



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Inspection of Veterans Health Administration Patient Transportation Services

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Contents

	Page
Executive Summary	i
Introduction	1
Purpose.....	1
Background	1
Scope and Methodology	4
Results and Conclusions	7
Issue 1: Management of Transportation Provided by Employee Drivers	7
Issue 2: Management of Transportation Provided by Volunteer Drivers.....	10
Issue 3: Vehicle Safety	14
Issue 4: Contract Driver Competencies	17
Issue 5: Patient Transportation in Emergencies	18
Issue 6: Incident and Accident Reporting.....	19
Recommendations	21
Appendices	
A. Employee Safety Alert.....	23
B. News Articles Concerning Volunteer Driver Disqualifications	24
C. Reference List	25
D. Under Secretary for Health Comments.....	26
E. OIG Contact and Staff Acknowledgments.....	34
F. Report Distribution	35

Executive Summary

Introduction

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection of Veterans Health Administration (VHA) patient transportation services (PTS). The inspection was conducted to determine if VHA facilities complied with VA and VHA policies and Federal regulations governing patient transportation, VHA facilities had effective internal controls to ensure safe patient transportation, and opportunities existed to improve patient safety by strengthening PTS programs.

Results

We made nine recommendations to the Under Secretary for Health to ensure that deficiencies and vulnerabilities identified in this report are corrected.

To improve and strengthen PTS programs at VHA facilities, we recommended that the Under Secretary for Health needed to:

- Improve initial and follow-up screenings of motor vehicle operators (MVOs), incidental operators, and volunteer drivers.
- Ensure annual safe driving training is provided to all employee and volunteer drivers and publish policy regarding mandatory training requirements to include instruction in handling medical emergencies.
- Ensure drivers' compliance with all aspects of VHA's Employee Safety Alert regarding transportation in 15-passenger vans.
- Ensure patient safety is maintained through the consistent practice of securing patient care equipment, other cargo, and vehicles and ensure that security of patients in vehicles is reviewed, policies are established, and observed.
- Publish policy describing required equipment needed in vehicles used to transport patients. This policy needs to specify that cellular phones and 2-way radios operate independent of the vehicle's battery and provide communication coverage throughout the patient transport.
- Provide guidance to VA facilities regarding employee escort for patients with special medical or mental health needs and ensure that incidents occurring during trips are reported to appropriate clinical staff and documented in the patients' medical records.
- Ensure contracts for transportation services require that vendors certify that their drivers have been screened, trained, and are competent to safely transport VA

patients, and that medical centers ensure that initial and follow-up certifications are received and retained.

- Ensure VA managers consider the use of volunteer drivers in emergency planning.
- Require that transportation incidents and accidents are reported to VHA Headquarters' managers and program officials.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Paula Chapman, Inspection Coordinator, Chicago Office of Healthcare Inspections.

Under Secretary for Health Comments

The Under Secretary for Health concurred with all recommendations and provided an action plan with target dates to implement the recommendations. The full text of the comments and action plan is shown in Appendix D, pages 26-33.

Assistant Inspector General for Healthcare Comments

The Assistant Inspector General for Healthcare Inspections has considered the response of the Under Secretary for Health and agrees with the proposed actions. The implementation of these recommendations will be monitored.

(original signed by:)

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Introduction

Purpose

The Department of Veterans Affairs Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection of Veterans Health Administration (VHA) patient transportation services (PTS). The inspection was conducted to determine if:

- VHA facilities complied with VA and VHA policies and Federal regulations governing patient transportation.
- VHA facilities had effective internal controls to ensure safe patient transportation.
- Opportunities existed to improve patient safety by strengthening PTS programs.

Background

To serve greater numbers of veterans and provide veterans cost effective medical care closer to where they live, VA has restructured the way in which it provides health care services. This restructuring shifted the focus of VA health care delivery from traditional hospital-based inpatient care to outpatient care offered through networks of VA medical centers, community-based outpatient clinics, and VA-contracted or fee-basis community health care providers and agencies. For example, patients who previously received long term care at VHA facilities may now receive care at VA-contracted community nursing homes (CNHs).

VHA provides health care services through an organization of 21 Veterans Integrated Service Networks (VISNs), each representing an alliance of medical centers and outpatient facilities serving veterans throughout a specific geographic area. To improve the quality of care, health care services such as specialty surgery may be offered only at designated medical centers or centers of excellence. Medical centers also partner with the Department of Defense (DoD) and community health care institutions to provide veterans medical services such as kidney dialysis, diagnostic testing, cancer treatment, and nursing home care.

Partnering, sharing, and community-based medical care has benefited veterans with expanded medical care services and health care closer to their homes. However, to provide these services VA needs to transport patients between VA facilities and treating facilities, or between the community nursing home where the patients reside and VA facilities for examination or follow-up medical care. These patients may be elderly, frail, or seriously ill. Transportation is provided by VA employee and volunteer drivers, or private ambulance and hired car vendors.

Transportation by Employee Drivers

Employee drivers are VA staff who are either employed to be VA MVOs or who may drive patients as part of their duties, such as recreation therapists, social workers, nursing assistants, or other clinical staff. Employees who have driving responsibilities in addition to other duties are called incidental operators. Employee drivers may use VA-owned or General Services Administration (GSA)-leased vehicles to transport patients.

Transportation by Volunteer Drivers

VA patients may also be transported through the Volunteer Transportation Network (VTN). The VTN is a volunteer-based transportation service, created in 1987 by the Disabled American Veterans (DAV).¹

DAV departments and/or chapters donate vehicles for the VTN program and fund Hospital Service Coordinator (HSC) positions to assist in coordinating patient transportation. HSCs are registered as VA Voluntary Service (VAVS) volunteers and partner with VAWS to ensure the availability and utilization of the full range of community transportation resources. As of February 24, 2004, there were 185 HSCs.

VTN volunteer drivers transport patients in DAV-donated or GSA-leased vehicles, or, in some cases, private automobiles. VA regulations require that medical centers screen volunteer-driver candidates to ensure they are suitable and provide driver training. HSCs and Voluntary Service managers collaborate in screening candidates. During 2003, VTN volunteers donated over 1,468,000 hours and logged nearly 27,400,000 miles transporting more than 734,000 VA patients.²



¹ The Disabled American Veterans is a veterans' service organization chartered by the Congress of the United States.

² Statistics provided by VHA's Voluntary Service Office.

Transportation by Private Ambulance and Hired Car Contractors



VA facilities also have contractual or fee-basis agreements with community vendors to transport VA patients. These vendors often have specialized vehicles, such as ambulances equipped with life support equipment or vehicles with wheelchair lifts. Drivers are screened and trained by the vendor. Drivers frequently hold specialized certifications, such as Basic or Advanced Cardiac Life Support.

