Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities

October 2003 through December 2003

Report No. 04-01010-111

March 18, 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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Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

Memorandum to:

Secretary (00)
Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2003 through December 2003

1. This report summarizes recommendations and suggestions made in reports of Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews conducted at Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities during the period October 2003 through December 2003. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls.

2. During the period covered by this summary report, the OIG published nine reports of CAP reviews conducted at VHA medical facilities. Each of the issues highlighted in this report was identified at two or more medical facilities. We also provided fraud and integrity awareness training for about 1,500 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. The Under Secretary for Health should ensure that all VHA directors and managers are advised of the issues identified in this summary report. We may follow up on the issues reported here in future CAP reviews and include new areas of inquiry. This report was prepared under the direction of Ms. Linda Halliday, Director, Audit Planning Division.

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

Introduction

Background

During the period October 2003 through December 2003, the OIG published nine reports of CAP reviews conducted at VHA medical facilities.

Scope of CAP Reviews

The scope of our CAP reviews is tailored to address both national and facility specific issues. Because the scope of review has been modified through time, the areas of inquiry described below were not necessarily reviewed at each medical facility included in this report. This report summarizes issues, reported in two or more CAP reports, for which recommendations or suggestions were made.

Fraud and integrity awareness briefings were also conducted during each of the 9 CAP reviews and about 1,500 VHA employees attended the briefings. The briefings included a film that describes the types of fraud that can occur in VA programs and the OIG's role in investigation of criminal activity, followed by question and answer sessions.

CAP Reports Issued

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, W.G. (Bill) Hefner VA Medical Center Salisbury, NC	6	03-02420-06	10/14/03
Combined Assessment Program Review, VA Medical Center Coatesville, PA	4	03-02278-08	10/29/03
Combined Assessment Program Review, VA Medical Center Grand Junction, CO	19	03-02290-012	11/04/03
Combined Assessment Program Review, VA Medical Center Muskogee, OK	16	03-02374-017	11/07/03
Combined Assessment Program Review, VA Greater Los Angeles Healthcare System Los Angeles, CA	22	03-01948-018	11/10/03
Combined Assessment Program Review, G.V. (Sonny) Montgomery VA Medical Center Jackson, MS	16	03-02446-23	11/13/03
Combined Assessment Program Review, VA Medical Center Tomah, WI	12	03-02067-29	11/21/03
Combined Assessment Program Review, VA Medical Center Sheridan, WY	19	03-02612-27	11/21/03
Combined Assessment Program Review, VA Medical/Regional Office Center Cheyenne, WY	19	03-02029-45	12/19/03

CAP Findings by VISN and by Medical Facility

Veterans Integrated Service Networks (VISNs)									
	4	6	12	16		19			22
Findings	VA Medical Center (VAMC) Coatesville, PA	VAMC Salisbury, NC	VAMC Tomah, WI	VAMC Muskogee, OK	VAMC Jackson, MS	VAMC Grand Junction, CO	VAMC Sheridan, WY	VA Medical/Regional Office Center Cheyenne, WY	Greater Los Angeles Healthcare System, CA
Agent Cashier		●							●
Community Residential Care	●		●				●		●
Contracting for Clinical Services and Sharing Agreements				●		●			●
Contracting for Non-Clinical Services	●	●	●		●				
Controlled Substances Accountability	●		●	●	●	●	●	●	●
Environment of Care	●		●						●
Government Purchase Cards	●	●						●	
Information Management Security	●	●	●	●	●	●	●	●	●
Management of Equipment Inventories				●			●		●
Management of Supply Inventories	●			●			●		●
Medical Care Collections Fund			●	●			●		
Quality Management	●	●	●	●		●	●	●	●

SHADED = AREA REVIEWED AT THIS SITE
● = IMPROVEMENT NEEDED AT THIS SITE

Summary of CAP Findings

1. Agent Cashier (findings at 2 of 3 medical facilities)

- Provide a security escort for the Agent Cashier during cash replenishment trips.
- Conduct unannounced audits of the Agent Cashier at least every 90 days.
- Provide refresher training to VHA staff charged with responsibilities to conduct Agent Cashier audits.
- Change the combination to the Agent Cashier vault after changes in the Agent Cashier position.

