Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California

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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 March 27–31, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Loma Linda Healthcare System, which is part of Veterans Integrated Service Network (VISN) 22. The purpose of the review was to evaluate selected healthcare system operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided fraud and integrity awareness training to 344 healthcare system employees.

Results of Review

This CAP review covered 19 operational activities. The healthcare system complied with selected standards in the following nine activities:

- Accounts Payable
- Accounts Receivable
- All Employee Survey Action Plan
- Beneficiary Travel
- Employee Travel
- Environment of Care
- Fee Basis
- Government Purchase Card Program
- Medical Care Collections Fund

We identified ten activities that needed additional management attention. To improve operations, we made the following recommendations:

- Strengthen information technology (IT) security controls.
- Reduce excess supply inventories and improve inventory controls.
- Strengthen the QM program by improving the disclosure process for patients who experience adverse events, provide detailed analyses of patient complaints and Utilization Management (UM) data, and develop a comprehensive medical record review process.
- Strengthen the service contract controls and administration process.
- Improve management of diabetic patients who are receiving atypical antipsychotic medications.
- Improve inventory procedures and controls over nonexpendable equipment.
- Strengthen mammography program administrative procedures.

- Improve controls over timekeeping for part-time physicians by conducting all required semiannual timekeeper desk audits.
- Improve inventory management controls and controlled substances inspections.
- Ensure monthly visits to patients in community nursing homes (CNHs).

This report was prepared under the direction of Ms. Janet Mah, Director, and Mr. Jeff Wieters, CAP Review Team Leader, Los Angeles Audit Operations Division.

VISN 22 and Healthcare System Director Comments

The VISN 22 and Healthcare System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–31, for the full text of the Directors' comments.) We will follow up on the implementation of planned improvement actions until they are completed.

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

Introduction

Healthcare System Profile

Organization. The VA Loma Linda Healthcare System consists of the Jerry L. Pettis Memorial VA Medical Center and five contracted community-based outpatient clinics (CBOCs) in Corona, Palm Desert, Sun City, Upland, and Victorville, California. The healthcare system is part of VISN 22 and serves a veteran population of approximately 260,000 residing in the San Bernardino and Riverside Counties, 2 of the largest and fastest growing counties in California.

Programs. The healthcare system provides a full range of primary and tertiary healthcare services. There are 118 hospital beds and 108 long-term care beds. The healthcare system provides state-of-the-art care in the areas of medicine, surgery, behavioral medicine, neurology, oncology, dentistry, geriatrics, and physical medicine and rehabilitation. The healthcare system has provided health care services to 2,034 Operation Enduring Freedom and Operation Iraqi Freedom veterans with combat-related injuries.

Affiliations and Research. The healthcare system is affiliated with the Loma Linda University School of Medicine and provides training for 105 medical residents and students in 50 other disciplines, including nursing, pharmacy, and dentistry. In fiscal year (FY) 2005, the healthcare system's research program had 147 active research projects and a budget of $1.8 million. Important areas of research include diabetes, heart disease, hypertension, and osteoporosis.

Resources. The healthcare system's FY 2005 medical care budget totaled $273 million, a 3 percent increase over the FY 2004 budget allocation. FY 2005 staffing was 1,770 full-time equivalent employees (FTE), including 122 physician FTE and 513 nursing FTE.

Workload. In FY 2005, the healthcare system treated 56,395 unique patients, a 2 percent increase over FY 2004. The inpatient care workload totaled 7,038 admissions, and the average daily census was 211, including long-term care patients. The outpatient care workload was 473,935 patient 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 patient care to identify and correct 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 19 activities:

Accounts Payable
Accounts Receivable
All Employee Survey Action Plan
Beneficiary Travel
Breast Cancer Management
Community Nursing Home Evaluations
Controlled Substances Accountability
Diabetes and Atypical Antipsychotic Medications
Employee Travel
Environment of Care
Equipment Accountability
Fee Basis
Government Purchase Card Program
Information Technology Security
Medical Care Collections Fund
Part-Time Physician Time and Attendance
Quality Management
Service Contracts
Supply Inventory Management

The review covered healthcare system operations for FYs 2004 to 2006 through March 2006 and was done in accordance with OIG standard operating procedures for CAP reviews.

During the review, we also presented 3 fraud and integrity awareness briefings for 344 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–16). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the

OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, we did not identify any reportable deficiencies.

Follow-Up to Previous CAP Review and Evaluation Recommendations

As part of this review, we followed up on recommendations from our prior CAP review of the healthcare system (*Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California,* Report No. 02-00988-170, September 30, 2002). The prior CAP review identified the need for improvements in three activities including supply inventory management practices, service contract award and monitoring procedures, and CBOC contracting practices. Our March 2006 CAP review found improvements were still needed to reduce excess medical and prosthetic supply inventories and to adhere to service contract award requirements. (See Opportunities for Improvement section, pages 5–6 and 8.)

During the CAP review, we also found that the healthcare system needed to ensure its Police and Security Service conducted more timely investigations of "Reports of Survey" ("ROS") for lost, damaged, or destroyed Government property. This is a repeat finding from a prior OIG review of the healthcare system (*Evaluation of Alleged Information Technology Equipment Mismanagement and Privacy Act Violations at the VA Loma Linda Healthcare System,* Report No. 04-00856-31, December 2, 2005). (See Opportunities for Improvement section, pages 10–11.)

Results of Review

Opportunities for Improvement

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. The Information Resource Management (IRM) 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. Accordingly, the healthcare system has implemented controls related to IT physical security, data security, and computer virus protection. We evaluated IT security to determine if the controls adequately protected information system resources. Procedures were in place to ensure controlled access to application and system software, segregation of IT duties, and monitoring of security incidents. However, we identified three areas that needed improvement.

Contingency Plan. The healthcare system's IT contingency plan did not include all critical elements as required by VA policy. The current Contingency Disaster Recovery Plan for the healthcare system did not include an alternate processing site. During the CAP review, the ISO entered into an agreement with the VA Greater Los Angeles Healthcare System to have it serve as the alternate processing site.