Patient Transportation Issues Identified in Prior OIG Reviews

A May 2000 Combined Assessment Program (CAP) review³ of a health care system found that shuttle drivers were not trained in basic first aid or cardiopulmonary resuscitation (CPR) and were not accompanied by support staff trained to manage patients with special needs. Patients were not always appropriately clothed for cold weather during transports, and drivers did not have effective cellular phones or 2-way radio communication during trips.

In a March 2002 report, we reviewed a hotline allegation⁴ that patients transported by VA shuttle between two VA divisions were “stranded” at the division where they had their appointments and frequently missed the last shuttle of the day back to the other division. We determined that this occurred because drivers did not keep track of patients riding the shuttle and did not know the time of each patient’s expected return. Patients who missed the last shuttle were either lodged at the visiting division or were returned to the home facility by VA personnel or contract transportation.

An OIG evaluation of the VA CNH program⁵ issued in December 2002 found that contracts with some nursing homes did not describe requirements for transporting patients who needed frequent return visits to VA medical facilities for rehabilitation or medical care. Contract drivers often delivered the patients to VA medical facilities much earlier than their scheduled appointments, and patients frequently experienced delays obtaining transportation back to their nursing homes. During the waiting periods,

³ Combined Assessment Program Review, VA Northern Indiana Health Care System, Ft. Wayne and Marion, Indiana, Department of Veterans Affairs Office of Inspector General Report No. 00-01199-72, May 25, 2000.

⁴ Healthcare Inspection, Treatment Quality and Service Issues at the VA Northern Indiana Health Care System, Department of Veterans Affairs Office of Inspector General Report No. 01-02748-64, March 7, 2002.

⁵ Healthcare Inspection, Evaluation of the Veterans Health Administration’s Contract Community Nursing Home Program, Department of Veterans Affairs Office of Inspector General Report No. 02-00972-44, December 31, 2002.

patients were often unsupervised and had difficulty taking medications, getting meals, or obtaining assistance in restrooms.

An August 2004 report investigated alleged problems with a VA-contracted transportation service.⁶ We found that medical center staff did not monitor contract requirements to ensure that the vendor's vehicles met safety and maintenance standards or that the vendor's drivers were adequately trained and otherwise suitable to transport VA patients. The medical center had not established appropriate controls to monitor transportation safety practices, vendor compliance with contractual requirements, service complaints, vendor timeliness, and corrective actions.

Scope and Methodology

We inspected PTS programs at 14 VA facilities from October 1, 2003, through January 31, 2004. We interviewed managers and program officials from VHA Headquarters and the National Center for Patient Safety (NCPS) to obtain an understanding of policies and regulations governing PTS and procedures for reporting patient transportation incidents and accidents. We also interviewed Human Resource managers, service managers responsible for oversight of MVOs, and Voluntary Service managers.



We evaluated local patient transportation policies for compliance with VA policies and Federal regulations. We also examined the policies to determine if they addressed vehicle maintenance, required vehicle equipment, procedures for managing roadside and patient emergencies, systems to track patients using transportation services, and use of employee escorts for patients with special needs.

We assessed driver screening procedures to determine if the procedures complied with Federal regulations,⁷ and ensured that MVOs and incidental operators had safe driving records, possessed valid State licenses, and demonstrated that they were medically qualified to operate motor vehicles safely. Federal regulations⁸ also require that agencies

⁶ Healthcare Inspection, Patient Travel and Contract Transportation Deficiencies, VA Medical Center Augusta, Georgia, Department of Veterans Affairs Office of Inspector General Report No. 04-00225-184, August 13, 2004.

⁷ Title 5 of the Code of Federal Regulations, Volume 2 – Administrative Personnel, Chapter I – Office of Personnel Management, Part 930 – Programs For Specific Positions and Examinations (Miscellaneous), Subpart A – Motor Vehicle Operators, Section 930.105 – Minimum requirements for competitive and excepted service positions, January 1, 2004 edition.

⁸ Same reference as in footnote 7, except Section 930.109 – Periodic review and renewal of authorization, January 1, 2004 edition.

reassess each driver's authorization to operate a Government-owned or Government-leased motor vehicle at least once every 4 years; they also require that agencies renew the employee's authorization to operate motor vehicles only after the appropriate agency official has determined that the employee is medically qualified and continues to demonstrate competence to operate the assigned type of motor vehicle. We also assessed compliance with VA requirements described in VHA Handbook 1620.2⁹ that volunteer drivers:

- Possess safe driving records
- Possess valid State licenses
- Possess current automobile insurance
- Receive required medical examinations and health screenings that parallel the standards of wage-grade van drivers at the local facility
- Receive a volunteer orientation and all training required by the VA facility

We inspected the training records of 32 MVOs, 11 incidental operators, and 41 volunteer drivers. VA Handbook 7700.1¹⁰ requires that VA facilities establish motor vehicle safety programs where motor vehicles are regularly operated on official business. Drivers are required to attend at least one safe driving program annually, focusing on safe driving practices, use of safety belts and shoulder harnesses, and defensive driving techniques.

We accompanied drivers on 15 patient transports to evaluate safety and security practices, the condition of the vehicles, vehicle equipment, and driver compliance with local transportation policies. Additionally, we evaluated compliance with the VHA Employee Safety Alert that defines van occupancy, passenger and cargo placement, and seat belt usage for 15-passenger vans (see Appendix A, page 22, for the full text of the alert).

We determined whether facilities monitored the qualifications of drivers employed by VA-contract transportation vendors. We inspected transportation contracts for provisions requiring documentation of drivers' licenses and specialized licenses such as commercial drivers' licenses, professional certifications such as Emergency Medical Technician certification, and requirements for employee training and screening. We determined if VA facilities received contract-required certifications and documentation of drivers' qualifications and if appropriate facility employees reviewed the information.

We interviewed top managers to determine how PTS is integrated into the facility's emergency preparedness plans and whether resources (vehicles and manpower) were

⁹ Volunteer Transportation Network, May 2, 2001.

¹⁰ Occupational Safety and Health, July 8, 1998.

adequate to provide patient transportation in the event of a facility evacuation, emergency, or disaster.

We also evaluated employee and volunteer driver accidents during the 5-year period preceding the inspection and assessed the circumstances of the accidents and injuries, along with associated costs for medical care, vehicle repair, and tort and OWCP claims.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.



Results and Conclusions

Issue 1: Management of Transportation Provided by Employee Drivers

Summary

VHA needs to establish policy and appropriate internal controls to ensure goals and expectations for patient safety are met.

Results of inspection show that:

- VHA and local policy governing employee drivers was not monitored or enforced.
- VHA facilities did not consistently verify whether employee drivers were medically fit to transport patients.
- VHA facilities verified licensure at the time of initial driver appointment but did not consistently conduct follow-up verifications.
- VHA facilities did not consistently ensure that applicants had safe driving records and did not conduct follow-up driving record reviews as required.
- VHA facilities did not consistently ensure that employee drivers completed annual safe driver training.

