Department of Veterans Affairs
Office of Inspector General

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

October 2004 through September 2005

Report No. 06-01754-123 **March 31, 2006**

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.
- Provide fraud and integrity awareness training to increase employee understanding of program fraud and the requirement to refer suspected criminal activity to the OIG.

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 2004 through September 2005

1. This report summarizes the results 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 2004 through September 2005. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and management controls.

2. This summary report covers the 48 CAP reviews conducted at VHA medical facilities. The issues highlighted in this report were identified at two or more medical facilities. We also provided fraud and integrity awareness training for 12,571 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 audits and other reviews. This report was prepared under the direction of Ms. Linda Halliday, Director, OIG Audit Planning Division.

original signed by Joseph M. Vallowe, for

MICHAEL L. STALEY
Assistant Inspector General for Auditing

Introduction

Background

During the period October 2004 through September 2005, the OIG published 48 reports of CAP reviews conducted at VHA medical facilities.

Scope of CAP Reviews

The scope of CAP reviews includes nationwide, Veterans Integrated Service Network (VISN), and facility specific issues. This report summarizes CAP review issues that were discussed in two or more CAP reports and had recommendations for improvement. Because the operational activities and risks evaluated during CAP reviews changed during the period summarized in this report, some operational activities were not reviewed at every medical facility.

Fraud and integrity awareness briefings were also conducted during each of the CAP reviews, and 12,571 VHA employees attended the briefings. The briefings included a video that described the types of fraud that can occur in VA programs and the OIG's role in the investigation of criminal activity, followed by question and answer sessions.

CAP Reports Issued

The table below lists, by Veterans Integrated Service Network (VISN), the 48 VHA CAP review reports that were issued during the period October 2004 through September 2005.

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the VA Medical Center White River Junction, Vermont	1	04-02592-107	03/16/05
Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire	1	05-00313-176	07/21/05
Combined Assessment Program Review of the Veterans Connecticut Health Care System West Haven, Connecticut	1	05-00859-216	09/30/05
Combined Assessment Program Review of the Canandaigua VA Medical Center Canandaigua, New York	2	04-01562-035	11/26/04
Combined Assessment Program Review of the VA New York Harbor Healthcare System New York, New York	3	04-01138-173	07/13/05
Combined Assessment Program Review of the Philadelphia VA Medical Center Philadelphia, Pennsylvania	4	04-01130-109	03/23/05
Combined Assessment Program Review of the VA Pittsburgh Health Care System Pittsburgh, Pennsylvania	4	05-01241-174	07/19/05
Combined Assessment Program Review of the VA Medical Center Wilmington, Delaware	4	05-01655-199	09/15/05
Combined Assessment Program Review of the VA Medical Center Martinsburg, West Virginia	5	04-02974-090	02/25/05
Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia	6	04-02277-048	12/13/04
Combined Assessment Program Review of the VA Medical Center Durham, North Carolina	6	05-00029-127	04/22/05
Combined Assessment Program Review of the VA Medical Center Hampton, Virginia	6	05-00115-136	05/06/05

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia	7	04-03028-049	12/13/04
Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center Charleston, South Carolina	7	05-00048-084	02/14/05
Combined Assessment Program Review of the VA Medical Center Miami, Florida	8	05-00502-171	07/08/05
Combined Assessment Program Review of the VA Medical Center Louisville, Kentucky	9	04-03270-172	07/08/05
Combined Assessment Program Review of the Louis Stokes VA Medical Center Cleveland, Ohio	10	04-02247-012	11/03/04
Combined Assessment Program Review of the VA Medical Center Dayton, Ohio	10	04-01822-045	12/07/04
Combined Assessment Program Review of the VA Medical Center Cincinnati, Ohio	10	04-03120-151	06/06/05
Combined Assessment Program Review of the VA Northern Indiana Healthcare System Fort Wayne and Marion, Indiana	11	04-01740-053	12/27/04
Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana	11	04-01852-115	03/28/05
Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan	11	05-01226-211	09/29/05
Combined Assessment Program Review of the Edward Hines Jr. VA Hospital Hines, Illinois	12	04-02499-063	01/06/05
Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin	12	05-01383-215	09/30/05
Combined Assessment Program Review of the VA Eastern Kansas Health Care System Leavenworth, Kansas	15	04-02331-112	03/25/05
Combined Assessment Program Review of the VA Medical Center St. Louis, Missouri	15	04-01893-148	06/02/05
Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri	15	05-00082-198	09/09/05