Access Privileges. VA policy requires computer access privileges to be promptly terminated or modified when automated information system (AIS) users separate from the healthcare system, change positions, or move to a different service, contractor, or volunteer organization. However, the IRM Chief did not ensure that computer access privileges were terminated when users separated from the healthcare system. Of the 363 AIS users who separated from the healthcare system between January 1, 2005, and January 31, 2006, 16 AIS users did not have their Local Area Network (LAN) access, and in 2 cases their Veterans Health Information Systems and Technology Architecture (VistA) access, promptly terminated at the time they separated. Because their access was not terminated until the week before the CAP review, these users retained their computer access privileges from 39 to 113 days after they separated from the healthcare system. LAN and VistA access were not promptly terminated for separated users because the ISO and Human Resources Management Service staff did not consistently monitor access to these systems and service chiefs did not always notify IRM when users no longer required access.

IT Security and Privacy Awareness Training. VA and Veterans Health Administration (VHA) policy require all VA employees, contractors, and other individuals who use AIS resources to complete the annual IT Security and Privacy Awareness training. In

addition, the ISO is responsible for ensuring all employees, including new employees, receive security and privacy awareness training as part of the healthcare system's security program. During FY 2005, 281 (13 percent) of the healthcare system's 2,162 AIS users did not complete the required annual IT Security and Privacy Awareness training. In addition, 63 (22 percent) of the healthcare system's 282 FY 2005 new hires did not complete their initial IT Security and Privacy Awareness training. The ISO stated the healthcare system did not fully comply with VA's IT security training requirements because service chiefs at the healthcare system had not made it a high priority to ensure their staff completed the required training, and new employees sometimes decided not to attend new employee orientation which included the IT Security and Privacy Awareness training.

Recommendation 1. We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) the ISO update the IT contingency plan to include an alternate processing site; (b) IRM staff promptly terminate computer access privileges when users separate from the healthcare system; and (c) the ISO ensures all users, including new employees, complete the required annual IT Security and Privacy Awareness training.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that the ISO has updated the healthcare system's contingency plan to include an alternate processing site, the Human Resources Management and IT Services have implemented procedures to ensure terminations and changes in employees' computer access privileges are promptly processed, and all employees have taken the required IT Security and Privacy Awareness training or had their computer access privileges suspended. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Supply Inventory Management – Excess Inventories Should Be Reduced

Conditions Needing Improvement. Supply Processing and Distribution (SPD) and Prosthetic Service managers needed to reduce excess medical and prosthetic supplies and manage supply inventories more effectively. VHA establishes a 30-day supply goal and requires medical facilities to use VA's Generic Inventory Package (GIP) and the Prosthetic Inventory Package (PIP) to manage inventories of medical and prosthetic supplies. SPD and Prosthetic Service managers should use GIP and PIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories. We reviewed a sample of 20 medical and 10 prosthetic line items and found that GIP and PIP inventory records accurately reflected quantities of stock on hand. However, we identified two areas that needed improvement.

Excess Medical Supply Inventory. As of March 29, 2006, the medical supply inventory consisted of 9,376 line items valued at $705,531. GIP reports showed that 894 (10 percent) of the 9,376 line items exceeded the 30-day supply goal, with inventory levels ranging from 31 to 9,999 days of supply on hand. The value of stock exceeding 30 days was $365,001, or 52 percent of the total inventory. The excess stock occurred because SPD staff were not effectively monitoring GIP stock levels to meet the 30-day standard.

Excess Prosthetic Supply Inventory. As of February 28, 2006, the prosthetic supply inventory consisted of 1,046 items valued at $313,875. PIP reports showed that 298 (28 percent) of the 1046 line items had stock on hand that exceeded the 30-day supply goal, with inventory levels ranging from 31 to 999 days of supply on hand. The value of stock exceeding 30 days was $304,020, or 97 percent of the total inventory. This excess occurred because some items had minimum order quantities and Prosthetic Service staff were not effectively monitoring stock levels.

Recommendation 2. We recommended that the VISN Director ensure that the Healthcare System Director requires that SPD and Prosthetic Service managers ensure staff monitor item usage rates and reduce excess inventories.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that the SPD Chief and the Logistics Service Manager are initiating more comprehensive monitors to review inactive supplies and implementing processes to reduce quantities of slow moving medical supply inventory items. In addition, the Prosthetic Service and SPD Chiefs and the Logistics Service Manager are coordinating a process to continue to reduce the surgical implant inventory and any additional excess prosthetic supply inventory and allow Prosthetic Service staff to monitor prosthetic supply inventory usage rates. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Quality Management – Adverse Event Disclosure, Utilization Management, Patient Complaints Analysis, and Medical Records Review Needed Improvement

Conditions Needing Improvement. The QM program was generally effective in providing oversight of the healthcare system's quality of care. Appropriate review structures were in place for 10 of the 14 program activities reviewed. However, we identified four program areas that needed improvement.

Adverse Event 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 VA Regional Counsel, inform them of their rights to file tort or benefits claims. During the period February 2005–February 2006, two patients experienced adverse events. However, clinicians only documented the adverse event discussion in the

progress notes of one patient, and neither patient was advised of the right to file a claim. To ensure proper disclosure after an adverse event, the healthcare system needed to revise its disclosure policy to clearly define the responsibilities of staff.

Utilization Management. Admission and continued stay reviews were performed as required by VHA policy, but no actions were documented when the reviewed cases did not meet local UM goals. For example, in the first quarter of FY 2006, less than 70 percent of admissions in cardiology, gastroenterology, and neurosurgery met the acute care admission criteria, yet no specific problems were identified, and no action plans were documented.

Patient Complaint Analyses. Although patient complaints were shared with service chiefs, no data analyses or trend identification was performed or reported. VHA policy requires that Patient Advocates aggregate complaints, analyze the data, and present trended reports to senior managers. The Patient Advocate needed to perform detailed patient complaints analyses and to compile trended reports that identified opportunities for improvement.

Medical Record Reviews and Analyses. Clinicians reviewed samples of medical records to verify the presence and assess the thoroughness of selected items, such as discharge summaries and care plans. However, there was no systematic review process in place for other items as required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), such as informed consents and problem lists. VHA directives and JCAHO standards require that facilities have a systematic medical record review process covering all required items with data analyses and actions to address areas where performance is below expectations.