These conditions occurred, in part, because national policy for patient transportation was not comprehensive and local policy was not always established or consistent with national policy. Additionally, facility managers told us they were unaware of policy requirements that were established or that they did not have sufficient staff to meet some policy requirements. As a result, there is no assurance that MVOs and incidental operators are properly screened and trained to transport VA patients safely.

Background

Federal regulations require that applicants for MVO positions demonstrate that they are medically qualified to operate motor vehicles safely, have safe driving records, and possess valid State drivers' licenses. Agencies are also required to reevaluate medical fitness and review driving records and licenses at least once every 4 years; they are supposed to renew the employee's authorization to drive only after the appropriate agency official has determined that the employee continues to meet standards. VA Handbook 7700.1 requires that all drivers (MVOs and incidental operators) complete at least one formal safe driving program annually.

Results of Inspection

Verification of Medical Fitness

Two of the 14 facilities we inspected did not employ MVOs to transport patients (VHA facilities are not required to employ MVOs). One facility was an outpatient clinic and used only volunteer drivers, and the second facility was a medical center that used incidental operators to transport patients. We focused our inspection on MVO medical examinations, although Federal regulations also require these examinations for incidental operators.

Applicants were required to complete a self-reported medical history form, such as Office of Personnel Management (OPM) Optional Form (OF) 345, “Physical Fitness Inquiry for Motor Vehicle Operators,” or Standard Form (SF) 47, “Physical Fitness Inquiry,” at 10 of the 12 facilities that used MVOs. These forms require the applicants to identify medical or psychosocial factors which may affect their driving ability. Medical examinations were conducted by the facility’s Occupational Health unit.

We found that 11 of the 12 facilities using MVOs performed initial medical examinations as required. The facility that did not conduct a medical examination was one of the two facilities that did not require completion of the self-reported medical history form. Seven of the 12 facilities with MVOs (58 percent) did not conduct follow-up medical examinations at least once every 4 years.

Verification of Licensure

All 12 facilities using MVOs conducted required initial State driver’s license verifications. However, 4 of the 12 facilities (33 percent) did not conduct follow-up verifications at least once every 4 years.

Driving Record Review

Three of the 12 facilities using MVOs (25 percent) did not verify that applicants had safe driving records before authorizing them to operate motor vehicles; 7 of the 12 facilities (58 percent) did not conduct follow-up reviews at least once every 4 years, as required by Federal regulations.

Driver Training

We inspected training records of 43 drivers (32 MVOs and 11 incidental operators) and found that 10 of 32 MVOs (31 percent) and 6 of 11 incidental operators (55 percent) did not receive required annual safe driving training. Only 4 of the 13 facilities with employee drivers fully met the requirement for annual training. Failure to provide annual safe driving training was the most frequently found employee driver deficiency in this inspection; it was also a problem identified during eight CAP reviews.

Two facilities had policies requiring that employee drivers receive CPR training in addition to annual safe driving training. However, managers at those facilities did not ensure that MVOs and incidental operators received CPR training. Only 8 of the 32 MVOs reviewed (25 percent) and 8 of the 11 incidental operators (73 percent) were trained in CPR. Thirteen of the MVOs (41 percent) and six of the incidental operators (55 percent) received training in basic first aid. It is important that drivers be trained to handle emergency situations since clinical support was not available on every trip.

Policy and Oversight Deficiencies

These conditions occurred because VHA and local policy governing employee drivers was inconsistent, incomplete, or not established, and because compliance with existing policy was not monitored or enforced. Medical center managers frequently told us that non-compliance resulted because they were unaware of policy requirements.

National Policy Deficiencies

VHA guidance is needed to describe the type of training required for employee drivers, in addition to the annual safe driving training. VHA policy does not specify the type or quality of training required. Some facilities provided employee drivers training that included:

- CPR
- Basic first aid
- Prevention and management of disturbed behavior
- Proper body mechanics for handling patients
- Techniques for safe patient assistance
- Proper loading and securing of patients in wheelchairs, stretchers, and electric scooters
- Management of exposure to blood-borne pathogens
- Vehicle safety inspection
- Procedures for reporting incidents and accidents

Local Policy Deficiencies

Facility managers needed to ensure that local policies were established that comply with and implement VA, VHA, and Federal regulations and requirements. Four of the 13 facilities using employee MVOs or incidental operators (31 percent) had not established

local transportation policy. All nine facilities that had published transportation policy required verification of licensure, but other important requirements were not addressed:

- Three policies (33 percent) did not require review of driving records for moving violations, driving under the influence of alcohol or drugs, history of accidents, and other violations.
- Five (56 percent) did not require initial medical examinations.
- Five (56 percent) did not provide guidance for management of patient emergencies.
- Four (44 percent) did not provide procedures for monitoring patients, such as recording the name of the patient, the clinic(s) to be visited, and expected time of return.
- Seven of the 14 facilities inspected (50 percent) did not have a policy to determine when employee escorts were needed for patients with special needs.

Conclusions

VHA needed to improve initial and follow-up driver screenings and ensure medical centers conduct medical fitness examinations, verify that applicants have valid State drivers' licenses, and conduct driving record reviews. Managers who supervise employee drivers needed to ensure that MVOs and incidental operators complete annual safe driving training, and VHA needed to establish policy describing what training is required.

VHA needed to publish comprehensive policy and guidance for management of employee drivers. The policy should provide detailed requirements for screening MVO and incidental operator employee drivers, to ensure that only qualified, medically fit, and competent drivers transport VA patients. The policy should also provide detailed instruction on the form, content, and frequency of driver training and establish controls to monitor local facility compliance with VA, VHA, and Federal policy and regulation.

Issue 2: Management of Transportation Provided by Volunteer Drivers

Summary

VHA needs to ensure that volunteer drivers are properly screened and trained and that internal controls are in place to ensure patient safety.

Results of inspection show that VHA facilities did not consistently:

- Comply with requirements for verification of medical fitness
- Comply with requirements for verification of licensure and driving record reviews

- Conduct initial and follow-up verifications of automobile insurance coverage
- Comply with requirements to provide annual safe driver training

The conditions occurred because VHA and local policy governing volunteer drivers was inconsistent, incomplete, or not established, and because compliance with existing policy was not monitored. Additionally, facility managers told us they were unaware of policy requirements, and at some facilities, Occupational Health managers were resistant to providing additional medical fitness tests for volunteers. As a result, there is no assurance that volunteer drivers were consistently screened and trained to transport VA patients safely.

Background

VHA Handbook 1620.2 states that: “A facility and/or VISN with a VTN is required to administer medical examinations and health screenings for volunteer drivers that parallel the physical examinations and health screenings required for wage-grade van drivers, on a regular basis, at the local facility or VISN.”

Office of Public Health and Environmental Hazards Information Letter 13-2003-001, Clearance of Volunteers for Driving Assignments, published April 11, 2003, provides instructions for conducting volunteer driver medical examinations through clarification of OPM’s OF 345. The clarification provides criteria for conducting medical examinations. The Information Letter states:

“Just as commercial standards are more stringent than those of a drivers license for personal use, so must the physical standards for drivers involved in transporting VHA’s veteran patients also derive from a stricter standard than those for private use.”