2. Community Residential Care (findings at 4 of 5 medical facilities)

- Ensure that clinicians perform and document monthly visits to Residential Care Facilities (RCF) and conduct annual physical examinations of RCF patients.
- Ensure the Community Residential Care (CRC) Coordinator and Veterans Benefits Administration Fiduciary and Field Examiners supervisors meet annually to address issues involving incompetent veterans with assigned fiduciaries.
- Require that fire safety inspectors conduct annual evaluations of RCFs.
- Require that CRC teams conduct inspections of RCFs at least every 2 years.
- Verify that CRC facility employees are not also employed by the medical center.
- Require that Memoranda of Understanding addressing CRC services and fees are developed and documented in the CRC sponsors' records.
- Provide and document annual training to RCF employees and train case managers and social workers to annotate changes in medical conditions in patient medical records and inform CRC sponsors of these changes.
- Ensure local CRC policies comply with VHA policies.

3. Contracting for Clinical Services and Sharing Agreements (findings at 3 of 5 medical facilities)

- Ensure that VHA contracting officers conduct price analyses for negotiated acquisitions.
- Ensure that the Medical Center Directors require the contracting officers to prepare and maintain Price Negotiation Memorandums (PNMs) for all non-competitive contracts in accordance with the Federal Acquisition Regulations.

4. Contracting for Non-Clinical Services (findings at 4 of 4 medical facilities)

- Ensure that Medical Center Directors plan and establish contracts for recurring procurements and conduct quarterly reviews of purchasing activities.
- Ensure Contracting Officer's Technical Representatives effectively monitor contractor performance and compliance with contract terms and adequately review invoices before payment is authorized.
- Write contract specifications clearly to prevent misinterpretations.
- Require Contracting Officers to document the rationale for awarding contracts in PNMs, in accordance with Federal Acquisition Regulation Part 15 (Contracting by Negotiation) Subpart 15.808 (PNM).

5. Controlled Substances Accountability (findings at 8 of 9 medical facilities)

- Conduct random unannounced controlled substances inspections in all areas where controlled substances are stored.
- Inventory controlled substances stored in ward refrigerators during change of shifts.
- Account for unusable and expired controlled substances in monthly inspections to ensure expired substances are destroyed quarterly.

- Resolve discrepancies in 72-hour pharmacy inventory checks.
- Establish controls to ensure that the Controlled Substances Inspection Program is operating effectively and provide refresher training to all inspectors in the program.
- Require that all controlled substances prescriptions waiting for outpatient pickup are properly secured and verify the identity of agents picking up controlled substances and other medications for patients.
- Ensure that VHA and local controlled substances inspection policies are followed, including reporting requirements regarding the loss of controlled substances.
- Ensure separation of duties for ordering and receiving of controlled substances and that both a Pharmacy Service and an Acquisition and Materiel Management Service (A&MMS) employee are the receipt witnesses.

6. Environment of Care (findings at 3 of 9 medical facilities)

- Properly secure all potentially hazardous chemicals, products, and sharp instruments.
- Correct maintenance and safety issues requiring immediate attention, such as treating patient care areas when insects or pests are reported.

7. Government Purchase Cards (findings at 3 of 5 medical facilities)

- Ensure acquisition personnel and purchase cardholders use mandatory Federal Supply Schedule or national contracts and document justifications for sole source procurements.
- Improve accountability for Engineering Service purchases which could be converted to personal use.
- Ensure that the Purchase Card Coordinator, Billing Official, and Dispute Officer are not designated cardholders and ensure adequate separation of duties. For those instances where it is not feasible to achieve adequate separation of duties, the facility Director should document reasons for lack of separation of duties and ensure that compensating controls are established.

- Require approving officials to approve purchase card transactions within 14 days of reconciliation.

- Require quarterly audits of all cardholder accounts not included in the monthly statistical sampling audits conducted by the VA Financial Service Center.

8. Information Management Security (findings at 9 of 9 medical facilities)

- Monitor computer room access and employee Internet usage.

- Develop contingency and recovery plans including identification of critical computer equipment and priorities for restoring equipment; designate an alternate processing facility consistent with VA policy; and update plans when changes occur.

