Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA San Diego Healthcare System San Diego, California

Report No. 06-00372-142 **May 12, 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 the potential for 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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Executive Summary

Introduction

During the week of January 23–27, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA San Diego Healthcare System (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 250 system employees. The system is part of Veterans Integrated Service Network (VISN) 22.

Results of Review

The CAP review covered 15 operational activities. The system complied with selected standards in the following five activities:

- Accounts payable
- All-employee survey results action plans
- Agent cashier
- Medical Care Collections Fund (MCCF)
- Monitoring patients on atypical antipsychotic medications

We identified the following organizational strengths:

- Safe Patient Handling and Movement Program
- Patient Flows and Delays Project
- Implementation of Computerized Patient Event Report
- Acute Coronary Syndrome Computerized Pathways

We made recommendations in 10 of the 15 activities reviewed. For these activities, the system needed to:

- Reduce excess medical supply inventories.
- Ensure that service contracts are properly awarded and administered.
- Improve the disclosure process for patients who experience adverse events and provide detailed patient complaints analyses.
- Meet the breast cancer screening performance measure and improve timeliness of scanning results into the computer and documenting receipt of results.

- Improve controls over patient medical information.
- Strengthen Equipment Inventory Listing (EIL) controls.
- Improve oversight of and training for the controlled substances inspections program.
- Strengthen information technology (IT) security controls.
- Provide timekeeper training and conduct desk audits.
- Ensure that all purchase cardholders complete refresher training.

This report was prepared under the direction of Ms. Julie Watrous, Director, Los Angeles Healthcare Inspections Division.

VISN and Healthcare System Director Comments

The VISN and Healthcare System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 14–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JON A. WOODITCH
Deputy Inspector General

Introduction

Healthcare System Profile

Organization. Based in San Diego, California, the system provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in Mission Valley, Chula Vista, Vista, Escondido, and Imperial Valley, California. The system is part of VISN 22 and serves a veteran population of about 280,000 in a primary service area that includes San Diego and Imperial counties in California.

Programs. The system provides a full range of primary and tertiary health care services. There are 198 hospital beds and 40 long-term care beds. The system operates several regional referral and treatment programs, including spinal cord injury and cardiovascular surgery.

Affiliations and Research. The system is affiliated with the University of California, San Diego School of Medicine and provides training for 780 medical residents, as well as 64 other disciplines, including nursing, pharmacy, and dental. In fiscal year (FY) 2005, the system research program had 1,022 projects and a budget of $61.8 million. Important areas of research include alcohol/drug addiction, the shingles vaccine, and molecular medicine.

Resources. In FY 2005, system medical care expenditures totaled $305 million, 9 percent more than FY 2004 expenditures. FY 2005 staffing was 2,061 full-time equivalent employees (FTE), including 148 physician FTE and 475 nursing FTE.

Workload. In FY 2005, the system treated 53,980 unique patients, a 3.47 percent increase from FY 2004. The inpatient care workload totaled 6,941 admissions, and the average daily census was 138, including long-term care patients. The outpatient care workload was 512,771 visits.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

- Accounts Payable
- Accounts Receivable
- Agent Cashier
- Breast Cancer Management
- Controlled Substances Accountability
- Environment of Care
- Equipment Accountability
- IT Security
- MCCF
- Monitoring of Patients on Atypical Antipsychotic Medications
- Part-Time Physician Time and Attendance
- Purchase Card Program
- QM
- Service Contracts
- Supply Inventory Management

The review covered system operations for FY 2005 and FY 2006 through January 15, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA San Diego Healthcare System*, Report No. 01-02946-58, April 1, 2002).

As part of the review, we used interviews to survey patient satisfaction with the quality of care. We interviewed 30 patients during the review and discussed the interview results with system managers.

During this review, we also presented seven fraud and integrity awareness briefings for 250 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–13). For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Organizational Strengths and Reported Accomplishments

Safe Patient Handling and Movement Program Reduced Employee Injuries. In 2003, the system initiated the Safe Patient Handling and Movement Program to reduce the number of staff injuries associated with patient handling and movement and to reduce associated costs. A key component of this program was to install ceiling lifts for moving patients, which was piloted on the Spinal Cord Injury (SCI) Unit. The program was analyzed after 1 year and found to have reduced staff lift-related injuries by 100 percent in the SCI Unit, with a savings of $600,000. The current goal is to fully implement this program throughout the system by the end of FY 2007.

Patient Flows and Delays Project Provided Data to Address Efficiency Issues. The Patient Flow and Delays Team was chartered in August 2005 to track patient flow with the long-term goal of improving bed utilization and efficiency. Important issues the group explored include why data reflects that the facility is over capacity when vacant beds actually exist and why some patients are held in the urgent care center for more than 2 hours because a bed is not available. Essential data elements, including available beds, admissions, and scheduled surgeries, are gathered daily and reported to leadership weekly.

Implementation of Computerized Patient Event Report Increased Reporting. A system initiative to develop a computerized Patient Event Report began in 2000 with the goal of providing an easy and efficient method to enter patient incident reports, such as falls and medication errors. These types of events are known to occur but are generally thought to be underreported. The computer program provides a means to manage the data and was fully implemented in February 2005. In its first year of use, the number of Patient Event Reports increased by 85 percent.