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the Central Arkansas Veterans Health Care System Little Rock, Arkansas	16	05-01837-214	09/30/05
Combined Assessment Program Review of the VA North Texas Health Care System Dallas, Texas	17	04-01878-034	11/26/04
Combined Assessment Program Review of the South Texas Veterans Health Care System San Antonio, Texas	17	05-00222-111	03/25/05
Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas	17	04-03403-133	05/05/05
Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, Texas	18	04-02293-073	01/28/05
Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico	18	05-01141-186	08/15/05
Combined Assessment Program Review of the Southern Arizona Veterans Health Care System Tucson, Arizona	18	05-02007-219	09/30/05
Combined Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado	19	04-01805-055	12/27/04
Combined Assessment Program Review of the VA Montana Health Care System Fort Harrison, Montana	19	04-02527-067	01/14/05
Combined Assessment Program Review of the VA Salt Lake City Health Care System Salt Lake City, Utah	19	05-01248-170	07/08/05
Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, Washington	20	05-00523-128	04/22/05
Combined Assessment Program Review of the Alaska Health Care System Anchorage, Alaska	20	05-02240-206	09/22/05
Combined Assessment Program Review of the VA Central California Healthcare System Fresno, California	21	04-01944-007	10/22/04
Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California	21	04-03359-105	03/16/05
Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, California	21	05-00735-160	06/27/05

Report Title	VISN	Report Number	Issue Date
Combined Assessment Program Review of the VA Long Beach Healthcare System Long Beach, California	22	04-02815-088	03/03/05
Combined Assessment Program Review of the VA Medical Center Fargo, North Dakota	23	04-03071-062	01/06/05
Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System Omaha, Nebraska	23	04-02398-070	01/18/05
Combined Assessment Program Review of the Minneapolis VA Medical Center Minneapolis, Minnesota	23	04-03408-113	03/25/05
Combined Assessment Program Review of the Sioux Falls VA Medical Center Sioux Falls, South Dakota	23	04-03069-135	05/05/05
Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, Iowa	23	05-00839-156	06/24/05

CAP Review Results by VISN and by Medical Facility

Veterans Integrated Service Networks (VISNs)	Locations	Issue Areas with Reported Weaknesses																		
		Accounts Receivable	Agent Cashier	Bulk Oxygen Management	Colorectal Cancer Management	Contract Award and Administration	Emergency Preparedness	Environment of Care	Government Purchase Cards	Information Security	Management of Equipment Inventories	Management of Supply Inventories	Medical Care Collections Fund	Moderate Sedation	Part-Time Physician Time and Attendance	Pharmacy Controlled Substances Accountability	Pharmacy Security	Pressure Ulcer Management	Quality Management	Uniliquidated Obligations
1	VA Medical Center (VAMC) White River Junction, VT			●		●		●	●	●	●	●	●				●			
	VAMC Manchester, NH					●	●	●	●		●				●			●	●	
	VA Connecticut Healthcare System (HCS) West Haven, CT					●		●	●	●	●		●					●		
2	VAMC Canandaigua, NY					●			●	●		●								
3	VA New York Harbor HCS New York, NY	●		●		●			●	●		●								
4	VAMC Philadelphia, PA	●				●		●	●	●	●	●	●	●		●				
	VA Pittsburgh HCS Pittsburgh, PA					●		●				●	●			●		●		
	VAMC Wilmington, DE				●	●				●		●	●							●
5	VAMC Martinsburg, WV			●		●			●	●		●	●			●				
6	VAMC Richmond, VA	●		●		●		●		●		●	●	●		●				●
	VAMC Durham, NC					●		●		●		●								
	VAMC Hampton, VA							●	●			●	●			●				
7	VAMC Dublin, GA									●		●		●		●			●	
	VAMC Charleston, SC					●	●			●		●								
8	VAMC Miami, FL						●	●	●	●		●			●					
9	VAMC Louisville, KY	●	●			●		●	●			●	●			●	●		●	
10	VAMC Cleveland, OH			●		●		●		●	●	●	●	●		●				
	VAMC Dayton, OH	●		●		●		●		●		●	●	●		●			●	
	VAMC Cincinnati, OH					●		●		●		●	●							●
11	VA Northern Indiana HCS Fort Wayne and Marion, IN							●				●		●			●		●	
	VAMC Indianapolis, IN	●	●	●		●	●	●	●	●		●	●	●		●				
	VAMC Detroit, MI	●		●	●	●		●	●			●	●			●		●		
12	VA Hospital Hines, IL			●		●				●		●				●				
	VA Hospital Madison, WI	●			●			●	●	●		●	●			●			●	