Recommendation 3. We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) designated staff members inform patients who experience adverse events of their rights to file claims and document these discussions in progress notes; (b) the Healthcare Quality Improvement Coordinator provides detailed analyses of UM data, and the Chief of Staff takes appropriate actions when goals are not met; (c) the Patient Advocate performs detailed patient complaints analyses and presents trended reports to senior managers; and (d) the Health Information Manager coordinates a comprehensive medical record review process that meets all applicable requirements.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that the healthcare system's policy now clearly defines the disclosure process and responsibilities of staff when a patient experiences an adverse event. The UM Oversight Committee has increased the frequency of its meetings to facilitate in-depth data analyses, provide more definitive feedback, and develop actions plans when problems are identified. In addition, the healthcare system has implemented a process whereby the Veterans Satisfaction Office reports areas with the highest patient

complaints to the Service Quality Council (SQC), and the SQC develops action items, forwards complaint data to the appropriate services and sections, and monitors progress on the resolution of identified issues. QM staff have also developed a systematic medical record review process which encompasses all required elements, and is completed at the point of care as required by JCAHO. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Service Contracts – Contract Award Requirements Needed To Be Followed

Conditions Needing Improvement. The Network Logistics Office Director needed to ensure that contracting officers follow the Federal Acquisition Regulation (FAR), VA Acquisition Regulations (VAAR), and VHA policies. We reviewed the award and administration of 10 contracts with a reported value of $28.8 million and identified 3 areas that needed improvement.

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 levels of education, experience, and training. Nevertheless, two contracting officers awarded three contracts that exceeded their warrant authorities. A contracting officer responsible for awarding two of the three contracts stated that she believed that her $5 million warrant threshold only applied to the contracts' base years rather than the total contract values (base years plus all option years).

Price Negotiation Memorandum. The FAR requires contracting officers to document in the contract file the principle elements of the negotiated agreement. The price negotiation memorandum (PNM) in the contract file explains how the contracting officer determined the fairness and reasonableness of the contract price. However, the contracting officers had not prepared PNMs for four of the eight negotiated contracts that were reviewed.

Recommendation 4. We recommended that the VISN Director ensure that the Network Logistics Office Director (a) ensures that contracting officers do not award contracts that exceed their authorized warrant authorities and (b) contracting officers prepare PNMs and document price determinations in the contract files of negotiated contracts.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that the findings regarding warrants and PNMs have been discussed with the contracting officers, will be provided to all acquisition staff, and will be discussed during staff meetings to remind the contracting officers of the need to adhere to these requirements. The Acquisition Section's use of Peer and Supervisory reviews and the Contract File Checklist to improve compliance in these areas will also be supplemented by the Network Contract Manager's implementation of a random monthly

review of all pending and active contract files. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Diabetes and Atypical Antipsychotic Medications – Blood Glucose and Cholesterol Management Needed To Be Improved

Condition Needing Improvement. Clinicians needed to manage abnormal blood glucose and cholesterol levels of patients who take certain prescribed medications. Studies have shown that some patients receiving atypical antipsychotic medications (used to treat a variety of mental illnesses) may have increased risk for developing diabetes. Appropriate screening, monitoring, and management of patients taking these medications are essential to optimize patient outcomes. We assessed these items in a sample of 13 patients who had taken 1 or more atypical antipsychotic medications for at least 90 days. The screening of patients who were at risk of developing diabetes was generally effective. However, management of diabetic patients who take these medications needed improvement.

VHA guidelines and performance measures for managing diabetic patients require that clinicians monitor the following three tests:

- Hemoglobin A1c (HbA1c)—a test used to reflect the average blood glucose level over a period of time. The goal is that no more than 15 percent of patients have HbA1c greater than 9 percent, which indicates poor blood glucose control.
- Blood pressure—the goal is that at least 72 percent of patients should have blood pressure equal to or less than 140/90 millimeters of mercury (mmHg).
- Low density lipoprotein cholesterol (LDL-C)—the goal is that at least 75 percent of patients should have LDL-C levels below 120 milligrams per deciliter (mg/dL).

For the three diabetic patients in our sample, the healthcare system did not meet the performance measure goals for HbA1c and LDL-C. These patients' medical records contained evidence that HbA1c, blood pressure, and LDL-C levels were monitored regularly. However, all three patients showed consistently high HbA1c levels and two patients also had high LDL-C levels. One patient did not show up for LDL-C testing (see table below).

Non-diabetic patients (10 patients)		Diabetic patients (3 patients)		
Received appropriate screening	Provided prevention counseling	HbA1c level greater than 9 percent (Goal: 15 percent or lower)	Blood pressure of 140/90 mmHg or less (Goal: 72 percent or higher)	LDL-C less than 120 mg/dL (Goal: 75 percent or higher)
10/10 (100 percent)	4/4 (100 percent)	3/3 (100 percent)	3/3 (100 percent)	0/2 (0 percent)

While we found that clinicians took actions, such as medication adjustments, more aggressive actions were needed.

Recommendation 5. We recommended that the VISN Director ensure that the Healthcare System Director requires clinicians to provide and document appropriate interventions for diabetic patients when HbA1c and LDL-C levels are elevated.

The VISN and Healthcare System Directors agreed with the finding and recommendation. They reported that the Associate Chief of Staff for Education, Chief of General Internal Medicine, Pharmacy Service staff, and the Behavioral Health Program Manager have developed and implemented various clinical reminders, monitoring processes, and administrative management reports to ensure patients taking atypical antipsychotic medications are appropriately screened, monitored, and managed for cholesterol, blood pressure, diabetes, and weight. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. The Acquisition and Materiel Management Service (A&MMS) Chief needed to improve controls over nonexpendable equipment (items costing more than $5,000 with an expected useful life of 2 years or more) and sensitive equipment. VA policy requires the completion of physical inventories to ensure equipment is properly accounted for and recorded on Equipment Inventory Lists (EILs). As of March 9, 2006, the healthcare system had 103 EILs containing 9,782 items valued at $93 million. We identified two areas that needed improvement.

"Reports of Survey." VA policy requires healthcare system staff to prepare "ROS" for lost, damaged, or destroyed Government property. For "ROS" where equipment losses equal or exceed $5,000, the "ROS" are to be forwarded to the Healthcare System Director, who is responsible for establishing a Board of Survey to conduct an investigation. Under no condition will a "ROS" be delayed longer than the time required to search the immediate area or question persons who may have knowledge of the incident. Upon completion of the Board of Survey and the Director's review and approval of the board's report, A&MMS will obtain the Board of Survey file and coordinate appropriate corrective actions.