Acute Coronary Syndrome Computerized Pathways Improved Care. Beginning in June 2004, a multidisciplinary team met regularly to develop clear, computerized critical pathways for acute coronary syndrome. The computerized pathways guide the clinicians through accepted treatment regimens, provide documentation templates, and assist with data collection. The algorithms start as soon as the patient enters the emergency room and continue until the patient is discharged. Through the use of the computerized order sets, the system currently achieves a performance level above most Joint Commission-accredited organizations and in many areas is comparable to the top 10 percent of hospitals in the nation.

Opportunities for Improvement

Supply Inventory Management

Conditions Needing Improvement. The Supply Processing Distribution (SPD) Director needed to reduce excess supplies and manage supply inventories more effectively. Veterans Health Administration (VHA) policy establishes a 30-day supply goal and requires facilities to use VA's automated Generic Inventory Package (GIP) to manage the medical supply inventory and Prosthetics Inventory Package (PIP) to manage the prosthetics supply inventory. We reviewed a sample of 20 medical and 10 prosthetic supply line items and found that GIP and PIP inventory records were accurate in a comparison of actual quantities on hand to quantities reported in the records. However, we identified one area that needed improvement.

As of December 31, 2005, the system's medical supply inventory had 3,067 items, valued at $1,330,408. We found that 2,462 (80 percent) of the 3,067 medical supply items had inventory levels that exceeded the 30-day supply goal. The excess items totaled $995,897, which was 75 percent of the total medical supply inventory value. Also, during calendar year 2005, the system had not used 1,038 (42 percent) of the 2,462 medical supply items. The SPD Director told us that many of these items were recently added to the inventory, resulting in lower usage rates. However, for these items, he could not show the dates the items were entered into GIP, the usage of each item, or the projected 30-day supply for each item.

Recommendation 1. We recommended that the VISN Director ensure that the Healthcare System Director requires the SPD Director to monitor medical supply item usage rates and reduce excess inventory.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will take actions, including performing a physical inventory, offering excess stock to other VA facilities, and implementing inventory management equipment. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Service Contracts

Conditions Needing Improvement. The Network Contracting Manager needed to ensure that contracting officers and the Contracting Officer's Technical Representative (COTR) follow the Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR). We reviewed the award and administration of 15 contracts, valued at $23.3 million, and identified three areas that needed improvement.

Contract Award Administration. The FAR requires contractors to administer and execute contracts in accordance with written terms and conditions established by the contracting

officer during the contracting process. As of our CAP review, the contracting officer had issued eight task orders, valued at $810,547, under a $3 million indefinite delivery, indefinite quantity task order construction contract.[1] Our review of the issued task orders found that the contractor included labor rates containing U.S. Department of Labor (USDL) system errors, incorrect construction estimate rates, and unauthorized work in pricing the task orders. The contract terms required the contractor to use specific labor and construction estimate rates and exclude specific work categories when pricing task orders. In spite of these terms, we found that the contractor overpriced the eight task orders for current and future work by as much as $308,000 because it used published Government labor rates specified by the contract that contained USDL system errors, used the incorrect construction estimation rates available, and included unauthorized work. A COTR responsible for reviewing Task Order 8 indicated that he did not identify the incorrect rates and excluded work because he did not thoroughly review the contractor's 257-page proposal; instead, the COTR compared the contractor's total cost to his overall estimate.

Contracting Officers' Authority. The FAR and VAAR require contracting officers to adhere to the contract value thresholds established in their warrants. These thresholds have been established to ensure that contracting officers only engage in procurements that are commensurate with their level of education, experience, and training. Nevertheless, a contracting officer with the authority to award contracts up to $100,000 awarded a 5-year contract for $217,000. The Network Contracting Manager stated that the contracting officer believed that she had the authority to award the contract because she thought that her $100,000 warrant threshold only applied to the contract's base year value rather than the total contract value (base year plus 4 option years).

Contract Documentation. The FAR requires contracting officers to conduct a price analysis to ensure that non-competitive contract prices are fair and reasonable. Documentation must be maintained in the contract file to support the analysis. Three of the 10 contracts did not have supporting documentation in the contract files. The three contracts were valued at about $493,000.

Recommendation 2. We recommended that the VISN Director ensure that the Network Contracting Manager requires that: (a) contracting officers ensure that contractors follow the contract terms, (b) contracting officers do not award contracts that exceed their authorized warrant thresholds, and (c) all applicable FAR and VAAR requirements are met.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will review the eight task orders and require the

[1] A task order contract requires the Government to order and the contractor to furnish at least a stated minimum quantity of supplies or services. This contract must further specify the length of the contract and the supplies or services the Government will acquire. Buyers use these contracts to place individual orders for supplies or services because they cannot predetermine the precise quantities of supplies or services at the time of contract award.

contractor to resubmit the task order proposals based on the contract terms. They will also conduct reviews of solicitations prior to issuance and remind contracting officers to adhere to contract value thresholds established in their warrants. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management

Conditions Needing Improvement. The QM program was generally effective. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, the disclosure process for patients who experienced adverse events and patient complaint analyses needed improvement.

Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with the patients and, with input from Regional Counsel, inform them of their right to file torts or benefits claims. In a sample of 16 patients who experienced adverse events during inpatient care from January 2005 through January 2006, we found that clinicians had documented the adverse events discussions in the progress notes for 13 patients. However, staff had not documented that they had advised any of the patients about their right to file torts or claims.

Patient Complaint Analyses. For FY 2005, patient complaint reports were limited to broad topic areas, such as access to and timeliness of care. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The Patient Advocate needed to expand data analyses in the patient complaint program to identify trends and opportunities for improvement.