SHADED = AREA REVIEWED AT THIS SITE

● = IMPROVEMENT NEEDED AT THIS SITE

CAP Review Results by VISN and by Medical Facility (Continued)

Veterans Integrated Service Networks (VISNs)	Locations	Issue Areas with Reported Weaknesses																		
		Accounts Receivable	Agent Cashier	Bulk Oxygen Management	Colorectal Cancer Management	Contract Award and Administration	Emergency Preparedness	Environment of Care	Government Purchase Cards	Information Security	Management of Equipment Inventories	Management of Supply Inventories	Medical Care Collections Fund	Moderate Sedation	Part-Time Physician Time and Attendance	Pharmacy Controlled Substances Accountability	Pharmacy Security	Pressure Ulcer Management	Quality Management	Uniliquidated Obligations
15	VA Eastern Kansas HCS Leavenworth, KS			●				●	●	●		●	●	●			●		●	●
	VAMC St. Louis, MO			●		●		●		●		●	●	●	●	●			●	
	Harry S. Truman Memorial VA Hospital Columbia, MO	●					●	●		●		●	●			●		●		
16	VA Central Arkansas HCS Little Rock, AR											●	●						●	
17	VA North Texas HCS Dallas, TX	●				●		●			●	●	●	●	●	●			●	
	VA South Texas HCS San Antonio, TX					●						●	●		●					
	VA Central Texas HCS Temple, TX					●						●	●						●	
18	VA West Texas HCS Big Spring, TX			●		●			●	●		●	●			●				
	VA New Mexico HCS Albuquerque, NM							●		●		●	●		●				●	
	VA Southern Arizona HCS Tucson, AZ					●				●	●	●	●			●				
19	VA Eastern Colorado HCS Denver, CO			●		●		●		●	●	●	●	●		●	●		●	
	VA Montana HCS Fort Harrison, MT					●				●	●		●			●			●	
	VA Salt Lake City HCS Salt Lake City, UT				●					●		●	●			●	●	●	●	
20	VA Puget Sound HCS Seattle, WA				●	●	●	●	●	●	●	●	●					●	●	
	VA Alaska HCS Anchorage, AK					●			●			●	●				●			
21	VA Central California HCS Fresno, CA		●	●					●	●	●	●	●			●				
	VA Palo Alto HCS Palo Alto, CA							●	●	●			●		●	●			●	
	VA Northern California HCS Sacramento, CA	●								●	●		●		●	●		●		
22	VA Long Beach HCS Long Beach, CA	●				●					●	●	●			●			●	
23	VAMC Fargo, ND							●		●	●	●	●				●		●	
	VA Nebraska Western Iowa HCS Omaha, NE			●		●						●	●	●						
	VAMC Minneapolis, MN	●						●	●	●	●	●	●			●			●	
	VAMC Sioux Falls, SD					●			●	●		●	●							
	VA Central Iowa HCS Des Moines, IA					●	●	●		●		●	●			●	●	●	●	

SHADED = AREA REVIEWED AT THIS SITE

● = IMPROVEMENT NEEDED AT THIS SITE

Summary of CAP Review Results

Findings and recommendations for improvement actions for each of the activities reviewed are summarized below.