- Test contingency plans under conditions that simulate a disaster.

- Establish an appropriate off-site storage location for critical backup files.

- Ensure the alternate data processing site is located a sufficient distance from the main computer processing location so that both sites are not subject to the effects of the same potential disaster.

- Ensure Veterans Health Information Systems and Technology Architecture (VistA) user access is promptly terminated for inactive users and individuals without a continuing need for system access, and ensure that all system users receive annual computer security awareness training.

- Establish policy and procedure to reinstate or reactivate VistA access for prior authorized users.

- Require background investigations for all key staff and contract employees having access to automated information systems.

- Require that the Information Security Officer (ISO) position is assigned as a primary duty and ensure that all ISO responsibilities are met.

- Ensure alternate ISO's do not have programmer level access to the medical center's automated information systems.

9. Management of Equipment Inventories (findings at 3 of 4 medical facilities)

- Ensure Equipment Inventory Lists (EILs) are completed by medical center management, verified by A&MMS staff timely, and inform Facility Management Staff (FMS) when equipment is moved or excessed.
- Require the Chief of FMS to include sensitive items such as handguns on EILs and that service chiefs ensure equipment purchased is put into service when received.
- Require medical center staff to promptly submit Reports of Survey when equipment is lost, damaged, or destroyed.
- Ensure FMS staff conduct quarterly inventory spot checks and update EILs as required.
- Require the Chief of A&MMS to develop and implement a detailed medical center equipment accountability policy.
- Send timely delinquent inventory notices to responsible officials when scheduled inventories are not performed.
- Conduct follow-up physical inventories of areas with accuracy rates below 95 percent within the required 6-month timeframe.

10. Management of Supply Inventories (findings at 4 of 6 medical facilities)

- Require Supply Processing and Distribution (SPD) and A&MMS to monitor medical supply usage, reduce excess inventory, and improve the accuracy of Generic Inventory Package (GIP) data.
- Require FMS to reduce excess engineering supply inventory and develop a comprehensive plan for controlling these supplies with GIP.
- Require Prosthetic and Sensory Aids Service to reduce excess prosthetic inventory and improve the accuracy of Prosthetic Inventory Package data.
- Implement the use of GIP automated tools.

- Reduce medical supply inventory levels to the 30-day supply goal and monitor supply usage rates.

11. Medical Care Collections Fund (findings at 3 of 4 medical facilities)

- Obtain and update veteran insurance information while patients are awaiting treatment.
- Review outstanding bills for coding accuracy to determine if there is further collection potential and submit amended bills as appropriate.
- Require the Medical Center Directors to reduce the number of invalid insurance bills and the backlog of unprocessed insurance bills.
- Pursue Medical Care Collections Fund receivables more aggressively by following up with insurance companies on a more regular basis.

12. Quality Management (findings at 8 of 9 medical facilities)

- Document communication of peer review results to providers and the provider's response.
- Establish evaluation and outcome criteria to measure patient care improvement actions.
- Report administrative and clinical issues discussed during peer reviews to the Medical Executive Board for follow up, and include the issues in the Quality Improvement program.
- Ensure that quality management (QM) data is consistently collected, trended, and analyzed in order to identify opportunities to improve the quality of patient care.
- Establish procedures to monitor the implementation and effectiveness of recommendations from QM reviews.
- Document action plans, including their effectiveness in meeting goals as required by the Joint Commission on Accreditation of Healthcare Organizations and VHA.

- Critically analyze and act upon patient complaints, results of medical record reviews, and Utilization Management (UM) studies.

- Consider all QM data; including patient complaints, UM, and medication management, when reprivileging practitioners.

- Require peer reviewers to complete the practitioner quality of care scale to ensure consistent documentation of peer review outcomes.

- Ensure that available benchmarks or goals are consistently used for analyzing data.

- Implement, evaluate, and document all corrective actions until problems are resolved or the desired improvements are accomplished, and communicate outcomes to responsible managers or committees.

- Require the Clinical Executive Board to review and evaluate the Special Care Unit Committee minutes quarterly.

Appendix A

OIG Contact

OIG Contact	Dennis Sullivan, OIG Office of Audit Planning Division Phone Number (202) 565-4685

Appendix B

Report Distribution

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