Recommendation 3. We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) responsible clinicians fully inform patients who experience adverse events and document the discussions and (b) the Patient Advocate perform more detailed patient complaint analyses and present trended reports to senior managers.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will address the disclosure issue through revised templates, training, and ongoing audits. Patient complaints will be analyzed and reported to designated committees quarterly. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

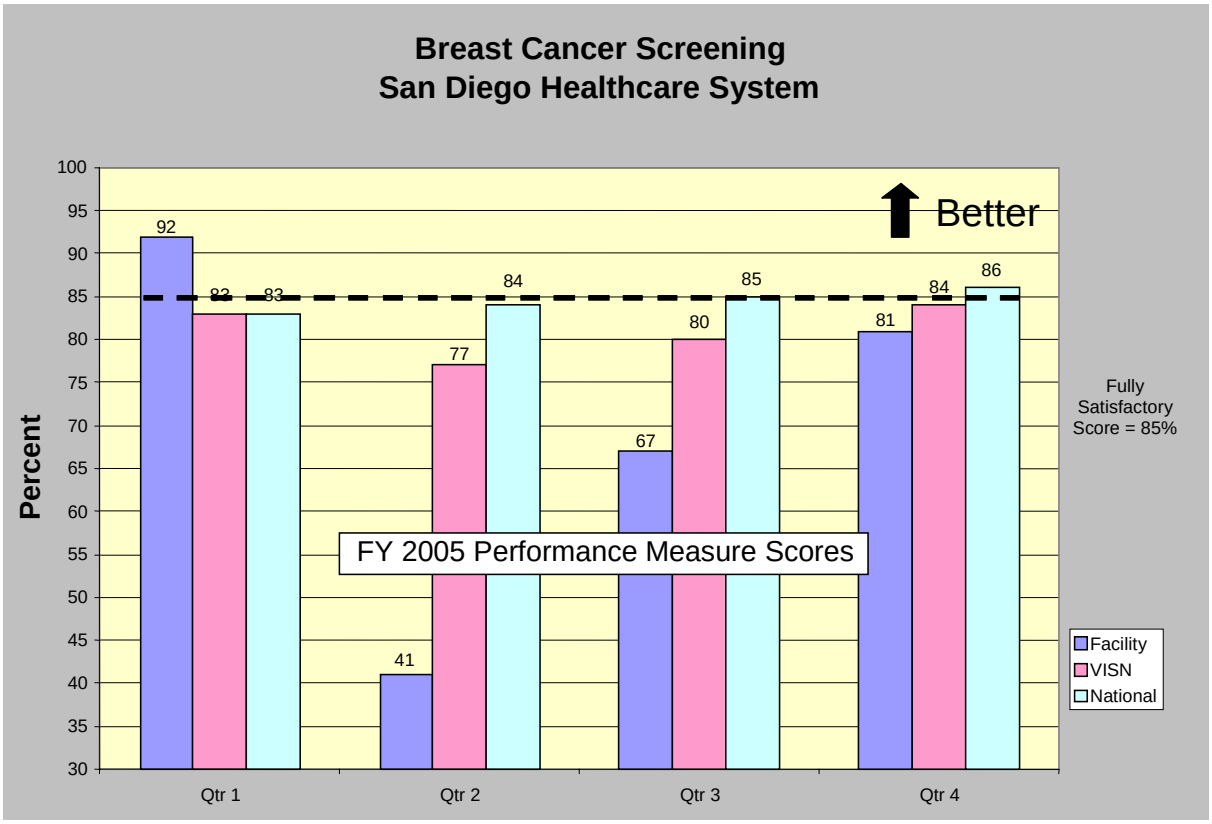
Breast Cancer Management

Conditions Needing Improvement. Clinicians needed to ensure that the number of women receiving breast cancer screening (mammography) services meets or exceeds VHA's established performance target of 85 percent. In addition, staff needed to ensure

that mammography reports are readily available to all clinicians by scanning results into the computer system within a reasonable timeframe.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of 10 patients who were either newly diagnosed with breast cancer or had abnormal mammograms during FY 2005. To determine compliance, we used the standards outlined in VHA and local policies. There are no published timeliness standards regarding report scanning.

Screening and Referral. The system did not meet the VHA performance measure for breast cancer screening in three of the four quarters for FY 2005, as indicated in the graph below. However, the 10 cases we reviewed received appropriate screening.



All 10 patients appeared to be aware of their diagnoses, as indicated in the table on the next page. Clinicians referred patients who had abnormal or highly suspicious mammograms to the surgery clinic for follow-up evaluation. Eight of the 10 patients

who were diagnosed with malignant cancer were referred to the appropriate clinic for timely surgery and/or hematology/oncology consultative services. The remaining two patients had either benign results or pending diagnoses at the time of our review.

Timeliness. The time between mammogram and biopsy procedure appeared excessive in 5 of the 10 cases. However, further review revealed that the delays appeared to be due to various patient issues, such as no shows, cancellation of scheduled appointments, and incorrect contact information. We also found that the length of time for scanning mammogram reports was excessive in five cases; the range was 47 to 170 days. Program managers agreed that mammography reports should be available in the medical records more quickly to facilitate interdisciplinary planning and coordination of care.

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedures
10/10	10/10	10/10	10/10	5/10

Since 2002, patients have had the option to obtain their mammograms at any one of 12 contract facilities. Program managers acknowledged that it was difficult to track compliance with the breast cancer screening measure because they had to rely upon notification by the facilities or patients. In March 2005, managers signed a sharing agreement for patients to have their mammograms done only at the Naval Medical Center in San Diego or one of its affiliates. Although the agreement has been in place less than a year, clinicians are optimistic that compliance with the breast screening measure will improve because mammography services are centralized.