Accounts Receivable

Financial controls over accounts receivable needed improvement at 13 of 21 facilities. To improve controls, the following recommendations were made:

- Establish accounts receivable and document accounts receivable actions accurately and promptly.
- Reconcile accounts receivable, including reconciliation of debts in the Financial Management System (FMS) with Integrated Funds Distribution Control Point Activity, Accounting, and Procurement (IFCAP) system.
- Strengthen the debt collection process by aggressively pursuing accounts receivable.
- Follow up on delinquent accounts receivable and properly write off uncollectible receivables.
- Provide training to Fiscal Service staff on procedures for debt cancellations, closings, and reconciliation of FMS and IFCAP.

Agent Cashier

Controls over the agent cashier function needed improvement at three of eight facilities. We identified instances where unannounced audits were not conducted properly or timely, imprest funds were not accessible and were not counted during unannounced audits, and agent cashier physical security needed to be strengthened. To improve operations, the following recommendations were made:

- Improve agent cashier office physical security to comply with VA policy.
- Ensure that facility staff assigned to perform the unannounced agent cashier audits open and count all imprest fund cashier cash boxes during unannounced audits.
- Store imprest fund cashiers cash boxes in a secure location that is accessible to facility staff assigned to perform the unannounced audits when cashiers are not on duty.
- Conduct unannounced audits of the agent cashier's cash advance at least every 90 days.

Bulk Oxygen Management

Bulk oxygen management needed improvement, including the security of bulk oxygen supplies and utility system contracts, at 15 of 19 facilities. The OIG's report, *Audit of Medical Oxygen Supply Management Practices, VA Medical Center San Juan, Puerto Rico* (Report No. 04-01901-19, November 3, 2005), identified similar problems including identifying an undersized oxygen tank and inadequate oxygen supply replenishment and monitoring procedures, which led to an oxygen depletion incident. To improve operations and prevent occurrences of inadequate oxygen supply replenishment, the following recommendations were made:

- Enforce compliance with safety and security requirements, including alarm systems.
- Ensure bulk oxygen utility system contract requirements are met, and that vendor performance is appropriate for VA facilities' needs, prior to paying invoices.
- Monitor oxygen tank operations and supply levels.
- Develop and implement appropriate bulk oxygen system policies and procedures.

Colorectal Cancer Management

VA needed to improve the timeliness of colorectal cancer screening and diagnosis at five of nine facilities. Patients experienced delays in obtaining diagnostic gastrointestinal (GI) procedures after their GI consultations had been performed. The OIG's report, *Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006), identified similar timeliness issues relating to colorectal cancer detection and management at VHA facilities. To improve operations, we recommended that management:

- Take action to reduce delays in performing diagnostic GI procedures.

Contract Award and Administration

The OIG's report, *Major Management Challenges Fiscal Year 2005* (Report No. 06-00480-26, November 15, 2005), identified VA procurement practices, including contracting for health care services, as a serious management problem in VA. The CAP reviews disclosed a need to improve contract activities such as conducting contract file reviews, providing Contracting Officer's Technical Representative (COTR) training prior to the COTR assuming duties and responsibilities, and conducting pre-award and post-award contract actions at 33 of 47 facilities. To improve procurement practices, the following recommendations were made:

- Ensure contracting officials follow appropriate policies and procedures.
- Strengthen contract requirements to ensure users' needs are met and to better protect the Government's interests.
- Monitor vendor performance and ensure payments are made in accordance with contract terms and specifications.
- Maintain required documentation in contract files such as certificates of insurance and price negotiation memorandums.
- Implement controls to prevent erroneous payments and take necessary actions to recover overpayments.
- Provide COTR training on duties, responsibilities, limited authority, and delegation of certification responsibilities.

