medical record quality trend data and reports
- peer review trend data and Level 3 cases
- JCAHO periodic performance review activity
- performance measures and performance monitors
- EPRP results

The LSC will be responsible for chartering and monitoring the activity of interdisciplinary task groups or performance improvement teams, as appropriate, to evaluate processes in need of improvement and recommend corrective process improvement action plans. The target completion date for this action is **March 2004**.

b. Appropriate communication channels:

Planned Action: As stated in the planned action for a. above, the redefined LSC, to include an effective oversight role for performance measures and performance improvement for quality management programs, will foster a culture of interdisciplinary collaboration and sharing of information among clinical services and programs. The target completion date for this action is **March 2004**.

Committees will report performance measures/performance improvement data directly to LSC to accomplish the sharing of information among clinical services and programs. Quality improvement data related to medical staff monitoring will be reported concurrently to Medical Staff Executive Committee (MSEC) and LSC. The target completion date for this action is **March 2004**.

To address the identified concern regarding effective interdisciplinary communication, the Associate Director for Patient/Nursing Services will be organizationally aligned under the Director. The target completion date for this action is **January 2004**.

c. Thorough data analysis and benchmarking in all QM program areas:

Planned Action: Patient Complaints: Patient complaints, which are currently categorized into broad topic areas and reported annually, will be done quarterly. In addition, the data will be analyzed into more detailed information by department or provider. The data will be trended and benchmarked against previous data. This detailed analysis will be presented quarterly to the Veteran Satisfaction Committee for action and recommendations. Target date is **February 2004** for initiating this process for 1st quarter FY 04 data.

Medical record quality reviews: The Medical Records Committee will organize and analyze medical record quality review data to identify trends. Data will be presented in a graph for trending. Meeting minutes will reflect indicator, numerator/denominator, percentage, benchmark/threshold/goal, problems, recommendations/action plan, action official, and target dates. Follow-up for identified problems will be reflected in minutes. Target completion date is **January 2004**.

Review of outcomes from resuscitation: The Special Care Units Committee will review outcomes from resuscitation monthly. Time and location of the code blue will be monitored concurrently and entered into a graph. Biannually, these results will be reviewed and analyzed for any trends and quality of care issues. Corrective actions for any identified problems and relevant outcome criteria will be developed as trends are identified. Target completion date is **January 2004**.

Medication management: The Medication Use/Nutrition Committee minutes will include all relevant spreadsheets and graphs for VISN trending of targeted initiatives. VISN benchmarks for target initiatives will be identified. Target completion date is **January 2004**. The drug use evaluation plan will include prescribing and ordering of medications, reviews of safety appropriateness of drugs prescribed, and dose, route, and time. Target completion date is **March 2004**. Data for ADRs and non-formulary medications will be placed on spreadsheets and graphs for trending by **March 2004**. Medication error data will be graphed for trending by March 2004. Benchmarks will be developed/provided by **March 2004**.

Blood products usage: All aspects of blood services to determine whether blood and blood products are appropriately ordered and stored, delivered, and provided in a safe, timely, and therapeutic manner. Evaluation of transfusion errors and reaction is included. Measures include ordering, distributing, handling and dispensing, monitoring blood and blood components effect on patients, review of availability of blood and blood components. Blood products usage will be reviewed monthly and cumulatively by the Surgical Case and Blood Usage Committee. Any adverse reaction will be reviewed to include treatments given. All blood incidents will be trended according to provider usage. The data will be analyzed, conclusions and recommendations will be documented, action items assigned, and evaluation of relevant outcomes will be done. Target completion date is **March 2004**.

Operative and other procedure reviews: Procedures will be reviewed by the Surgical Case and Blood Usage Committee for appropriateness and will include unit procedures and complications. Procedures will be analyzed for problems, tracked, and trended for each provider. Meeting minutes will include conclusions, recommendations, actions, and evaluation of actions taken. All incidents will be benchmarked for each provider. Summary of incidents will be reported every six months. Target completion date is **March 2004**.

Committee chairpersons for QM programs have been instructed on the requirements of data management and to have meeting minutes demonstrate the inclusion of benchmarking, evaluation criteria, implementation, evaluation, and follow-up. Quality Manager, QM staff, and staff responsible for data management will receive training by the Network Data Analysis and Information Office (NDAIO) on quality management trending, benchmarking, and retrieving data from various VA and non-VA data websites. Target completion of training is **June 2004**. Managers, program coordinators, quality management staff, committee chairpersons, and staff responsible for data management will receive training on quality improvement tools, which focuses on teaching teams to collect the right data, analyze it, and apply their findings to their improvement project. Target completion **is September 2004**.