Recommendation 4. We recommended that the VISN Director ensure that the Healthcare System Director takes action to: (a) improve compliance with VHA's breast cancer screening performance measure and (b) ensure that mammogram reports are scanned within a reasonable timeframe.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will ensure tracking of patients through the mammogram process from consult to completion, audit charts of veterans meeting criteria for required mammograms, and ensure these veterans receive telephonic and written notification. Fee Basis staff began scanning mammogram reports into medical records upon receipt and monitoring the timeliness of scanning these reports weekly. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Patient Medical Information

Condition Needing Improvement. During our inspection of patient care areas, we found patient-specific medical records and test results in two unattended offices and on a cart in a patient care hallway. Federal law and VHA policy require that confidential patient information be secured. Managers took immediate steps to correct the deficiencies. However, the need to safeguard patient information should be emphasized to all system employees.

Recommendation 5. We recommended that the VISN Director ensure that the Healthcare System Director requires that all confidential patient information is secured.

The VISN and Healthcare System Directors agreed with the findings and recommendation and reported that they will re-emphasize the importance of securing confidential information, modify the screen saver on all computer workstations to include a warning about securing confidential patient information, and implement ongoing inspections for unsecured information. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Equipment Accountability

Conditions Needing Improvement. The Acquisition and Materiel Management Service (A&MMS) Chief needed to improve controls to properly account for nonexpendable equipment (items costing more than $5,000 with an expected useful life of 2 years or more) or equipment sensitive in nature. VA policy requires the completion of physical inventory counts to ensure equipment is properly accounted for and recorded on EILs. As of November 30, 2005, the system had 206 EILs containing 24,431 items, valued at $89 million. We identified two areas that needed improvement.

EIL Inventory Counts. VA policy requires staff to complete EIL inventory counts within 10 days of notification (20 days if the EIL contains 100 items or more). A&MMS staff is required to send delinquency notices to responsible officials and to the Healthcare System Director. Under VA policy, the Healthcare System Director is the only official authorized to grant extensions for delinquent inventory counts. We found that 13 (8 percent) of 162 EIL inventory counts due in FYs 2004–2005 were not completed. The A&MMS Chief told us that she had notified all responsible officials of the scheduled inventory counts, and she had notified the responsible officials and the Healthcare System Director about those that were delinquent. However, there was no evidence that the Healthcare System Director granted extensions or held the responsible officials accountable for the deficiencies. Without current and accurate reviews, the status of these 13 EILs (containing 951 items valued at about $5 million) is unknown, and they are vulnerable to theft, vandalism, and misuse.

Quarterly Spot Checks. VA policy requires A&MMS staff to conduct quarterly spot checks of all EILs to verify inventory accuracy. For FYs 2004–2005, A&MMS staff did not perform any quarterly spot checks. The A&MMS Chief stated that the quarterly spot checks were not performed due to other priorities.

Recommendation 6. We recommended that the VISN Director ensure that the Healthcare System Director requires the A&MMS Chief to: (a) ensure that responsible staff complete EIL inventory counts within the proper timeframes and (b) conduct quarterly spot checks of EILs to verify inventory accuracy.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they notified all services of the proper, established timeframe for completion of their inventory counts. Services that did not meet the established timeframes were sent a delinquency memo and asked that their inventory be completed. They will also track quarterly spot checks. The improvement plan is acceptable, and we will follow up on completion of the planned action.

Controlled Substances Accountability

Conditions Needing Improvement. The Controlled Substances Coordinator (CSC) needed to improve controlled substances inspections, inspector training, and controlled substances accountability controls. Controls over drugs maintained in the Pharmacy Vault were effective, and the 72-hour controlled substances inventory counts were performed.

Controlled Substances Inspections. VHA policy requires the CSC to conduct monthly unannounced inspections of all areas where controlled substances are stored. We found that about 68,600 controlled substances pills, valued at about $21,600, in the Mission Valley Satellite Outpatient Clinic were not included as part of the July 2005 inspections. The CSC needs to monitor the unannounced inspections to ensure that all areas where controlled substances are stored are included.

Inspector Assignments. VHA policy prohibits assigning the same inspector to the same area over 2 consecutive months. For the 2-month period of March–April 2005, a controlled substances inspector checked the same research areas. The CSC told us that the assigned and alternate inspectors took unexpected leave, and he had no other trained inspector or alternate inspector available to inspect these research areas on short notice.

Annual Inspector Training. VHA policy requires the CSC to provide annual training to all controlled substances inspectors and maintain documentation, such as certificates, for all training. For FYs 2004–2005, 7 (15 percent) of the 46 inspectors who conducted inspections had not completed the required annual training. These seven inspectors had all exceeded the training deadline requirement by at least 3 months. In addition, the CSC could not produce documentation that any of the controlled substances inspectors had

completed training. The CSC was not aware that inspectors had to complete annual training or that certificates needed to be maintained to support training completion.

Recommendation 7. We recommended that the VISN Director ensure that the Healthcare System Director requires the CSC to: (a) ensure all areas containing controlled substances are inspected, (b) avoid assigning the same inspector to the same inspection area over 2 consecutive months, and (c) ensure the timely completion of annual training and the maintenance of training certificates for all inspectors.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they revised the current inspections monitoring process, requested training certificates from all inspectors, and required inspectors who were not able to provide a certificate to take the certification training. The implementation plans are acceptable, and we consider the issues resolved.