During FY 2005, 7 of the facility's 10 "ROS" were not properly processed. Healthcare system staff prepared 7 "ROS" from November 2004–August 2005 to report the loss of 144 equipment items valued at $203,674. As of March 2006, six "ROS" for $84,541 in missing equipment were not forwarded to the Director so that Boards of Survey investigations could be initiated because these "ROS" were still under investigation by the Police and Security Service. A Board of Survey investigation had been completed for the seventh "ROS" for $119,133 in missing equipment, but A&MMS still had not

addressed the recommended corrective actions at the time of the CAP review. The Inventory Management Specialist stated that he was still searching for the missing equipment for the six "ROS," and that he had not completed the recommended corrective actions for the one completed Board of Survey investigation due to an oversight.

Sensitive Equipment Items. VA policy requires A&MMS to conduct an annual inventory of all EILs including sensitive items regardless of cost. As of FY 2006, A&MMS staff had not included all sensitive equipment items on their EIL inventories. From our review of the healthcare system's EILs, we found that not all handheld and portable telecommunication devices, cell phones, and ammunition had been included in the annual EIL inventories. As of our review, we could not determine the number and value of sensitive equipment items that had not been included in the EILs, since A&MMS had not been keeping records of these items. The Inventory Management Specialist stated that he would use the records of the using services to add these items to the EILs. The Chief Logistics Officer stated that A&MMS was aware of this requirement, but because of other workload issues, it had not taken the time to enter the sensitive items on the EILs.

Recommendation 6. We recommended that the VISN Director ensure that the Healthcare System Director requires A&MMS staff to promptly forward "ROS" to the Director and include all sensitive equipment items on EILs.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that the six "ROS" were forwarded to the Director's Office so that Boards of Survey could be convened and that the Chief Logistics Officer and A&AMMS Chief took actions to respond to the recommendations made in the seventh "ROS." By May 30, 2006, all of the "ROS" had been completed, recommendations were approved by the Director, and final dispositions were documented for the missing equipment. In addition, all sensitive items have now been inventoried and recorded on EILs and all new sensitive items will be added as they are received. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Breast Cancer Management – Administrative Procedures Needed Improvement

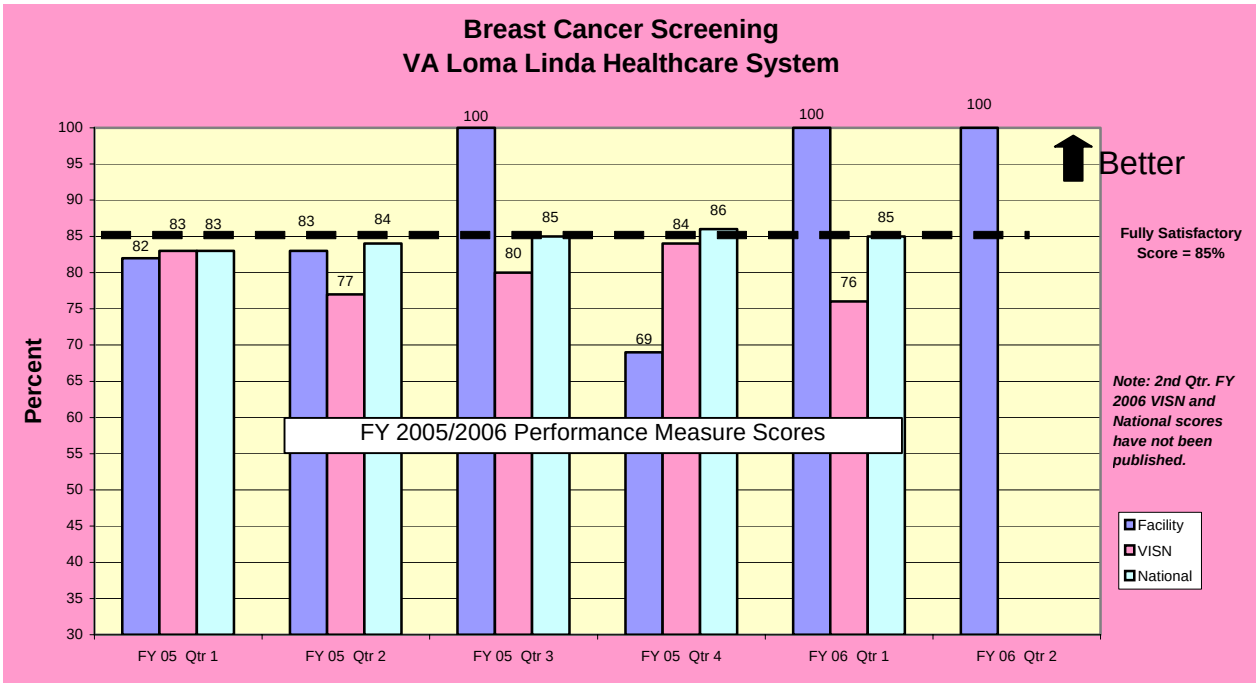
Conditions Needing Improvement. Radiology Service needed to develop policies governing the mammography program. In addition, the Radiology Service Chief needed to ensure that the mammography reporting methodology is consistent with the guidelines established by the American College of Radiology (ACR).

Timely breast cancer 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 in 2005. To

determine compliance, we used the standards outlined in VHA policy and the ACR Mammography Standards.

Local Mammography Policy. The healthcare system did not have written policies for the mammography program as required by VHA policy. Radiology Service managers provided us with a draft copy of a newly developed local policy at the conclusion of the CAP site visit. In addition, we found that final mammogram reports for the 10 patients in our sample did not contain the ACR-developed final assessment category. Radiology Service managers acknowledged the need to be consistent with the ACR Mammography Standards.

Screening, Biopsy Timeliness, and Referral. The healthcare system did not meet the VHA performance measure target goal of 85 percent for breast cancer screening in 3 of the 4 quarters of FY 2005. However, scores exceeded the target goal during the first and second quarters of FY 2006, as indicated in the graph below. Program managers stated that several aggressive action plans implemented in FY 2005, such as offering mammography services during the weekend and reminding patients of appointment times, resulted in improved compliance in FY 2006. The 10 patients' medical records showed that all were appropriately screened. Recent actions appeared to be effective in meeting this performance measure, and we have no recommendation about the healthcare system's breast cancer screening process.