The Information Letter recommends that managers incorporate provisions in local policy that volunteer drivers not be cleared to drive if the Occupational Health examination shows they are not suitable based upon criteria established in the Information Letter. These criteria include standards for vision, hearing, and physical health. The Information Letter also notes:

“A diagnosis of any of the following medical conditions (list included as an Attachment to the Information Letter) may not necessarily result in the declination of a volunteer as a driver as the qualification is made on an individual basis after review of all appropriate medical documentation from the volunteer candidate’s primary care or other provider.”

The Information Letter further states, “Follow-up physical examination, testing, or other appropriate action, including denial of driving duties, may be indicated.” However, the

Information Letter does not specify the frequency of follow-up examinations. VHA Handbook 1620.2 also requires that volunteer drivers have a safe driving record and possess a valid state driver's license and current automobile or private insurance. If a volunteer has an automobile, they would carry automobile insurance. If the volunteer does not have an automobile, they would be required to have private insurance. Volunteer drivers are considered "without compensation employees" within the purview of the Federal Tort Claims Act (FTCA). Therefore, while they are acting within the scope of their duties, they are afforded the protection of the FTCA. However, protection extends only to the period of time in which they are performing the assignment. For example, a volunteer driver who makes a side trip to the bank or dry cleaners while the veteran is in the vehicle may not be covered. For this reason, all volunteer drivers are required to carry current automobile or private insurance.

VHA Handbook 1620.2 states that volunteer drivers are required to complete training required by Voluntary Service, Engineering Service, Police and Security Service, Health Administration Service, Fiscal Service, Social Work Service, and other services, as appropriate.

Results of Inspection

Verification of Medical Fitness

All 14 facilities in our inspection utilized volunteer drivers to transport patients. Managers at these facilities were aware of the Information Letter and the criteria for volunteer driver medical examinations; however, some facilities did not conduct medical examinations pending further VHA guidance. Seven facilities (50 percent) had not conducted initial medical examinations of volunteer driver candidates prior to the issuance of the Information Letter, even though medical examinations and health screenings were required by VHA Handbook 1620.2. Additionally, nine facilities (64 percent) had not established processes for ensuring follow-up medical examinations at least once every 4 years, prior to the issuance of the Information Letter.

We found inconsistencies in the manner in which Occupational Health clinicians performed examinations at facilities that were conducting examinations. Some medical examinations only consisted of review of the applicant's self-reported medical disclosure and, if this review was considered sufficient, the volunteer was qualified to drive. Other VA facilities included laboratory, vision, hearing, and other testing, as determined by the provider.

Voluntary Service managers told us that some volunteer drivers had been disqualified after examination because they had one or more disqualifying conditions described in the Information Letter. While managers agreed that a medical examination was necessary to screen out drivers who were unfit to drive, they were also concerned about replacing the

disqualified drivers. Recent media attention focusing on the disqualification of VA volunteer drivers is shown in Appendix B (page 23).

Verification of Licensure

We inspected the files of 41 volunteer drivers, selected from among all 14 facilities inspected. Initial verification of licensure was conducted at 12 of the 14 facilities (86 percent). One facility had verified the licensure of only one of three volunteer driver applicants, and another facility initiated verification of licensure immediately prior to our inspection. Six of 14 facilities (43 percent) did not conduct follow-up verifications at least once every 4 years as required.

Driving Record Review

Five of 14 facilities (36 percent) did not conduct an initial review of volunteer driver applicants' driving records, and 8 facilities (57 percent) were not conducting follow-up driving record reviews at least once every 4 years as required.

Verification of Insurance Coverage

Five of 14 facilities (36 percent) did not conduct initial verifications of automobile insurance coverage, and 7 facilities (50 percent) were not conducting follow-up verifications at least once every 4 years as required.

Driver Training

We inspected a sample of 41 volunteer driver training records selected from among all 14 facilities. Seventeen of 41 volunteer drivers (42 percent) did not receive annual safe driving training as required.

One facility required that volunteer drivers complete first aid and emergency procedures training, in addition to annual safe driving training. We inspected three volunteer drivers' training records from that facility and found that none received the required training. Only 6 of the 41 volunteer drivers reviewed (15 percent) received CPR training, and 8 of the volunteer drivers (20 percent) completed basic first aid training. Failure to provide annual safe driving training was the most frequently found deficiency in this inspection; it was also a problem identified during seven CAP reviews.

Policy and Oversight Deficiencies

These conditions occurred because VHA and local policy governing volunteer drivers was inconsistent, incomplete, or not established, and because compliance with existing policy was not monitored or enforced. Additionally, facility managers frequently told us they were unaware of the requirements that had been published.

Local Facility and VHA Policy

All 14 facilities inspected had established local policies for management of volunteer driver services. Thirteen of 14 facilities had policy that required initial medical examination of volunteer driver applicants, and all required verification of valid State drivers' licenses. VHA Handbook 1620.2 also requires that volunteer drivers possess current automobile insurance, but one facility did not include this requirement in their local policy. Four of the 14 facilities (29 percent) did not require review of applicant driving records and did not specify driver training requirements.

We learned that some VA facilities had already established and implemented processes to provide medical examinations for volunteer drivers prior to our on-site CAP reviews. At other VA facilities, Occupational Health managers were resistant to assuming the additional workload needed for these examinations; consequently these facilities were not conducting the examinations.

Conclusions

VHA needed to improve initial and follow-up screenings of volunteer drivers by ensuring applicants received medical examinations and by verifying licensure, automobile insurance coverage, and driving records. VHA also needed to publish requirements for volunteer driver medical examinations in a VHA directive. These requirements should include, at a minimum: (a) the timeframes for initial and follow-up examinations; (b) criteria and instructions describing how the examinations will be administered; and (c) other responsibilities of the services involved in the process. Each individual VA facility needed to ensure that their policies for volunteer drivers complied with VA, VHA, and Federal regulations.

It is reasonable to expect volunteer drivers who transport patient to meet the same training requirements as those for employee drivers. Voluntary Service managers needed to ensure that volunteer drivers received initial orientations and appropriate follow-up training to maintain drivers' skills and knowledge and ensure that training was documented.

Issue 3: Vehicle Safety

Summary

VHA needs to establish policy and appropriate internal controls to ensure vehicle safety requirements are met. Vehicles used to transport VA patients must be safe, appropriately equipped, and properly maintained. Patients should be screened prior to transport to determine if an employee escort is needed because of the patient's special medical or mental health needs.

Results of inspection show that:

- VHA facilities were not consistently in compliance with vehicle occupancy and passenger seating requirements for 15-passenger vans.
- VHA policies did not address the need for drivers to secure patient care equipment, other cargo, and the vehicles.
- VHA facilities did not consistently follow policies to ensure passenger safety and security and that patients were secured by seat belts.
- VHA policies did not prescribe how patient transport vehicles should be equipped.
- VHA facilities did not consistently establish policies for employee escorts for patients.