Managers, program coordinators, quality management staff, and staff responsible for data management will receive MS Excel training. Target completion date is **June 2004**.

The VHA QMO group is in the process of developing a web-based data management/analysis training program in collaboration with EES. Once developed, clinical managers, program coordinators, committee chairpersons, quality management staff, and staff responsible for data management will be required to take the training. Target completion date is **December 2004**.

Committee chairpersons will receive training on conducting meetings by **June 2004**.

d. Consistent identification of corrective actions for identified problems and relevant outcome criteria:

Planned Action: Medication Use/Nutrition Committee will clearly delineate in meeting minutes corrective actions/responsible officials, expected outcomes, and criteria for evaluation. Target completed date is **January 2004**.

The Utilization Review Committee changed the meeting minutes format for data analyses and management to present performance improvement data clearly. Meeting minutes will reflect analysis, conclusions, recommendations/action plans, and follow-up for identified problems with admissions and continued stay appropriateness. Target completion date is **January 2004**.

e. Timely follow-up on identified problems:

Planned Action: The MSEC meets monthly, held the third Tuesday of each month at 9:00 a.m. with updated standing agenda items to review deaths and systems issues through Peer Review Subcommittee, Medical Morbidity/Mortality reviews, discussions, outcomes, and recommendations. A tracking and trending spreadsheet has been developed for follow-up action taken by the MSEC and its subcommittees. In addition, membership was updated to include the Director and the Manager, Quality Management & Performance Improvement Department. The Director approves the MSEC minutes. All non-confidential issues are discussed at the

Leadership Staff Council meetings. Additionally, the following action plan has been developed for the Peer Review Subcommittee to address the following:

- Addition of an experienced physician as co-chairperson to ensure that meetings are held monthly.
- Future meetings will be held once a month, first Tuesday of each month, at 8:45 a.m. Members will adjust their clinics to permit attendance at this meeting.
- A tracking and trending spreadsheet has been developed for follow-up action taken by the Peer Review Subcommittee (PRSC).
- Quality Improvement Coordinator/Risk Manager will forward any new cases to be discussed to specific provider at least one week prior to scheduled meeting to allow time for provider to review case.
- Internal rotation for review of individual cases will be kept by Quality Improvement Coordinator/Risk Manager to avoid possible conflict of interest.
- Copies of policy regarding functioning of PRSC (MCM 011-27) provided to all members by Recorder, PRSC for their information.
- Recorder, PRSC will keep flow sheet of discussion at PRSC. This flow sheet will be reviewed twice/yearly for any trends that were discussed at PRSC.
- Quality Improvement Coordinator/Risk Manager will have the responsibility to monitor and track implementation of all the recommendations coming from PRSC and MSEC and to report status of these recommendations at each PRSC.

Action is completed and ongoing.

2. Fee Basis Program – Program Administration Should Be Strengthened and Contracting Considered For Some Fee Services

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director require that: (a) criteria is established for performing URs, (b) all necessary URs are performed for fee services, (c) invoices for fee services are properly supported and reviewed before being paid, (d) supported fee basis invoices are paid within 30 days of receipt, (e) authorization and payment duties are separated, and (f) contracts are considered as an alternative to fee services.

Concur with recommended improvement actions

a. Criteria is established for performing URs:

Planned Action: The medical center has already begun the development of specific criteria for performing utilization review within the Fee Basis Section in conjunction with the existing fee basis assistance contract with BearingPoint. The development of the utilization review criteria is expected to be completed by **March 31, 2004**.

b. All necessary URs are performed for fee services:

Planned Action: The medical center has identified the need to add a utilization review nurse to the staff of the Fee Basis Section in the immediate future to perform necessary URs within the Fee Basis Section. The target completion date for this action is **March 31, 2004**.

c. Invoices for fee services are properly supported and reviewed before being paid:

Planned Action: All non-VA providers will be advised at the time of authorization that invoices submitted for payment must include supporting documentation or payment will be denied. The target completion date for this action is **March 31, 2004**.

d. Supported fee basis invoices are paid within 30 days of receipt:

Planned Action: Actions have been underway since October 2003, in conjunction with Bearing Point contract, to eliminate the current payment backlog. This action is targeted to be completed by **February 29, 2004**.

e. Authorization and payment duties are separated:

Planned Action: The medical center will revise current procedures and split payment and authorization duties. The target date for completion of this action is **March 31, 2004**.

f. Contracts are considered as an alternative to fee services:

Planned Action: The medical center will identify services considered appropriate for contracting out and conduct a market analysis of the available institutions in the community who have the interest in negotiating a contract for those services. The target completion date for this action is **September 30, 2004**.