Patients who were screened appropriately, notified of results within 30 days, notified of diagnoses, and received timely biopsy procedures	10/10 (100 percent)
Patients who received timely consultative services	8/8 (100 percent)

Recommendation 7. We recommended that the VISN Director ensure that the Healthcare System Director requires that Radiology Service managers (a) develop and implement mammography program policies as required and (b) comply with the ACR Mammography Standards reporting methodology.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that policies and procedures for a mammography program were developed and implemented on March 28, 2006, and that the reporting methodology now complies with the ACR Mammography Standards reporting methodology. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Part-Time Physician Time and Attendance – Desk Audits Needed To Be Completed

Condition Needing Improvement. The healthcare system needed to ensure that required semiannual timekeeper desk audits are performed. As of March 2006, the healthcare system had 11 timekeepers recording the time and attendance of 61 part-time physicians. VA policy requires the completion of semiannual timekeeper desk audits to ensure timekeepers properly record physician time and attendance. During FYs 2004 and 2005, the Payroll Supervisor did not perform 38 (86 percent) of the required 44 timekeeper desk audits. The Human Resources Management Service Chief stated that the audits were not performed due to a staffing shortage. In August 2005, the Network Payroll Manager became responsible for the completion of the healthcare system's timekeeper audits after the consolidation of the payroll activities within the VISN.

Recommendation 8. We recommended that the VISN Director and Healthcare System Director ensure the completion of the required semiannual timekeeper desk audits in accordance with VA policy.

The VISN and Healthcare System Directors agreed with the finding and recommendation. They reported that each payroll office will complete semiannual timekeeper audits by April and October of each year and that the payroll office completed all required timekeeper and desk audits by April 30, 2006. The timekeepers received a copy of the audits and any serious timekeeping issues which were identified were shared with the timekeepers and the immediate supervisors. The improvement plans are

acceptable, and we will follow up on reported implementation actions until they are completed.

Controlled Substances Accountability – Inventory Management and Controlled Substances Inspections Needed Improvement

Conditions Needing Improvement. The Pharmacy Service Chief and the Controlled Substances Coordinator (CSC) needed to improve inventory management controls and controlled substances inspections. Controls over drugs maintained in the pharmacy vault and physical security safeguards were generally effective. However, we identified four areas which needed improvement.

Controlled Substances 72-Hour Inventories. VHA policy requires that Pharmacy Service staff perform an inventory of all controlled substances a minimum of every 72 hours, or the equivalent of 2 to 3 inventories a week based on whether the pharmacies are open 5 days or more a week. Our review of the 72-hour inventory records for the period September 2005–February 2006 determined that nine inventories were not completed as required for the healthcare system's inpatient and outpatient pharmacies. According to the Pharmacy Service Chief, the inspectors called in sick and he could not find replacements at the last minute.

Controlled Substances Receiving Procedures. VHA policy requires that a Pharmacy Service employee and an accountable official from A&MMS receive and verify controlled substances orders, and that both employees must annotate receipts of the controlled substances on the appropriate forms. Our review of invoices for purchases of controlled substances during the period April–September 2005 showed that only a Pharmacy Service employee annotated the receipts of controlled substances. The Pharmacy Service Chief stated that he was unaware of the requirement to have an accountable official from A&MMS receive and verify controlled substances orders.

Monthly Controlled Substances Inspections. VHA policy requires controlled substances inspectors to conduct monthly unannounced inspections of all controlled substances storage areas. From March 2005–February 2006, 371 (94 percent) of the required 394 unannounced inspections were completed. During July–September 2005 and January 2006, 23 inspections (6 percent) were not completed. According to the CSC, these inspections were not completed because inspectors had problems accessing controlled substances storage areas, some inspection areas were closed due to patient related activities, and some inspectors did not consider the inspections a high priority.

Monthly Controlled Substances Inspection Procedures. VHA policy requires inspectors to verify that controlled substances are not outdated to ensure the safety of patients. During an OIG-observed controlled substances inspection, the inspector did not verify the expiration dates of all controlled substances stored in the Pyxis automated dispensing machine. According to the inspector, she did not verify the expiration dates of the

controlled substances because she was nervous in the presence of the auditor and did not want a confrontation with the Nurse Manager.

Recommendation 9. We recommended that the VISN Director ensure that the Healthcare System Director requires the Pharmacy Service Chief and CSC to ensure: (a) all 72-hour inventory checks are performed, (b) the accountable official annotates invoices, (c) all areas containing controlled substances are inspected monthly, and (d) inspectors verify all controlled substances expiration dates.

The VISN and Healthcare System Directors agreed with the findings and recommendations. They reported that staff have been assigned to complete controlled substance inventories; Logistics Service staff are now witnessing, verifying, and signing the shipping documents with Pharmacy Service staff when orders of controlled substances are received; all controlled substances storage areas are being inspected as required; and controlled substances expiration dates are verified during the daily refills of the Pyxis machines as well as during the monthly controlled substances inspections. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Community Nursing Home Evaluations – Monthly Follow-up Visits Needed Improvement

Condition Needing Improvement. The CNH program generally complied with VHA policy. However, patients did not consistently receive monthly follow-up visits. VHA policy requires a social worker or registered nurse to visit each VA patient in a CNH at least every 30 days, unless otherwise indicated by the patient's visit plan. These follow-up visits are necessary to ensure that treatment goals are being met and that the patient care provided is appropriate. Clinicians are also required to document observations and impressions about the overall quality of care in the CNH in the patients' medical records.

A review of the medical records of 10 patients who resided in CNHs during FY 2005 disclosed that the required monthly follow-up visits had not been completed. Program managers told us that the gaps in the monthly visits occurred because one program staff member was on extended leave. They acknowledged the oversight process needed to be improved.

Recommendation 10. We recommended that the VISN Director ensure that the Healthcare System Director requires CNH program staff to perform monthly follow-up visits.