These conditions occurred because the drivers were unaware of VHA policy requirements, or because VHA managers needed to establish or strengthen local policy, monitor compliance with training requirements, and improve communication and management of patient transportation.

Background

A VHA Employee Safety Alert, issued June 11, 2003 (see Appendix A, page 22), warns of increased risk of rollover that exists in the design and handling characteristics of 15-passenger vans. The Safety Alert warns that rollover risk is related to vehicle occupancy and seating arrangement, cargo storage, and road conditions.

The alert also describes six steps to mitigate the risk of rollover:

1. Vans should have no more than 9 occupants, including the driver.
2. Vans should be operated only by experienced, trained drivers.
3. Occupants should wear seat belts at all times. (The National Highway Traffic Safety Administration reported that 87 percent of passengers who died in 15-passenger van crashes were not wearing seat belts.)
4. Passengers and cargo should not be placed in a seat or space behind the rear axle.
5. Cargo or luggage should not be stored on top of the vehicle.
6. Tire pressure and tread wear should be checked monthly.

We accompanied 15 scheduled patient transports at the facilities inspected, to evaluate compliance with the requirements of the Employee Safety Alert and to assess whether local policy and procedure addressed the special needs of patients' including providing for employee escorts when appropriate.

Results of Inspection

Vehicle Occupancy

At one facility, an employee driver was observed preparing to transport 10 passengers in a 15-passenger van. Two patients were seated in the rear seat of the van, which was located behind the rear axle. The driver told us he encouraged the passengers to “spread out,” so that there would be more room; he said he was not aware that passengers should not be seated behind the rear axle or that only eight passengers were permitted in the van. All other facilities were in compliance with vehicle occupancy requirements.

Placement of Cargo and Passenger Security

During one transport, the driver did not secure two wheelchairs he carried in the van; in fact, he asked one of the patients in the van to hold one of the wheelchairs during the trip. Another driver did not secure a patient’s walker. One volunteer driver parked a van in front of the medical center with a patient inside and left the vehicle running while he went into the facility. Another driver failed to lock the vehicle while parked at the medical center and other trip destinations.

On two trips, drivers did not ensure that all passengers were secured by seat belts, and another van did not have an appropriate configuration so a seat belt was available for each patient. Some seat belts were too small and were not designed to accommodate large patients.

Equipment

VHA has not issued policy regarding how patient transport vehicles should be equipped. However, we noted that 11 of 15 vehicles we inspected were equipped with fire extinguishers; 10 with personal protective equipment such as latex gloves; 9 with basic first aid kits; 7 with towels for use in the event of spills; and 5 with portable airways for use during CPR. Drivers of all 15 transports had cellular phones; however, the phones in two vehicles were dependent on the vehicle’s battery for operation.

Employee Escorts

Seven of the 14 facilities (50 percent) did not have policy that required employee escorts for patients with special medical or mental health needs. Drivers frequently need to deal with patient incidents or manage illness and behavioral problems. Without clinical support,¹¹ drivers may be required to take action or make decisions for which they have had no training.

¹¹ Clinical support are employees who are trained to handle special medical or mental health patient care needs.

Incidents or emergencies occurring during transports should be communicated to appropriate clinical staff and recorded in the patient's medical record. One facility inspected had not established a process to ensure that incident or emergency information was communicated and documented in the medical record, although there are VHA policies regarding the reporting of patient incidents and accidents.

Conclusions

Controls are needed to ensure compliance with the Employee Safety Alert regarding 15-passenger vans, specifically requirements for occupancy, passenger and cargo placement and security, and seat belt use. Facility policy should require vehicle occupants to use seat belts and require that drivers are trained to secure passengers, including those in wheelchairs, stretchers, or electric scooters.

VHA should issue guidance describing how vehicles should be equipped to transport patients. Cellular phones and 2-way radios should operate independent of the vehicle's battery and should have a range to cover the entire trip.

VHA and local facility guidance is needed to define when clinical support staff are necessary for management of patients who have special medical or mental health care requirements. The guidance should also describe how incidents and emergencies occurring during transports will be communicated to clinical employees and documented in the patient's medical record.

Issue 4: Contract Driver Competencies

Summary

VHA facilities need to ensure that contract drivers are screened, trained, and competent to do their job.

Results of inspection show that:

- VHA facilities did not consistently require documentation or certification of driver competencies from vendors.
- VHA facilities did not consistently receive and review information regarding contract driver competencies.

Background

VA facilities frequently contract with private ambulance or hired car vendors to provide transportation services for VA patients. These agencies screen their drivers, and provide driver training. In some cases, drivers are required to have advanced certifications, such

as Advanced Cardiac Life Support, or specialized training to assist and appropriately secure patients who are transported on a stretcher or in a wheelchair. VA facilities should ensure that these drivers have been properly screened and trained to manage VA patients with special needs.

Results of Inspection

Nine of the facilities we inspected had established contracts with private transportation vendors to transport VA patients, and two facilities paid for private transportation services on a fee-for-service basis. Four contracts did not require documentation or certification of driver competencies by the private transportation vendors. Three facilities had contracts that required competency documentation, and information was received and reviewed by medical center employees. Two facilities required documentation of driver competency, but the facilities did not receive the information.

Conclusions

Contracts with private transportation vendors should require that the contractors certify that their drivers are screened, trained, and competent to safely transport patients. Six of the nine contractual transportation agreements we inspected (67 percent) either did not require certifications from the contractor or the VA facility did not receive certification from these agencies.

Issue 5: Patient Transportation in Emergencies

Summary

Emergency preparedness plans should consider how patients will be transported or evacuated. Results of inspection show that the VHA facilities inspected had strategies and plans for patient transportation in the event of an emergency and collaborated with DoD and community services as part of contingency planning. However, VHA and local policy generally did not consider or plan for use of volunteer resources for emergency transportation of patients.

Background

VA facilities develop emergency preparedness plans to manage natural disasters and public health emergencies, including acts of terrorism. Joint Commission on Accreditation of Healthcare Organizations standard EC.1.4 requires “cooperative planning among health care organizations that provide services to a contiguous geographic area,” and EC.2.9.1 makes clear the requirement of the organization to participate in at least one community-wide drill yearly. These requirements became effective January 1, 2003.

Results of Inspection

Thirteen of the 14 facilities inspected had strategies for patient transportation in their emergency preparedness plans. These plans included use of VA's fleet of vehicles, community public transportation and school buses, ambulances, and where available, helicopter services. Many VA facilities collaborated with the DoD as part of their contingency planning and included DoD vehicles and manpower in their plans. However, 8 of the 13 facility plans (62 percent) did not consider use of volunteer resources.