Information Technology Security

Conditions Needing Improvement. The Information Technology Security (ITS) Chief, and Information Security Officer (ISO) needed to strengthen IT security controls. VA policy requires the implementation of physical devices and control measures to protect IT assets and sensitive information from destruction and unauthorized access. We evaluated IT security to determine if the controls adequately protected information system resources. Information Resources Management (IRM) staff had implemented procedures to ensure controlled access, segregation of IT duties, and monitoring of security incidents. However, we identified three areas that needed improvement.

Access Privileges. VA policy requires computer access privileges be promptly terminated or modified when users separate from the system, change positions, or transfer to another service, contractor, or volunteer organization. However, the system did not comply with this policy. According to the ITS Chief, this occurred because separations, position changes, or transfers of the system's 5,108 users (including employees, contractors, volunteers, and students) were not communicated to IRM staff. In addition, we could not determine the number of users who should have had their access terminated or modified because the system did not maintain a list that showed each user's employment status.

Contingency Plan. The system's IT contingency plan did not include all critical elements as required by National Institute of Standards and Technology guidelines to ensure the continuity of operations during a disaster or emergency. The plan did not include designation of an alternate processing location, logistics for operating at an alternate site or a current list of computer equipment. The plan also did not identify the specific roles and responsibilities of system personnel assigned to execute data recovery procedures and did not include test results from prior exercises. The ITS Chief and ISO did not include the alternate site requirements in the plans because they did not believe an

alternate site was required. The lack of a computer equipment list had previously been identified by an internal risk analysis in April 2005 and by a VA Office of Cyber and Information Security Certification and Accreditation Audit in July 2005 but had not been addressed due to higher IRM priorities.

IT Security Awareness Training. According to VA and VHA policy, all VA employees, contractors, and other individuals using automated information systems resources are required to attend annual IT security and awareness training. The ISO, who is responsible for establishing IT security awareness training, did not ensure that all users completed the required annual training. The December 2005 active user directory showed that 5,108 users had computer access compared to the 3,039 (60 percent) who had completed annual training during FY 2005. The ISO needs to effectively monitor users' completion of the annual training requirement.

Recommendation 8. We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) IRM staff terminate computer access privileges when users separate from the system, or modify computer access privileges when users change positions or transfer to another service, contractor, or volunteer organization; (b) the ITS Chief and ISO update the IT contingency plan to include all required elements; and (c) the ISO ensures that all users who have computer access privileges complete the annual IT security awareness training requirement.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will review all active accounts and close inappropriate or inactive accounts, develop a mechanism to identify inter-service transfers, and audit compliance with account termination. They will develop a contingency plan with the modifications needed to meet standards. They will also track annual training. The improvement plan is acceptable, and we will follow up on completion of the planned actions.

Part-Time Physician Time and Attendance

Conditions Needing Improvement. The Network PAID[2] Manager needed to ensure that annual timekeeper training is provided and that timekeeper desk audits are performed. As of January 2006, the system had 159 part-time physicians, with 35 timekeepers recording their time and attendance. To evaluate part-time physician time and attendance procedures, we reviewed time and attendance records and desk audit reports, interviewed system managers and part-time physicians, and verified the attendance of selected part-time physicians.

Timekeeper Annual Training. VA policy requires annual training be provided to all timekeepers. We found that, for FYs 2004–2005, training was not provided to

[2] PAID is VA's Personnel Accounting Integrated Data System.

timekeepers. This occurred because there was no Payroll Supervisor, and the Acting Human Resources (HR) Manager, who was responsible for the timekeepers, was not aware of the training requirement.

Timekeeper Desk Audits. VA policy requires that semiannual timekeeper desk audits be performed to ensure timekeepers properly record physician time and attendance. We found that the Acting HR Manager did not perform any desk audits in FY 2004 and only 14 (20 percent) of 70 desk audits in FY 2005. The Network Paid Manager told us that the Acting HR Manager was not aware of the desk audit requirement.

Recommendation 9. We recommended that the VISN Director ensure that the Network Paid Manager requires that: (a) all timekeepers receive annual training and (b) all timekeeper desk audits are performed as required.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will require all timekeepers to attend annual training and will perform desk audits twice per year. The improvement plan is acceptable, and we will follow up on completion of the planned actions.

Purchase Card Program

Condition Needing Improvement. The Financial Resource Management Chief and the Purchase Card Coordinator (PCC) needed to ensure that all cardholders promptly complete the required refresher training covering their purchase card program responsibilities and procedures. VA policy requires the PCC to ensure that cardholders receive training every 2 years. For the period July–September 2005, we found that the PCC performed the required monthly purchase card transactions audits and purchases were made for valid VA purposes.

For calendar years 2003–2005, 61 (27 percent) of the 226 cardholders did not complete the refresher training within the required 2-year period. The PCC told us that cardholders' scheduling conflicts contributed to the delays in completing the required training.

Recommendation 10. We recommended that the VISN Director ensure that the Healthcare System Director requires the PCC to ensure that all cardholders complete the refresher training within the required 2-year period.

The VISN and Healthcare System Directors agreed with the findings and recommendation and reported that they have implemented a tracking process that will ensure that all cardholders complete training as required. The implementation plans are acceptable, and we consider the issues resolved.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 19, 2006

From: VISN Director

Subject: **VA San Diego Healthcare System, San Diego, California**

To: Director, LA Office of Healthcare Inspections (54LA)

1. Thank you for your Draft Report of the Combined Assessment Program Review which was conducted at the VA San Diego Healthcare System, January 23-27, 2006. I have reviewed your findings and agree with the recommendations and corrective actions taken by the San Diego Healthcare System.