The VISN and Healthcare System Directors agreed with the finding and recommendation. They reported that an improved auditing tool has been implemented in the Computerized Patient Record System to monitor monthly CNH visits. Reports from this audit tool are presented to the Geriatrics & Extended Care Oversight Committee and

the Review Team Committee on a monthly basis and to the healthcare system's Performance Improvement Council on a quarterly basis. In addition, the healthcare system's social worker and community health nurse plan to make early visits to the CNHs to ensure coverage when they have periods of planned leave. The improvement plans are acceptable, and we will follow up on reported implementation actions until they are completed.

Appendix A

VISN 22 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 2, 2006

From: Director, Veterans Integrated Service Network 22 (10N22)

Subject: **Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California**

To: Director, Los Angeles Audit Operations Division, Office of Inspector General (52LA)

I have reviewed and support the Director, VA Loma Linda Healthcare System, and the Acting Director, Network 22 Logistics Officer, responses to the VA Loma Linda Healthcare System's Combined Assessment Program (CAP) survey recommendations. Each recommendation has been individually addressed in the attached document, and acceptable action plans have been outlined for the remaining open items.

(original signed by:)

Kenneth J. Clark, FACHE

Attachment

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2006

From: Director, VA Loma Linda Healthcare System

Subject: **Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California**

To: Director, Los Angeles Audit Operations Division, Office of Inspector General (52LA)

Thru: Network Director, VISN 22 (10N/22)

Please find attached VA Loma Linda Healthcare System's response to the Combined Assessment Program (CAP) survey recommendations conducted March 27-31, 2006.

If you require any further information or clarification, please contact me or Ms. Mary D. Berrocal, Associate Director for Administration, at (909) 583-6002.

Sincerely,

Dean R. Stordahl

Attachment

Healthcare System Director Comments to Office of Inspector General's Report

The following Healthcare System Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) the ISO update the IT contingency plan to include an alternate processing site; (b) IRM staff promptly terminate computer access privileges when users separate from the healthcare system; and (c) the ISO ensures all users, including new employees, complete the required annual IT Security and Privacy Awareness training.

(a) Concur **Target Completion Date**: Completed – March 24, 2006

The Information Security Officer has updated the VA Loma Linda's IT contingency plan to include the Greater Los Angeles Healthcare System as the alternate processing site. An agreement with the Greater Los Angeles Healthcare System was submitted and approved on March 24, 2006.

(b) Concur **Target Completion Date:** September 30, 2006

The VA Loma Linda Medical Center's clearance form has been revised to ensure that Information Technology and Information Security clearance is a top priority. When Human Resources Management Service is aware of a situation that prompts placing an employee on administrative leave or detailed out of their assigned duties which stipulates specific computer access (CPRS, etc.), Human Resources Management Service immediately notifies Information Technology Service and/or the Information Security Officer to take appropriate action. In all cases where Information Technology Service is informed of a separation from duty through the appropriate clearance paperwork, Information

Technology staff promptly terminates computer access. Human Resources and Information Technology Service are coordinating a comprehensive process to ensure compliance with VA Loma Linda Healthcare System's policy on termination of computer access codes.

(c) Concur **Target Completion Date:** Completed – June 28, 2006

VA Loma Linda Healthcare System has ensured all staff complied with VA mandated training. Computer access codes for individuals that did not complete the training were suspended until the training was accomplished.

Recommendation 2. We recommend that the VISN Director ensure that the Healthcare System Director requires that SPD and Prosthetic managers ensure staff monitor item usage rates and reduce excess inventory.

Concur **Target Completion Date:** November 30, 2006 (SPD), September 30, 2006 (Prosthetics)

SPD managers continue to remain diligent in the use the Generic Inventory Package to manage supply inventories, monitor reports, and conduct physical inventories. The Stock Status Reports generated from VHA CO, which are used as a measure of the efficiency of this program, are reviewed for compliance monthly. The Stock Status Reports for this facility were pulled from the national reporting site and during the same timeframe as the OIG visit, March 31, 2006. The Inactive Supplies reported for Loma Linda SPD were 101 Inactive ($42,822.49), which is 5 percent of the March 31, 2006, closing balance of $819,579.30.

Although there appears to be some inconsistency in how these reports are interpreted, the Chief SPD and Logistics Manager continue to monitor both inactive and long supply inventory items to determine where inventory levels can be reduced or adjusted. We are currently reviewing the potential of reducing the number of items that are required to be maintained because of the clinical necessities. This necessitates weighing the guidelines against the need to have critical items for surgical procedures on-hand at a moment's

notice, which oftentimes creates an inactive or long supply status.

The Chief, SPD and Logistics Manager are initiating more comprehensive monitors to review inactive supplies and implementing processes to reduce slow moving inventory items.

The OIG Cap Report revealed a snapshot of the Prosthetic Inventory Program (PIP) from March 2005 to February 2006. The PIP inventory report from March 1 to July 18, 2006, was reviewed and the status of the PIP inventory is as follows:

1. Active PIP inventory lines totaled 424. There has been a reduction of 622 inventory lines items which contain zero balances.
2. Inventory line items exceeding the 30-day supply is 314.

The monthly comparison of "Items Greater than 30-days Stock on Hand All New Item" which is reported by Prosthetics and the Clinical Logistics Office (10FP) indicates the dollar value of stock on hand greater than 30 days is $191,820. This total represents 1.62 percent (Yellow Indicator) of the total June 2006 inventory budget. Currently, Prosthetics is well within the Scorecard Performance Guidelines for PIP Inventory. (Scorecard Indicators: Green indicator = 1% <the budget allocation; Yellow indicator = 1.01% to 1.90%; Red indicator = >1.90%).

The Chief of Prosthetics, Logistics Manager, and Chief of SPD are coordinating a process to continue to reduce the surgical implant inventory and any additional excess inventory. The process will include a mechanism for staff to monitor inventory usage rates.

Recommendation 3. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) designated staff members inform patients who experience adverse events of their rights to file claims and document these discussions in progress notes; (b) the Healthcare Quality Improvement Coordinator provides detailed analyses of UM data, and the Chief of Staff takes appropriate actions when goals are not met; (c) the Patient Advocate performs detailed patient complaints analyses and presents trended reports to senior managers; and (d) the Health Information Manager coordinates a comprehensive medical record review process that meets all applicable requirements.