Conclusions

VHA needed to ensure that VA facilities consider use of volunteer drivers to transport patients during emergencies, evacuations, and disasters. Volunteers who are appropriately screened and trained could provide valuable assistance during emergencies.

Issue 6: Incident and Accident Reporting

Summary

Transportation-related incidents should be reported to VHA Headquarters and the National Center for Patient Safety (NCPS) for tracking, trending, cost analysis, and planning and policy-making.

Results of inspection show that:

- VHA patient transportation incident and accident data is not effectively captured.
- VHA facilities were unable to provide complete accident-related costs.
- VHA facilities did not always report adverse events to the VISN and the NCPS.
- Transportation incidents and vehicle accidents were not trended or assessed.

Background

VHA National Patient Safety Improvement Handbook 1050.1 requires that adverse patient events be reported to the NCPS. Adverse events are unfavorable outcomes associated with medical care provided to a patient(s) or untoward incidents or occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other VHA facility.

Adverse events are also to be reported to the facility Patient Safety Manager (PSM) or designee. The PSM uses the Safety Assessment Code (SAC) Matrix to determine what action is required. The SAC Matrix is a method used to assess the severity of an incident and the probability of reoccurrence. All events receiving a SAC score of three are to

receive either a Root Cause Analysis (RCA)¹² or an aggregated review.¹³ Adverse events that score a SAC three are those that present the highest risk, and may have resulted in death or permanent loss of function. The initial report of the event must be entered into the Patient Safety Information System, a database maintained by the NCPS. The handbook also requires that each VISN ensure that facilities report adverse events to the VISN and the NCPS.

We asked each facility to provide information on motor vehicle accidents involving employee and volunteer drivers during the 5-year period prior to this inspection. We requested information on the circumstances of the accident, whether the driver was an employee or volunteer driver, whether drivers or patients were injured or died as a result of the accident, and associated costs for medical care, OWCP and tort claims, and vehicle repairs. Additionally, we determined whether further review, such as an RCA, was conducted.

Results of Inspection

Patient Transportation Incident and Accident Data Is Not Captured

VHA should capture and review patient transportation incidents and accidents. The 14 facilities in our inspection reported that 177 accidents had occurred transporting VA patients in the 5 years preceding our inspection. One facility reported no accidents; four facilities reported 1-5 accidents; four facilities reported 6-10 accidents; two facilities reported 14-20 accidents; one facility reported 27 accidents; and two facilities each reported 38 accidents. Employee drivers were involved in 86 accidents and volunteer drivers were involved in 91 accidents.

Fourteen accidents involved injury to patients, employees, or volunteers. The reported monetary value of associated tort claims, medical expenses, and OWCP claims totaled \$44,177 and the cost of damage to vehicles was \$229,700. Six of the 14 facilities inspected were unable to provide complete accident related costs, so these data represent only a portion of the actual total costs.

VHA Headquarters' managers and program officials told us that VA facilities did not consistently report incidents and accidents involving employees and volunteer drivers, but that this information would be beneficial to trend and make transportation-related decisions. The analysis of accident data could improve patient safety and potentially provide cost savings to VHA.

¹² A root cause analysis is a process for identifying basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. The review is interdisciplinary in nature with involvement of those knowledgeable about the processes involved in the event.

¹³ Aggregated reviews provide greater utility of the analysis as trends or patterns not noticeable in individual case analysis are more likely to show up as the number of cases increases. Common themes may be more readily identified and effectiveness of actions taken to prevent events or close calls may be evaluated.

Conclusions

VHA guidelines for reporting patient adverse events to the VISN and the NCPS did not require explicitly reporting incidents and accident information involving employee or volunteer drivers to VHA Headquarters. The NCPS's Patient Safety Information System database lacked consistent transportation-related incident and accident information. VHA program officials should analyze this information to determine what problems may exist and what additional policy and guidance may be needed for patient transportation services.

Recommendations

We recommend that the Under Secretary for Health ensure that:

- a. Initial and follow-up screenings of MVOs, incidental operators, and volunteer drivers are accomplished. These screenings should include medical examinations, verification of current drivers' licenses, and reviews of driving records. Additionally, initial and follow-up verifications of current automobile insurance coverage are needed for volunteer drivers.
- b. Annual safe driving training is provided to all employee and volunteer drivers and policy is published describing mandatory training requirements to include instruction in handling medical emergencies.
- c. Drivers comply with requirements described in VHA's Employee Safety Alert regarding transportation in 15-passenger vans.
- d. Patient safety is maintained through the consistent practice of securing patient care equipment, other cargo, and vehicles. Security of patients in vehicles is reviewed, policies are established, and observed.
- e. Policy is published describing required equipment needed in vehicles used to transport patients. This policy needs to specify that cellular phones and 2-way radios operate independent of the vehicle's battery and provide communication coverage throughout the patient transport.
- f. VHA and local VA facilities provide guidance regarding employee escort for patients with special medical or mental health needs and ensure that incidents occurring during trips are reported to appropriate clinical staff and documented in the patients' medical records.
- g. Contracts for transportation services require that vendors certify that their drivers have been screened, trained, and are competent to safely transport VA patients, and

medical centers ensure that initial and follow-up certifications are received and retained.

- h. Use of volunteer drivers is considered in emergency planning.
- i. Transportation incidents and accidents are reported to VHA Headquarters' managers and program officials.

Employee Safety Alert

Employee Safety Alert

Veterans Health Administration Warning System
Published by VA Headquarters

DATE: June 11, 2003

Item: Rollover Warning on 15-Passenger Vans

Specific Incident: The US DOT National Highway Traffic Safety Administration (NHTSA) issued a repeat warning that may affect VHA Van Drivers. Vehicle occupant fatalities in rollover crashes continue to increase in single vehicle accidents of 15-Passenger Vans. The rollover rate increases with the number of occupants and weight of cargo, speed, and the location of the passengers and cargo in the rear of the vehicle. Such events happen even at speeds below 45 mph, particularly on rural roads, where curves and inappropriate speeds may lead to increased lateral acceleration. These factors move the center of gravity up and rearward, which contribute to lateral instability and loss of control.

Action:

1. Beginning October 1, 2003 (FY 2004), VHA will no longer purchase or accept donations of 15-Passenger Vans at VHA Healthcare Facilities nationwide. However, use of 15 passenger vans already in inventory (or in the GSA fleet) may continue in use.

The following safety measures shall be taken to reduce the risk for 15-passenger vans currently in use:

- a. Limit the capacity of vans in use to fewer than 10 occupants. Studies show that passenger vans with 15 occupants had a rollover rate in single vehicle crashes of nearly 3 times the rate of those with fewer than 10 occupants.
- b. These vans shall be operated by experienced, trained drivers. Enroll the driver in a van driver course. An example of such a course is the specially designed National Safety Council Van Driver II course. Ordering information can be obtained by dialing 1-800-621-7619.
- c. Insist that all occupants wear seat belts at all times. 80% of those who died in 15-passenger van rollovers were not buckled up.
- d. Passengers and cargo should be loaded as far forward in the vehicle as possible to increase stability and avoid rollovers. Do not place passengers or cargo in the seat or space rear of the rear axle.
- e. Do not store cargo or luggage on the top of the vehicle.
- f. Check tire pressure and treadwear monthly to ensure that the tires are properly inflated and the tread is not worn down.