Emergency Preparedness

Emergency preparedness and disaster plans and procedures needed strengthening at 7 of 16 facilities. To improve operations, the following recommendations were made:

- Ensure facility plans comply with emergency and disaster planning requirements and require that plans address all contingencies.
- Develop plans that address identified emergency preparedness vulnerabilities.
- Ensure that plans include all applicable facility buildings.
- Provide appropriate training for staff and ensure that training is properly documented.
- Ensure that plans include requirements for non-VA employees, including measures to identify such individuals while they are in VA health care facilities.

Environment of Care

Environment of care deficiencies were reported at 28 of 48 facilities. These included problems with safety, cleanliness, and sanitation, which were identified in various facility areas including Supply, Processing, and Distribution (SPD) areas. Other deficiencies

included infection control and patient privacy. To improve conditions identified, the following recommendations were made:

- Store and secure medical items and supplies in appropriate locations.
- Keep hospital areas including SPD areas clean, safe, sanitary, and secure.
- Ensure that medical supplies are kept in satisfactory condition.
- Store and secure hazardous or contaminated materials.
- Ensure copies of facility evacuation plans are accessible in patient care and public areas.
- Ensure that patient care equipment is kept in good working order, and that actions are taken to repair, replace, or remove equipment that is malfunctioning or otherwise unusable.

Government Purchase Cards

The *Major Management Challenges Fiscal Year 2005* report identified the Government purchase card program as a serious management problem in VA. CAP reviews found various purchase card deficiencies at 21 of 45 medical facilities, including failure to follow policies and procedures governing the administration of the program, misuse of the cards, inadequate accounting for purchases, and numerous instances where purchases exceeded purchasing limits. To improve purchase card activities and controls, the following recommendations were made:

- Ensure that staff follow the policies and procedures governing the program.
- Implement controls to prevent misuse of the cards, including controls to ensure purchase card holders do not exceed their spending limits.
- Ensure documentation is appropriate for purchase card use, approvals, purchases, billing statements, reconciliations, and other purchase card activities.
- Require adequate segregation of duties for cardholders, approving officials, purchase card coordinators, and dispute officers.
- Verify receipt of goods and services purchased.
- Take appropriate disciplinary action if cardholders misuse cards.
- Provide necessary training for all staff who participate in the purchase card program.

Information Security

The *Major Management Challenges Fiscal Year 2005* report identified information security as a serious management problem in VA. The CAP reviews found information security deficiencies at 35 of 46 facilities. Areas for improvement included access control, contingency planning, risk assessments, and security training. To improve information security, the following recommendations were made:

- Prepare and implement security and contingency plans that include all key elements.
- Conduct risk and vulnerability assessments in accordance with established guidelines.
- Monitor access to key information systems, including the VHA Veterans Health Information Systems and Technology Architecture and the Internet.
- Improve physical security of information technology (IT) equipment, including computer rooms and communication closets that contain data communication equipment and wiring.
- Ensure background investigations are conducted for VA or contract personnel designated to have access to VA computer systems and sensitive information.
- Terminate system access for separated employees in a timely manner.
- Ensure that all software program changes are adequately documented.
- Restrict users' access to VA computer systems and sensitive information to their tour of duty days and hours.
- Provide annual security awareness training for all VA and contract employees, and refresher training for all IT system users.

Management of Equipment Inventories

Management of equipment inventories needed improvement at 15 of 19 facilities. To improve the management of these inventories, the following recommendations were made:

- Ensure that responsible VA employees perform equipment inventories properly, accurately, and timely, and conduct follow-up inventories when required.
- Maintain appropriate property records, including updated lists to show the status and current locations of facility equipment.