(a) Concur **Target Completion Date:** Completed – April 3, 2006

Adverse Event Disclosure Process: VA Loma Linda Healthcare System's disclosure policy now clearly defines the responsibilities of staff. The patient's treating physician determines who will disclose the clinical aspect of the event. Social workers, chaplains, patient advocates, or other staff may be present to offer support. Institutional disclosure may be appropriate depending on the severity of injury and/or the degree of risk for legal liability. The Chief of Staff or his designee will invite the patient to meet for institutional disclosure to inform them of their right to file a claim. The Risk Manager, treating physician, or other VHA personnel as appropriate may be included in this conference.

(b) Concur **Target Completion Date:** August 31, 2006

Utilization Management: The Medical Center's UM Oversight Committee is chaired by the Chief of Staff and members include the Associate Director for Patient Care and Nursing Services, the Chiefs of Medicine, Surgery, Neurology and Behavioral Medicine Services, a Medicine Service Hospitalist, the QM Coordinator and a UM Review Nurse. Upon reviewing the OIG/CAP input provided during the site visit, the committee realized that, in fact, actions had been taken that were not well documented as a result of analysis of UM data. For example, the need for a Surgical Step-Down Unit was identified in 2004 because some surgeons admitted their post-op patients to ICU because the

only other option was the regular surgical ward. The Unit was established in 2005, but not well documented in Committee minutes.

The Committee has increased the frequency of their meetings from quarterly to monthly to facilitate in-depth analysis of data. We determined that it was difficult locally to identify specific problems because VISN 22 Reason Code categories are broad, e.g., "Practitioner Factors" includes four subcategories and an "Other" for reasons not covered by the other four subcategories. We further defined the "Other" subcategory to identify problems specific to our Medical Center. Consistently, the greatest percentage of our admissions that do not meet criteria are due to the "reason code" that states "Monitoring orders do not reflect acuity as indicated by SI criteria," i.e., the patient is not sufficiently ill to warrant the level of care to which that are admitted. Beginning in second quarter of 2006, we added to the "reason code" an element that further defines that the patient met criteria for acute care but fell out because they were admitted to ICU because no acute-care bed was available. This is but one example of elements we have added to reason codes to provide more definitive feedback to providers and thus develop action plans.

(c) Concur **Target Completion Date:** Completed – June 15, 2006 and Ongoing Process

Starting at the June 15, 2006 Service Quality Council (SQC) meeting, the Veterans Satisfaction Office reported on May 2006 patient complaints, and will report monthly on those areas with the highest number of complaints. The May data showed that the top three areas of complaints centered on 1) requesting information, 2) information assistance, 3) and access and timeliness in Pharmacy and two modules. Discussion and action items are now reflected in the minutes of each meeting. In the June SQC meeting, it was identified that complaints were not reaching the supervisory level, such as in ambulatory nursing, for action. The major SQC action item identified at the meeting was to work on the module complaints. The Nursing Module Clinic Manager will be informed of any module complaints so she can act to resolve

these issues immediately. The Nursing Module Clinic Manager and the Veteran Satisfaction Office will report back to the SQC on how the new process is working. It was requested that we provide the complaints by the name of the sections that requested a breakout of data and we will monitor the complaints for those sections. SQC will forward complaint data to all service chiefs to monitor areas that impact their own services.

Patient complaints and compliments are entered into the national database by the patient advocates at the facility as well as the Community Based Outpatient Clinic nurse coordinator. Complaints and compliments arise from personal contacts, Congressional letters, phone calls, "We Care" surveys, and patient letters. The Veterans Satisfaction Coordinator audits the patient complaint logs on a monthly basis to assure they are being entered into the national database.

(d) Concur **Target Completion Date**: July 10, 2006 – Item Closed

Medical Record Reviews and Analyses: In June 2006, QM developed a systematic review process that encompasses all required items. Records are reviewed by staff at the point of care as required by JCAHO. The review is structured so that each discipline is responsible for reviewing records pertinent to the care they provide. Documentation by all appropriate disciplines on the Interdisciplinary Plan of Care and documentation of early discharge planning have been identified as problematic issues and are being addressed.

Recommendation 4. We recommend that the VISN Director ensure that the Network Logistics Office Director: (a) ensures that contracting officers do not award contracts that exceed their authorized warrant authorities and (b) contracting officers prepare PNMs and document price determinations in the contract files of negotiated contracts.

(a) Concur **Target Completion Date:** Completed

Concur with recommendations for two contracting officers and three awarded contracts. The CAP Review finding has

been communicated to the two contracting officers that did not have authority to award the three contracts. 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 Loma Linda Healthcare System will also be provided to the acquisition staff. Lastly, the Network Contract Manager (NCM) has implemented a procedure to review pending and active contract files monthly on a random basis, as per memorandum dated June 8, 2006.

(b) Concur **Target Completion Date:** Completed

Price Negotiation Memorandum: Concur with recommendations for four of the eight negotiated contracts reviewed.

The CAP Review finding has been communicated to the contracting officers involved. The Acquisition section will continue to utilize the Contract File Checklist. In addition, the Acquisition supervisors will remind contracting officers during staff meetings to adhere to the requirement for a PNM. The final report of the CAP Review of the VA Loma Linda Healthcare System will also be provided to the acquisition staff. Lastly, the NCM has implemented a procedure to review pending and active contract files monthly on a random basis, as per memorandum dated June 8, 2006.

Recommendation 5. We recommend that the VISN Director ensure that the Healthcare System Director requires clinicians to provide and document appropriate interventions for diabetic patients when HbA1c and LDL-C levels are elevated.