3. Service Contracts – Contract Monitoring and Administration Should Be Strengthened

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires contracting officers to: (a) designate contracting officer's technical representatives (COTR) for all contracts and monitor COTR appointments to verify that they are current and appropriate, (b) ensure that COTRs thoroughly review and certify acceptance of contractor invoices, (c) provide COTRs initial and annual refresher training on their roles and responsibilities, (d) prepare PNMs for all negotiated contracts, and (e) verify contractor liability insurance for all clinical service contracts.

Concur with recommended improvement actions

a. Designate COTRs for all contracts and monitor COTR appointments to verify that they are current and appropriate:

Planned Action: All contracts will be reviewed for designated COTR representatives. Those COTRs that need to be added or deleted will be identified and the appropriate delegation of authority memorandum will be signed. This will be completed by **January 30, 2004**.

b. COTRs thoroughly review and certify acceptance of contractor invoices:

Planned Action: COTR training, which will include certification of invoices from contractors, will be provided by **June 30, 2004**.

c. Provide COTRs initial and annual refresher training on their roles and responsibilities:

Planned Action: COTR training will be scheduled by **June 30, 2004** and annual refresher training will be provided.

d. Prepared Price Negotiation Memorandums (PNMs) for all negotiated contracts:

Planned Action: PNMs have been implemented for negotiated contracts. Action will be completed by **June 30, 2004**.

e. Verify contractor liability insurance for all clinical service contracts:

Planned Action: The medical center will contact all of the contractors for the medical contracts and request copies of insurance documentation. This will be completed by June 30, 2004.

OIG Suggestions:

4. Automated Information Systems Security – Controls Need To Be Strengthened

Suggested Improvement Action. We suggest that the VISN Director ensure that the Medical Center Director requires that: (a) CBOCs are routinely included in contingency plan training and testing, (b) VISTA access be promptly terminated for all individuals who do not have a continued need for access, (c) computer room access is consistently monitored, and (d) backup storage files are stored at a location that meets local risk considerations.

Concur with suggested improvement actions

a. CBOCs are routinely included in contingency training and testing:

Planned Action: Testing of the contingency plan for each Community Based Outpatient Clinic (CBOC) is planned for implementation on March 30, 2004. The Outpatient Coordinator, CBOC staff, and Information Security Officer (ISO) will be involved in the testing. Testing will involve loss of computers, loss of telephone services, and/or loss of electrical power. Staff will be trained in implementing their contingency plan. Documentation will include description of services that were provided, recovery, and any recommendations resulting from the test. Quarterly reports of this contingency plan testing will be submitted by **March 30, 2004.**

b. VistA access be promptly terminated for all individuals who do not have a continued need for access:

Planned Action: ISO and AISO will be trained by IRM staff to conduct monthly VistA access monitoring to ensure that continued need for user access and privileges is conducted every 90 days. Training will be completed by **January 30, 2004**. Monthly reports will be submitted to Manager, QM/PI, with the first report to be submitted by **February 10, 2004**.

c. Computer room access is consistently monitored:

Planned Action: Effective January 5th, 2004, all employees who enter the Computer room will sign in on a paper sign-in log provided to IRM by the Information Security Officer. ISO will monitor completion of form on a monthly basis, with first report to be submitted to Manager, QM/PI, by **February 10, 2004**. This item is closed.

d. Backup storage files are stored at a location that meets local risk considerations:

Planned Action: Backup storage files will be maintained in Johnstown CBOC, which is an acceptable distance away from local weekly backup storage. Fireproof safes were ordered for housing of backup storage files in the Telephone Building and in Johnstown CBOC in **November 2003**. Follow-up on purchase status of these fireproof safes was conducted by ISO on **December 30, 2003**. Acquisition and Materiel Management staff advised that this purchase request falls under equipment funds and cannot be ordered until equipment funds become available. ISO will check on status of purchasing of fireproof safes on a monthly basis and will submit findings to Manager, QM/PI monthly, with the first report to be submitted **by February 20, 2004**.

5. Supply Inventory Management – Engineering Inventory Should Be Reduced and Controls Improved

Suggested Improvement Action. We suggest that the VISN Director ensure that the Medical Center Director requires Facilities Service to fully implement Generic Inventory Package (GIP) and reduce excess engineering supply inventory.

Concur with suggested improvement action

Planned Action: The medical center will continue to implement GIP, monitor new items ordered by using item master file, and will work with engineering personnel to reduce excess stock items by **December 31, 2004**. Actions will be ongoing after the completion date as new items are procured.