- Require inventory spot-checks for equipment, including sensitive IT equipment.
- Ensure proper documentation for loaned equipment.
- Ensure that reports of survey are appropriately completed, signed, and dated.

Management of Supply Inventories

The *Major Management Challenges Fiscal Year 2005* report identified supply inventory management as a serious management problem in VA. CAP reviews identified supply inventories deficiencies at 43 of 45 facilities. Supply inventories were either not performed or were inaccurate. Certain automated controls were either not fully implemented or not effectively utilized. Inventory levels maintained exceeded current requirements. Ordering, receiving, and distributing functions were not properly segregated. To improve the management of supply inventory, the following recommendations were made:

- Perform timely, accurate, and complete supply inventories, using the Generic Inventory Package (GIP), VA's automated inventory control system.
- Require staff to accurately record inventory transactions in GIP and keep stock levels current.
- Monitor item usage rates, reconcile differences between actual and recorded stock levels, and adjust stock levels and inventory records.
- Reduce excess inventories.
- Ensure proper segregation of ordering, receiving, and distributing functions.
- Require that prosthetics staff monitor item usage rates, and use the Prosthetics Inventory Package (PIP) to adjust stock levels and records.
- Adjust inventory management staffing levels as needed to implement GIP and PIP.
- Ensure action is taken to train staff responsible for using and maintaining GIP and PIP, and provide refresher training as needed.

Medical Care Collections Fund

The *Major Management Challenges Fiscal Year 2005* report identified Medical Care Collections Fund (MCCF) as a serious management problem in VA. We found MCCF

deficiencies at 39 of 42 facilities. To improve program activities, the following recommendations were made:

- Document services provided, billable providers, and identify episodes of patient care.
- Issue bills for all treatment episodes.
- Assure that fee basis care bills and documentation are forwarded to health insurers for payment.
- Collect amounts owed and follow up on outstanding bills.
- Train staff in MCCF procedures and processes.

Moderate Sedation

Controls over moderate sedation of patients needed improvement at 12 of 19 facilities. CAP reviews identified a wide variance in training requirements and program development among facilities. Also, facility directors had not ensured that all physicians were privileged to perform procedures. OIG's report, *Healthcare Inspection Evaluation of Management of Moderate Sedation in Veterans Health Administration Facilities* (Report No. 04-00330-15, November 1, 2005), identified similar moderate sedation issues. To improve operations, the following recommendations were made:

- Ensure clinicians have evidence of proper certification and privileging.
- Train and monitor clinicians to ensure appropriate moderate sedation actions are taken and document performance.
- Evaluate workload requirements to determine appropriate staffing levels.
- Monitor sedation of individual patients.

Part-Time Physician Time and Attendance

The *Major Management Challenges Fiscal Year 2005* report identified part-time physician time and attendance as a serious management problem in VA. Additional management attention is needed to address systemic weaknesses associated with controls over physicians' time and attendance, as CAP reviews continue to show that some part-time physicians are not fully meeting their VA employment obligations. CAP reviews

identified areas for improvement at 8 of 30 facilities. To improve operations, the following recommendations were made:

- Ensure that timekeeping meets VA policy requirements for documenting physicians' compliance with their VA employment responsibilities.
- Require physicians to submit leave requests when appropriate.
- Ensure that VA supervisors maintain current written agreements with all part-time physicians that describe VA expectations and the physicians' responsibilities.
- Require that timekeeping desk audits are performed.
- Ensure that automated VA time and attendance records agree with subsidiary time and attendance reports.
- Provide appropriate training to timekeepers.