Addl. Information: "Reducing Risk of Rollover Crashes in 15-Passenger Vans", <http://www.nhtsa.dot.gov/Hot/15PassVans/index.htm> and "Coaching the Van Driver II" <http://secure.nsc.org/onlinecart/product.cfm?id=278>

Source: U.S. Department of Transportation (DOT) – POC: Rae Tyson, (202) 366-9550. National Highway Traffic Safety Administration (NHTSA) 27-02 –April 15, 2002

VHA Contact: For further information contact John Heywood, Senior Safety Engineer, at the VA Center for Engineering & Occupational Safety and Health, (314) 543-6710.

News Articles Concerning Volunteer Driver Disqualifications

From USA Today “Across the USA” section from Iowa, published April 19, 2004:

“Supporters of a free medical shuttle service for aging veterans say the program is in trouble because of a new federal regulation. Two of the four drivers from the Waterloo area were barred because they can’t pass a physical. Officials say the regulation eliminates more drivers in the eastern part of the state, even as the veteran population rises.”

From an Associated Press article, dated May 24, 2004, from The Columbus Republic:

“A recent Veterans Administration policy change has left some Indiana veterans without a ride to the VA’s Indianapolis clinic by disqualifying their volunteer drivers... That change resulted in the disqualification of all the Columbus-area volunteer drivers who once made the 80-mile roundtrip between Columbus and Indianapolis... Most of the volunteer drivers are older veterans. Of the 30 drivers across the state who took the physical in the past month, only six passed.”

From an Associated Press article, dated June 7, 2004, from the Bloomington Herald-Times:

“Veterans who had traveled in vans to Indianapolis for hospital care now cannot because new federal regulations have led to a decline in the number of volunteer drivers. Last May, the Department of Veterans Affairs began requiring that volunteer drivers of Disabled American Veterans vans pass the same physical examinations required for a commercial driver’s license... ‘Some of our drivers quit because they figured they’d fail the exam; others tried to pass the exam and failed it.’”

Reference List

Code of Federal Regulations, Title 5, Volume 1 – Administrative Personnel, Chapter I – Office of Personnel Management, Part 339 – Medical Qualification Determinations, Subpart B – Physical and Medical Qualifications.

Code of Federal Regulations, Title 5, Volume 2 – Administrative Personnel, Chapter I – Office of Personnel Management, Part 930 – Programs For Specific Positions and Examinations (Miscellaneous), Subpart A – Motor Vehicle Operators.

Employee Safety Alert, Veterans Health Administration Warning System Published by VA Headquarters, June 11, 2003.

IL 13-2003-001, Public Health and Environmental Health Information Letter, Clearance of Volunteers for Driving Assignments, April 11, 2003.

VA Directive 7239, Interagency Fleet Management Systems, October 29, 1996.

VA Handbook 7700.1, Occupational Safety and Health, July 8, 1998.

VHA Handbook 1050.1, VHA National Patient Safety Improvement Handbook, January 30, 2002.

VHA Handbook 1620.1, Department of Veterans Affairs Voluntary Service Procedures, July 19, 2001.

VHA Handbook 1620.2, Volunteer Transportation Network, May 2, 2001.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 24, 2005

From: Under Secretary for Health (10/10B5)

Subject: **OIG Draft Report, Inspection of Veterans Health Administration Patient Transportation Services (EDMS 305337)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and I believe the report shows that the VHA Patient Transportation Services (PTS) program meets its goal of providing a safe patient transportation program. I concur with the recommendations.
2. VHA shares your concern about the need for developing a comprehensive VHA policy for the patient transportation program that will provide consistent guidance to the medical facilities in areas such as the screening of drivers, driver training and screening requirements, vehicle safety, and the reporting of vehicle accidents and incidents. A directive will be developed by an interdisciplinary workgroup to address these issues. We anticipate that the directive will be published by the end of this fiscal year.
3. An action plan to implement the recommendations is included as an attachment to this memorandum.

Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

A handwritten signature in black ink, appearing to read "Jonathan B. Perlin".

Jonathan B. Perlin, MD, PhD, MHSA, FACP

Attachment

Under Secretary for Health Comments to Office of Inspector General's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

Recommended Improvement Action (a) We recommend that the Under Secretary for Health ensure that initial and follow-up screenings of MVOs, incidental operators, and volunteer drivers are accomplished. These screenings should include medical examinations, verification of current drivers' licenses, and reviews of driving records. Additionally, initial and follow-up verifications of current automobile insurance coverage are needed for volunteer drivers.

Concur **Target Completion Date:** September 30, 2005

Goal: To ensure VHA facility compliance with Federal and State regulations and VA policies that require applicants for motor vehicle operator positions demonstrate that they are medically qualified to operate motor vehicles safely, have current drivers' licenses, safe driving records, and current automobile insurance coverage.

Strategy: The current VHA Directive 2004-040, Clearance of Volunteers for Driving Assignments, is very specific about the criteria for medical screenings of all volunteer drivers. Each VA Voluntary Service (VAVS) manager was given a copy of this directive and it has been discussed on monthly VAVS conference calls. A special conference call was set up in September 2004 with Occupational Health and VAVS personnel in the field for each to be informed of the directive and to allow for questions. VHA Directive 1620.2, Volunteer Transportation Network, also identifies VHA policy to ascertain a copy of a safe driving record and automobile insurance.

Voluntary Service will once again reiterate the need for all facilities to adhere to these policies in our upcoming monthly calls, and will further define in the next version of VHA Directive 1620.2 the need for follow-up records for insurance and safe driving records. We expect to have the revised directive issued by the end of this fiscal year.

This will also be addressed in an upcoming VHA directive that focuses on Patient Transportation Services (PTS) in the medical facilities. The Office of the Chief Public Health and Environmental Hazards Officer will work closely with the Office of the Deputy Under Secretary for Health for Operations and Management, Office of the Chief, Voluntary Service and the Office of the Director, National Center for Patient Safety in developing this directive. It may require union review and concurrence through Labor Management Relations (LMR). This directive is expected to be published in fall 2005 and will include volunteer drivers, with consistency to the revised VHA Directive 1620.2 referred to above.

Recommended Improvement Action (b) We recommend that the Under Secretary for Health ensure that annual safe driving training is provided to all employee and volunteer drivers and policy is published describing mandatory training requirements to include instruction in handling medical emergencies.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure VHA facilities comply with VHA requirements to provide annual safe driver training.

Strategy: VHA Directive 1620.2 provides policy for ensuring volunteers receive proper training and provides a sample training documentation form. VAVS managers have been advised to ensure proper training on voluntary service conference calls and they have been provided with sample training materials from various locations on our VAVS website.