6. Patient Waiting Times – Waiting Times for Initial Primary Care Appointments Should Be Reduced

Suggested Improvement Action. We suggest that the VISN Director ensure that the Medical Center Director takes action to review appointment scheduling procedures to increase the number of initial appointment slots available to newly enrolled veterans.

Concur with suggested improvement action

Planned Action: For the 2003 and 2004 Network Director's Performance Measures, waiting time for primary care was measured by utilizing the access scores from the Survey of Healthcare Experiences for Patients (SHEP). Our current overall SHEP scores for access are exceeding the performance target of 79%, and are better than the national average. Despite this, our goal is to schedule all appointments within 30 days of the desired date. We are meeting this goal in all of our CBOCs. Clinics at the medical center are not meeting the waiting time standards. KLF data for the month of November 2003 shows that the number of available appointments was 567 and number of new appointments requested was 419. We are not meeting the standard due to the volume of new patients who continue to seek care, and the practice of scheduling two appointment slots for new patients. All primary care clinics will open additional clinic slots, converting the time currently allotted for administrative work to clinic appointment slots, and establish 30 minute appointment slots for new patients. This process is **effective immediately**. If a new patient cannot be scheduled within 30 days, the clerk will notify the provider to determine if overbooking is required. Although not a requirement, we are also in the process of implementing open access in some of the primary care clinics. Clinic profiles for open access had already been developed for one provider. Open access is defined as allocating a limited number of appointment slots for walk-ins. These actions will be monitored by Primary Care and reported to the Enhanced Access Steering Committee monthly.

7. Patient Transportation Program – Driver Medical Evaluations and Training Should Be Improved

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

Concur with suggested improvement actions

a. Provide and document initial medical evaluations for drivers:

Planned Action: Human Resources Department initiated action prior to the OIG visit to have all volunteer drivers receive a baseline physical examination. A letter signed by the Director was sent to each volunteer driver requesting they schedule a physical examination with their primary care physician, if being treated as a veteran, or the personnel health physician, for those not receiving health care at the medical center. To date, approximately 50% of the 85 volunteers have either had their physicals or are scheduled. Human Resources will follow-up with the volunteers who have not responded to schedule their physicals. The results of physical examinations will be filed in the volunteer driver's record, which is maintained in Human Resources. The target completion date for this action is **March 2004**.

b. Periodically re-evaluate all drivers:

Planned Action: Volunteer drivers receiving baseline physicals will be scheduled for re-evaluation upon in close proximity to the date their Pennsylvania Driver's License is due for renewal. Volunteers will continue to receive annual driver training and have periodic re-evaluations. Results of re-evaluations will be filed in the volunteer driver's record, which is maintained in Human Resources. This action has been initiated and is **ongoing**.

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

Planned Action: Medical center motor vehicle operators receive annual driver training which is documented in TEMPO. Volunteer motor vehicle operators receive initial safe driver's training during their orientation, which is provided by the Disabled American Veterans (DAV) Coordinator. Human Resources will coordinate with the DAV Coordinator to develop annual refresher training for all volunteer drivers that will be documented in their volunteer record maintained in Human Resources. The target completion date for this action is **February 2004** and **ongoing**.

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

Planned Action: A medical center policy on rules and regulations for transporting veterans on the shuttle buses will be written and implemented with a completion date of **June 30, 2004**. Human Resources is in the process of revising Facilities Department Policy 3, DAV Transportation Network, to assure it meets current VHA policies and procedures and clearly delineates our local procedures. The target completion date is **February 2004**.

8. Enrollment Applications – Processing Time Should be Improved

Suggested Improvement Action. We suggest that the VISN Director require that the Medical Center Director review and adjust Health Benefit Advisor (HBA) staffing and workload levels to ensure enrollment applications are processed within seven days of receipt.

Concur with suggested improvement actions

Planned Action: The continued turnover in HBA staffing has made this area problematic. As of December 31, 2003, the backlog of unprocessed enrollment applications is at 30 days. The vacant position for an HBA is being evaluated for prioritization and funding. In the interim, overtime and compensatory time will be used to reduce the backlog and bring the processing of new applications to 7 days or less in compliance with VHA Directive 2003-068. In addition to local monitoring, the VISN will monitor medical center achievement through the monthly collection of waiting time reports. The target completion date for medical center action is **June 30, 2004**.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Better use of funds by pursuing an MRI services contract.	$48,400

Appendix D

OIG Contact and Staff Acknowledgments

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Acknowledgments	Gary Abe Danny Bauwens Kevin Day Barry Johnson Theresa Kwiecinski Claire McDonald Ron Stucky John Tryboski Wilma Wong

Appendix E

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