2. I would like to take this opportunity to thank the CAP Survey Team for conducting an effective, careful, and comprehensive survey. We very much appreciate the professional manner in which the survey was conducted and the interactions that occurred between the surveyors and facility staff.

3. Should you have any questions regarding our response, please contact me directly or Ms. Teresa Osborn, Network Quality Management Officer at (562) 826-5963.

(original signed by:)
Kenneth J. Clark, FACHE

Attachment

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs

Memorandum

Date: April 19, 2006

From: Director, VA San Diego Healthcare System (664/00)

Subject: **VA San Diego Healthcare System, San Diego, California**

To: Director, Network 22 (10N22)

We concur with the Office of Inspector General's recommendations and findings. Plans of Action are outlined within the attached document.

These recommendations are a result of the Combined Assessment Program review of the VA San Diego Healthcare System, January 23-27, 2006.

(original signed by:)
Gary J. Rossio, CHE

Attachment

VA San Diego Healthcare System
Response to the Office of Inspector General's Combined Assessment Report

Comments and Implementation Plan

1. Supply Inventory Management

Recommended Improvement Action 1. We recommend that the VISN Director ensures that the Healthcare System Director requires the SPD Director to monitor medical supply item usage rates and reduce excess inventory.

Concur with recommended improvement action

Planned Action: Review the report for items greater than 30-days stock on hand by **March 1, 2006**. Determine validity of data by performing a physical inventory. Clean up database per fund control point by **June 1, 2006**. Request each Inventory Management Specialist (3) assigned to the SPD department to determine the top 50 line items with the highest cost in each fund control point. Each week, review 10 items from this list. Using the last 6 months usage reports, adjust stock levels and reorder levels. Submit 2237 turn-ins for excess stock to be offered to other VA facilities for use by **July 1, 2006**. This will be done on a quarterly basis after that date. Implementation of point-of-use equipment (Omnicell) by **December 30, 2006**, will assist in day-to-day inventory management. Continue to determine items that are no longer required and eliminate stock. Continue to determine those items that are required for emergency or special needs and assign them to a "seasonal" or "must have" category in GIP with the understanding that these items will typically show a level greater than 30-days stock on hand by **July 1, 2006**. Work with VISN 22 facilities to identify common items in this category and strategize group purchase and distribution of these items. Develop a formal process for new item requests to include anticipated monthly usage and identify all available purchase quantity information.

2. Service Contracts

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Network Contracting Manager (NCM) requires that: (a) contracting officers ensure that contractors follow the contract terms, (b) contracting officers do not award contracts that exceed their

authorized warrant thresholds, and (c) all applicable FAR and VAAR requirements are met.

Concur with recommended improvement actions

a. Contracting officers ensure that contractors follow the contract terms:

Planned Action: The CAP review found that the contractor, under the task order construction contract (V664C-0513), included incorrect labor rates and included a specific work category that was not authorized, when pricing task orders. The VA is currently reviewing a revised proposal submitted by the contractor on March 27, 2006, for Task Order 8. The NCM anticipates completion of review, discussion, and issuance of modification for Task Order 8 by **May 15, 2006**. The contracting officer along with the COTR will also be reviewing the other seven task orders for the incorrect labor rates and the unauthorized work category, with completion of review expected by **June 30, 2006**. The contractor will then be notified to submit revised proposals, if required. Until all task orders are reviewed, the NCM will not be able to determine the amount of overpayment. Projected completion date for all corrective actions is **August 18, 2006**.

b. Contracting officers do not award contracts that exceed their authorized warrant thresholds:

Planned Action: The CAP Review finding has been communicated to the contracting officer that did not have authority to award contracts above $100,000. The Acquisition section will continue to conduct Peer and Supervisory Reviews of solicitations prior to issuance and to utilize the Contract File Checklist. In addition, the Acquisition supervisors will remind contracting officers during staff meetings to adhere to contract value thresholds established in their warrants. The final report of the CAP Review of the VA San Diego Healthcare System will also be provided to the acquisition staff. Lastly, the NCM will implement a procedure to review pending and active contract files monthly on a random basis by **April 28, 2006**.

c. All applicable FAR and VAAR requirements are met:

Planned Action: The CAP Review finding has been communicated to the contracting officers that did not have supporting price analysis documentation in the contract files. The corrective actions and target completion date for this item are the same as Item b above.

3. Quality Management

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) responsible clinicians fully inform patients who experience adverse events and document the discussions and (b) the Patient Advocate perform more detailed patient complaint analyses and present trended reports to senior managers.

Concur with recommended improvement actions

a. Responsible physicians fully inform patients who experience adverse events and document the discussions:

Planned Action: Review and revise the Peer Review Template and Peer Review Committee Template to include a section addressing disclosure of adverse events to patients and documentation of disclosure in CPRS by **May 1, 2006**. Develop and implement a training module for all providers on disclosure and documentation requirements by **June 1, 2006**. Implement ongoing audits of significant adverse events to ensure disclosure took place and is appropriately documented by **June 1, 2006**.

b. The Patient Advocate performs more detailed patient complaint analyses and presents trended reports to senior managers:

Planned Action: Revised Patient Advocate Report from bar graph to Pareto chart. Date completed: **February 6, 2006**. Report will include an executive summary of data with analysis and recommendations for improvements. It will be reported quarterly to the Communication and Leadership Council (CLC) and the Veterans Employee Service Council (VESC), who will be responsible for overseeing improvement efforts. Date to be completed by: **June 1, 2006**.