This will be addressed in greater detail in the upcoming VHA directive on Patient Transportation Services which will encompass both employee and volunteer patient transportation vehicle drivers. It is expected to be published by September 30, 2005.

Recommended Improvement Action (c) We recommend that the Under Secretary for Health ensure that drivers comply with requirements described in VHA's Employee Safety Alert regarding transportation in 15-passenger vans.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure compliance with VHA Employee Safety Alert issued June 11, 2003.

Strategy: VHA has prohibited the purchase or acceptance of 15 passenger vans since 2003 and provides on-going reinforcement of this prohibition via email, conference calls, and individual consultations with field personnel. Each facility has been provided with the guidance on numerous occasions. In addition, the Disabled American Veterans (DAV) provided a donation of rear view mirror tags to remind the drivers of the alert. These were distributed by VHA to each facility's transportation service. This issue will be addressed in the upcoming VHA directive on Patient Transportation Services.

Recommended Improvement Action (d) We recommend that the Under Secretary for Health ensure that patient safety is maintained through the consistent practice of securing patient care equipment, other cargo, and vehicles. Security of patients in vehicles is reviewed, policies are established, and observed.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure patient safety through consistently securing patient care equipment, other vehicle cargo, establishing policy in regard to this and ensuring compliance with that policy.

Strategy: VHA will draw on subject matter experts from the Offices of the Chief, Public Health and Environmental Hazards Officer, and the Director, National Center for Patient Safety to develop minimum program requirements, including compliance, as a part of the new directive on Patient Transportation Services to be developed.

Recommended Improvement Action (e) We recommend that the Under Secretary for Health ensure that policy is published describing required equipment needed in vehicles used to transport patients. This policy needs to specify that cellular phones and 2-way radios operate independent of the vehicle's battery and provide communication coverage throughout the patient transport.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure vehicles used to transport patients have equipment on board for use in event of emergencies, such as cell phones, 2-way radios that operate independent of the vehicles batteries.

Strategy: VHA will draw on subject matter experts from the Offices of the Chief Public Health and Environmental Hazards Officer, and the Director, National Center for Patient Safety to develop minimum program requirements, including compliance, as a part of the new directive on PTS to be developed.

Recommended Improvement Action (f) We recommend that the Under Secretary for Health ensure that VHA and local VA facilities provide guidance regarding employee escort for patients with special medical or mental health needs and ensure that incidents occurring during trips are reported to appropriate clinical staff and documented in the patients' medical records.

Concur **Target Completion Date:** September 30, 2005

Goal: To ensure the needs of patients with special medical or mental health needs are met.

Strategy: VHA will establish criteria for the safe transportation of patients based on medical condition, to include escort, equipment needs, and medical needs. Such criteria already exist to determine appropriateness for Volunteer Transportation. These criteria will be included in the new directive being prepared on Patient Transportation Services.

Recommended Improvement Action (g) We recommend that the Under Secretary for Health ensure that contracts for transportation services require that vendors certify that their drivers have been screened, trained, and are competent to safely transport VA patients, and medical centers ensure that initial and follow-up certifications are received and retained.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure that contract drivers are competent to safely transport VA patients.

Strategy: VHA will require contractor submittals in the upcoming VHA directive on Patient Transportation Services that will specify that the contract drivers have been screened, trained, and are competent to safely transport VA patients. It will also indicate when and how initial and follow-up certifications are received and retained.

Recommended Improvement Action (h) We recommend that the Under Secretary for Health ensure that use of volunteer drivers is considered in emergency planning.

Concur **Target Completion Date:** September 30, 2005

Goal: Ensure volunteer resources are considered for emergency transportation of patients.

Strategy: VHA will review the appropriate use of utilization of volunteers during emergencies. This will be detailed in the new directive being prepared on Patient Transportation Services.

Recommended Improvement Action (i) We recommend that the Under Secretary for Health ensure that transportation incidents and accidents are reported to VHA Headquarters' managers and program officials.

Concur **Target Completion Date:** September 30, 2005

Goal: To improve patient safety.

Strategy: Voluntary Service maintains a log of the accident reports it receives. It has an informal agreement with the Disabled American Veterans (DAV), so that Voluntary Service informs them of any notification of accidents and they notify Voluntary Service of any notification of accidents involving Volunteer Transportation network vans. VHA will ensure that all motor vehicle accidents are reported and reviewed by each facility's Accident Review Board. Facilities will report accident data to the Network offices and in turn to the Office of the Deputy Under Secretary for Health for Operations and Management. The specific elements of transportation incident reporting will be further developed and outlined in the upcoming VHA directive.

OIG Contact and Staff Acknowledgments

OIG Contact	John D. Daigh Jr., M.D. Assistant Inspector General for Healthcare Inspections (202) 565-8305
Acknowledgments	Verena Briley-Hudson, M.N., R.N. Director, Chicago Office of Healthcare Inspections Paula Chapman, Inspection Coordinator Bertha Clarke Linda DeLong Marnette Dhooghe Dorothy Duncan Theresa Golson Katherine Owens Michelle Porter Leslie Rogers Virginia Solana Vishala Sridhar John Tryboski Wilma Wong Jaclyn Yamada
Photography	Chicago Office of Healthcare Inspections

Report Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Executive Secretariat (001B)
Chief of Staff (00A)
General Counsel (02)
Under Secretary for Health (10B5)
Deputy Under Secretary for Health (10A)
Chief of Staff to the Under Secretary for Health (10B)
Deputy Under Secretary for Health for Operations and Management (10N)
Chief Quality and Performance Officer (10Q)
Director, National Center for Patient Safety (10X)
Medical Inspector (10MI)
Chief Patient Care Services Officer (11)
Assistant Secretary for Policy and Planning (008)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Congressional Affairs (009C)
Veterans Integrated Service Network (1-23)
Director, Voluntary Service Office (10C2)
Director, Occupational Health Program (136)
Director, Safety and Technical Services (10NB)

Non-VA Distribution

Office of Management and Budget
Government Accountability Office
Congressional Committees (Chairmen and Ranking Members):
 Committee on Veterans' Affairs, U. S. Senate
 Subcommittee on Military Constructing and Veterans' Affairs
 Committee on Appropriations, U. S. Senate
 Committee on Veterans' Affairs, U. S. House of Representatives
 Committee on Appropriations, U. S. House of Representatives
 Subcommittee on National Security, Emerging Threats, and International Relations,
 Committee on Government Reform, U.S. House of Representatives

Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs,
U.S. House of Representatives
Subcommittee on Health, Committee on Veterans' Affairs,
U.S. House of Representatives
Subcommittee on Military Quality of Care and Veterans' Affairs, Committee on
Appropriations, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on
Veterans' Affairs, U.S. House of Representatives

This report will be available in the near future on the OIG's Web site at <http://www.va.gov/oig/52/reports/mainlist.htm>. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.