Pharmacy Controlled Substances Accountability

Improvements in accountability of controlled substances were needed at 27 of 46 facilities. To improve accountability, the following recommendations were made:

- Account for all controlled substances received, by verifying delivery counts before signing for them and posting information to inventory records.
- Ensure that accountable officers witness the receipt and posting of all controlled substances into pharmacy inventory records.
- Ensure responsibilities for ordering and receiving pharmaceuticals are properly segregated.
- Verify that all controlled substances are stored in secure locations.
- Conduct and document 72-hour inventories of controlled substances.
- Reconcile discrepancies between inventory results and recorded balances in a timely manner.
- Ensure inventory records are complete and available for the unannounced monthly inspections of controlled substances.
- Conduct unannounced controlled substances inspections, in accordance with VHA and Drug Enforcement Administration (DEA) requirements, at all storage locations.

- Account for and remove unusable drugs and ensure expired drugs are returned to the pharmacy for destruction.
- Require that controlled substances inspectors properly witness and document the destruction of all expired controlled substances.
- Provide appropriate training for controlled substances inspectors.
- Comply with VHA policy for reporting missing controlled substances to the OIG.

Pharmacy Security

Physical security for pharmacy areas needed improvement at 9 of 19 facilities tested. To improve security, the following recommendations were made:

- Ensure that controlled substances security is in accordance with VA and DEA requirements.
- Require use of appropriate motion intrusion detection systems in pharmacy areas.
- Ensure that pharmacy dispensing windows, walls, and doors are constructed of materials that meet security requirements.
- Preclude unauthorized personnel from gaining access to pharmacy areas.
- Keep medication carts locked, log the removal of drugs from the carts, and follow up on identified discrepancies when restocking the medication cart.
- Ensure physical security of the pharmacy cache, using lockable steel cabinets or a vault, and improve accountability of security bands that seal pharmacy cache storage containers.

Pressure Ulcer Management

Areas for improvement in pressure ulcer prevention and management were identified at 9 of 20 facilities. OIG's report, *Healthcare Inspection Management of Patients with Pressure Ulcers in Veterans Health Administration Facilities* (Report No. 05-00295-109, March 22, 2006), identified similar issues. At the time of this report, only 4 of the 22 VISNs reported that they had provided pressure ulcer guidance to their facilities. System-wide comprehensive pressure ulcer preventative management guidance is needed, along with more consistent reporting, tracking, and cost avoidance. Pressure ulcer incidence, prevalence, and key cost factors provide useful information for managing patient care. Preventing pressure ulcers is the most important way to avoid patient

complications and increased cost. Vulnerabilities exist in identifying at-risk patients, performing reassessments according to applicable policy, performing treatments as prescribed, and providing patient and staff education. To improve operations, the following recommendations were made:

- Require that clinical staff perform and document patient skin integrity assessments, identify patients at risk for pressure ulcers, and institute preventive measures.
- Ensure that pressure ulcer treatments are completed and documented as required, and that the status of conditions is documented in medical records.
- Require training for nurses in all aspects of pressure ulcer prevention and management.
- Provide appropriate education and training to patients and/or their caregivers, and ensure the training is documented in medical records.

Quality Management

Reviews of QM program activities found that improvements were needed at 21 of 48 facilities. To improve operations, the following recommendations were made:

- Conduct data collection, analysis, trend identification, and implementation and evaluation of corrective actions.
- Conduct mortality review analysis.
- Notify patients who experienced adverse outcomes about their situations, including their rights to file tort or benefits claims.
- Document evidence of resident supervision.
- Document evidence of current cardiopulmonary resuscitation certifications for licensed independent practitioners.
- Ensure that sufficient numbers of caregivers are available to provide safe, quality care to patients.

Unliquidated Obligations

Improvements were needed in controls over unliquidated obligations at 4 of 10 facilities. Obligations should have been canceled for undelivered orders and accrued services

payable when the requirement was no longer valid or necessary. To improve controls, the following recommendations were made:

- Reconcile unliquidated obligations monthly.
- Follow up with requesting services to ensure continued need.
- Cancel unneeded obligations in a timely manner when identified.

Appendix A

OIG Contact

OIG Contact	Dennis Sullivan, OIG Audit Planning Division (202) 565-4685

Appendix B

Report Distribution

VA Distribution

Office of the Secretary
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Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security & Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

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.