4. Breast Cancer Management

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Healthcare System Director takes action to: (a) improve compliance with VHA's breast cancer screening performance measure and (b) ensure that mammogram reports are scanned within a reasonable timeframe.

Concur with recommended improvement actions

a. Improve compliance with VHA's breast cancer screening performance measure:

Planned Action: Review current processes utilized to identify and track veteran patients requiring mammogram screening. Flowchart these processes and identify areas for improvement by **April 21, 2006**. Redefine processes to ensure tracking of patient through the mammogram process from consult to completion and entry in CPRS. Completion and implementation of redesign no later than **May 5, 2006**. Improvement efforts will be monitored by Women's Clinic clinicians and the Women's Program Support Assistant by monitoring consult status and completion on a weekly or more frequent basis. Re-audit charts of veterans meeting criteria for required mammograms and ensure these veterans receive telephonic notification and written notification via a letter from their Primary Care Provider. Additional education will be provided to all VA San Diego Healthcare System clinicians, who order mammograms, no later than **April 6, 2006**. The VA San Diego Healthcare System will offer a program in October 2006 as part of National Breast Cancer Awareness month to educate patients and staff about early detection of breast cancer and encourage mammography for our patients. The date has been tentatively set for **October 5, 2006**.

b. Ensure that mammogram reports are scanned within a reasonable timeframe:

Planned Action: Results of mammograms performed through our Sharing Agreement with the Department of Defense (DoD) are available as Remote Data in the Computerized Patient Record System (CPRS) as soon as the report is filed electronically into the DoD medical records. Hard copies of the mammography report are faxed weekly to the Women's Program Support Assistant (WPSA). These are reviewed by a clinician within 3 days of receipt to ensure any significantly abnormal results (such as BIRADS 4 and 5) are being appropriately responded to. The WPSA logs the receipt of the mammogram reports into the dedicated spreadsheet weekly and sends the reports to Fee Basis for scanning. Fee Basis is now scanning these reports into CPRS on receipt. The Program Analyst for Fee Basis is instituting **weekly** monitoring of the timeliness of scanning these reports as well as reports from all other mammography providers, utilizing both the mammography spreadsheet and the **monthly** invoices. If he finds a disparity of reports, particularly if there is an indication a study was done but has not been received, he will contact the WPSA, who will in turn discuss the disparity with the Mammography Nurse Case Manager at the US Navy Medical Center in San Diego.

5. Patient Medical Information

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Healthcare System Director requires that all confidential patient information is secured.

Concur with recommended improvement action

Planned Action: Information Security Awareness training incorporates education regarding the importance of securing confidential information. This is a mandatory training element for all facility employees and will be tracked and improved as described in Recommendation 8c. In addition, the mandatory security screen saver displayed on all facility computer workstations will be modified to include a warning about securing confidential patient information by **June 30, 2006**. In order to provide on-going audits of compliance with requirements, inspection of all facility areas for unsecured information will be incorporated by **March 31, 2006**, into the ongoing Environment of Care rounds (twice monthly) and Information Security Team inspections (monthly) and the results aggregated and reported to leadership and the Informatics Committee for improvement activities.

6. Equipment Accountability

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Healthcare System Director requires the A&MMS Chief to: (a) ensure that responsible staff complete EIL inventory counts within the proper timeframes and (b) conduct quarterly spot check of EILs to verify inventory accuracy.

Concur with recommended improvement actions

a. Ensure that EIL inventories are completed within proper timeframes:

Planned Action: Effective **March 1, 2006**, notifications sent to services regarding their inventories reflected the proper, established timeframe for completion. From the time of notification, services were required to have their inventories completed within 10 days if their EIL contained less than 100 items and 20 days if the said EIL contained more than 100 items. Services that did not meet the established timeframes were sent a delinquency memo from the Director, Financial Resources Management Service, and asked that their inventory be completed. A copy of the memo is sent to the Director, VA San Diego Healthcare System. If inventories are

not completed within the timeframe of the delinquency memo, currently 3 working days, the Director, VA San Diego Healthcare System, will initiate further action.

b. Conduct quarterly spot checks of EILS to verify inventory accuracy:

Planned Action: Effective **April 1, 2006**, an Excel spreadsheet or similar tracking system will be used to track quarterly spot checks, until such time that we can effectively and efficiently work this into our Access Equipment Inventory database. At present the database has been restructured to include many new features for tracking the status of inventories. We anticipate having the quarterly spot checks incorporated into our database by **June 1, 2006**. A manual method in Excel will be used until then.

7. Controlled Substances Accountability

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Healthcare System Director requires the CSC to: (a) ensure all areas containing controlled substances are inspected, (b) avoid assigning the same inspector to the same inspection area over 2 consecutive months, and (c) ensure the timely completion of annual training and the maintenance of training certificates for all inspectors.

Concur with recommended improvement actions

a. Ensure all areas containing controlled substances are inspected:

Planned Action: The current monitoring process for inspections was revised as of **January 27, 2006**. A spreadsheet assigning dates and inspection locations defines the locations and individuals assigned to perform inspections. Reminder notices are sent out to teams to ensure timely inspections, and inspection results are tracked to ensure that required inspections are completed.

b. Avoid assigning the same inspector to the same inspection area over two consecutive months:

Planned Action: The current monitoring process for inspections was revised as of **February 1, 2006**. A tracking spreadsheet that defines team members and inspection locations is used to ensure that inspectors are not assigned to the same location for two consecutive months.

c. Ensure the timely completion of annual training and the maintenance of training certificates for all inspectors:

Planned Action: All inspectors were required to submit a Certificate of Training for all controlled substance certification training activities by **February 1, 2006**. Inspectors who are not able to provide a certificate are required to retake the web-based certification training. A spreadsheet tracking has been implemented to ensure that Certificates of Training do not "expire" prior to inspectors conducting inspections.

8. Information Technology Security

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) IRM staff terminate computer access privileges when users separate from the system, or modify computer access privileges when users change positions or transfer to another service, contractor, or volunteer organization; (b) the ITS Chief and ISO update the IT contingency plan to include all required elements; and (c) the ISO ensures that all users who have computer access privileges complete the annual IT security awareness training requirement.

Concur with recommended improvement actions

a. IRM staff terminate computer access privileges when users separate from the system, or modify computer access privileges when users change positions or transfer to another service, contractor, or volunteer organization:

Planned Action: All employees are required to check out with IT Service when terminating employment. The form used to monitor and direct the check-out process includes this requirement, and ITS is disabling access within 24 hours of notification. **(Completed February 28, 2006.)** In order to assure computer access is disabled for those employees who neglect to check out with IT Service, a report is run from the PAID database bi-monthly, and appropriate accounts are disabled at that time. **(Completed February 28, 2006.)** An additional mechanism will be developed to identify inter-service transfers and a process implemented to assure review of computer access by Service IT Application Coordinators and Service Chiefs by **August 15, 2006**. With this mechanism, an ongoing audit of compliance with account termination and access review will be implemented, and the results will be incorporated as an ongoing monitor by the facility Informatics Advisory Council by **August 15, 2006**.

b. The ITS Chief and ISO update the IT contingency plan to include all required elements:

Planned Action: A draft of the Contingency Plan with the modifications needed to meet all NIST standards has been developed and is currently in review with the Chief of IT and the ISO. This includes identification of an alternate processing site and site logistics, listing of IT equipment, and roles of IT personnel during data recovery operations. The final Contingency Plan will be reviewed and approved by facility leadership by **May 31, 2006**.

c. The ISO ensures that all users who have computer access privileges complete the annual IT security awareness training requirement:

Planned Action: Information Security Training was previously identified as one of the annual mandatory training requirements for all employees with required tracking by supervisors and Service Chiefs. The current active directory account list does not accurately identify current system users. All active accounts will be reviewed, inappropriate or inactive accounts will be closed, and 'service accounts' not corresponding to active users will be identified by **May 31, 2006**. A report that matches current system users against Tempo training records will be developed and used for tracking compliance with IT Security Awareness training by **July 31, 2006**. Using this report, Service Chiefs will be provided reports of users without evidence of current fiscal year IT Security Awareness Training, and any user without documentation of training within the appropriate time frames will have access removed by **August 31, 2006**.

9. Part-Time Physician Time and Attendance

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Network PAID Manager requires that: (a) all timekeepers receive annual training and (b) all timekeeper desk audits are performed as required.

Concur with recommended improvement actions

a. All timekeepers receive annual training:

Planned Action: A separate training plan is being developed for part-time physician timekeepers to ensure issues unique to posting/tracking/record maintenance for part-time physicians are addressed with the timekeepers. This training will be scheduled for June of each year with the first training

occurring **June 2006**. Additional refresher training, as well as training for new timekeepers, will be provided by payroll upon request by the service. Refresher training for all other timekeepers will be scheduled for June of each year beginning **June 2006**. The Payroll manager is developing an on-line timekeeper question and answer review, and all timekeepers will be expected to take this test once a year for TEMPO credit. This project should be ready for implementation by **July 2006**.

b. Timekeeper desk audits are performed as required:

Planned Action: The payroll office will be completing timekeeper desk audits every **April** and **October** with no exceptions. Payroll technicians will complete an electronic review of individual timekeeper data and also visit each timekeeper at their work area to ensure all supporting documentation for leave requests and other appropriate documents (e.g., military orders, 5631a sign-in sheet, jury duty, travel orders) are maintained by the timekeeper. A copy of the payroll desk audit form will be provided to the timekeeper and supervisor/service chief along with notification of any significant discrepancies identified during the audit. All completed desk audits will be maintained by the payroll office and available for review for any internal or external audit. As of March 27, 2006, the payroll office has completed approximately 37 percent of the timekeeper desk audits. The remainder will be completed by **April 30, 2006**.

10. Purchase Card Program

Recommended Improvement Action 10. We recommend that the VISN Director ensure that the Healthcare System Director requires the PCC to ensure that all cardholders complete the refresher training within the required 2-year period.

Concur with recommended improvement action

Planned Action: A purchase card database is now in use to remind the Purchase Card Coordinator (PCC) which cardholders and Approving Officials are due for their 2-year Purchase Card Refresher Training. Cardholders and Approving Officials will be sent invitations for Purchase Card Refresher Training six months before their 2-year refresher training is due. If the individual does not comply within 3 months, a memo will be sent from the Director, Financial Resources Management, to the cardholder's service chief. If the individual still does not comply within 2 months, a memo will be sent from the Director, Financial Resources Management, to the VA San Diego Healthcare System Associate Director

for administration personnel or to the VA San Diego Healthcare System Chief of Staff for clinical personnel. If the personnel are still unable to attend training, their purchase cards will be inactivated for cardholders or their approving officials will be taken off the service's fund control points.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by reducing excess medical supply inventories.	$995,897
2	Better use of funds by monitoring contract terms.	308,000
	Total	$1,303,897

Appendix D

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Appendix E

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