Concur: **Target Completion Date:** Completed

Action Plan and Status:

Issue	Action	Responsible Person(s)	Status
1. Ability to run reports on patients with atypical antipsychotic medications for cholesterol, blood pressure, diabetes and weight.	1. Create Clinical Reminders for reporting purposes	ACOS/Education	Completed
2. Ongoing monitoring of patient's for patients blood pressure, glucose, weight and cholesterol a. Not all patients have primary care provider b. Psychiatrists need protocols and reminders to order tests in a timely manner and to refer patients when tests abnormal c. Psychiatrists need a means of referring patients for further treatment if abnormalities are found	1. Develop Clinical Reminders for BHOST physicians to monitor FBS, Hgb A1c 2. Patients without a Primary Care Provider who need to be referred when tests are abnormal will be seen same day and assigned a provider through the Intake Clinic.	1. ACOS/ Education 2. Chief General Internal Medicine	Completed Completed
3. Order sets for atypical antipsychotic medications to include required labs.	1. Develop order sets for medications that include monitoring labs as outlined in the directive	1. Pharmacy Service	Completed
4. Administrative management of reports	1. Physicians will receive alerts on patients with abnormalities. 2. Pharmacy run routine reports for patient on medication for purposes of monitoring compliance 3. Administrative reporting of compliance through the CGC.	1. Pharmacy Service 2. Pharmacy Service 3. Program Manger Behavioral Health	Completed Completed Completed

Clinical Reminders for Atypical Antipsychotic Medications used for reporting.

1 Atypical Antipsychotic Medications
2 Atypical Antipsychotic Meds A1c<10
3 Atypical Antipsychotic Meds A1c<7
4 Atypical Antipsychotic Meds A1c<8
5 Atypical Antipsychotic Meds A1c<9
6 Atypical Antipsychotic Meds BMI<25
7 Atypical Antipsychotic Meds BMI<25 DM
8 Atypical Antipsychotic Meds BMI<27 DM

9 Atypical Antipsychotic Meds BMI<30 DM
10 Atypical Antipsychotic Meds BMI<35 DM
11 Atypical Antipsychotic Meds BMI<40 DM
12 Atypical Antipsychotic Meds BP<130/80 DM
13 Atypical Antipsychotic Meds BP<140/90
14 Atypical Antipsychotic Meds BP<140/90 DM
15 Atypical Antipsychotic Meds BP<150/90 DM
16 Atypical Antipsychotic Meds BP<160/100
17 Atypical Antipsychotic Meds BP<160/100 DM
18 Atypical Antipsychotic Meds LDL<100 DM
19 Atypical Antipsychotic Meds LDL<110 DM
20 Atypical Antipsychotic Meds LDL<120 DM

*DM – means Diabetes Mellitus and denotes reminders developed to monitor diabetic patients on Atypical Antipsychotic Medications.

Recommendation 6. We recommend that the VISN Director ensure that the Healthcare System Director requires A&MMS staff to promptly forward "ROS" to the Director and include all sensitive equipment items on EILs.

(a) Concur **Target Completion Date:** Completed – May 30, 2006

Report of Survey (ROS) Boards of Survey were immediately appointed (beginning the first week in April 2006) for the six (6) ROS totaling $84,541.Chief, Logistics Officer and Chief, of Materiel Management, immediately reviewed the Board of Survey recommendations for the seventh ROS. A response to the recommendations was prepared and forwarded to the Director for review and approval/disapproval. All Reports of Survey were completed on May 30, 2006, and recommendations approved by the Director's Office. Final disposition of equipment has been documented.

(b) Concur **Target Completion Date:** Completed – May 30, 2006

Sensitive Items: VA Directive 7127/4 was issued in October 2005. Loma Linda Healthcare System (LLHCS) started the process in late 2005 of adding sensitive items to appropriate EILS as scheduled inventories were conducted. All sensitive items have now been physically inventoried and recorded on the appropriate EIL(s). A total of 713 sensitive items have

been added to the LLHCS EILs. As new equipment is purchased, sensitive items are placed on the appropriate EIL. During the OIG Visit the Surveyor was informed that Materiel Management has a process in place to conduct a quarterly inventory to account for ammunition. After discussions with National and VISN Materiel Management Officials, it was decided that the feasibility of tracking ammunition in the EIL package would be inefficient and it should be included in the Generic Inventory Package (GIP).

Recommendation 7. We recommend that the VISN Director ensure that the Healthcare System Director requires that Radiology managers: (a) develop and implement mammography program policies as required and (b) comply with the ACR mammogram reporting methodology.

(a) Concur **Target Completion Date:** Completed – March 28, 2006

The policies and procedures requested for the mammography program were developed and implemented on March 28, 2006.

(b) Concur **Target Completion Date:** Completed – March 27, 2006

The mammography reporting methodology was changed to reflect the OIG/CAP recommended numerical system (0,1,2,3,4,5) on March 27, 2006.

Recommendation 8. We recommend that the VISN Director and Healthcare System Director ensure the completion of the required semiannual timekeeper desk audits in accordance with VA Policy.

Concur **Target Completion Date:** Completed – April 30, 2006

The semiannual timekeeper audits will be completed by April and October of each year by each payroll office. The Loma Linda payroll office completed all required timekeeper and desk audits by April 30, 2006. Timekeepers received a copy of the audit and the originals are filed in the payroll office. Any serious timekeeping issues identified were shared with the timekeeper and immediate supervisor.

Recommendation 9. We recommend that the VISN Director ensure that the Healthcare System Director requires the Pharmacy Service Chief and CSC to ensure: (a) all 72-hour inventory checks are performed, (b) the accountable officer annotates invoices, (c) all areas containing controlled substances are inspected monthly, and (d) inspectors verify controlled substances expiration dates.

(a) Concur **Target Completion Date:** August 15, 2006

Staff are being assigned to complete inventories as described. Implementation by August 15, 2006.

(b) Concur **Target Completion Date:** Completed – May 2006

Action has already been implemented to address this recommendation. Logistics personnel have been witnessing the receipt and verification of controlled substances orders received from suppliers with Pharmacy staff and began signing the shipping documents for controlled substances since May 2006.

(c) Concur **Target Completion Date:** Completed – June 2006

All controlled substance storage areas are inspected during the unannounced monthly inspections. From February 2006 through June 2006, 175 (100%) of the required 175 unannounced inspections were completed.

(d) Concur **Target Completion Date:** Completed/Ongoing

Controlled substance expiration dates are verified daily during Pharmacy Service refill of the Pyxis machines, and

during monthly inspections the inspectors verify all controlled substances expiration dates. This is annotated in the facility's inspector monthly report. The reported discrepancy was a human error (checking of expiration dates). These types of errors are corrected timely and during continuing training.

Recommendation 10. We recommend that the VISN Director ensure that the Healthcare System Director requires CNH program staff to consistently perform monthly follow-up visits.

(a) Concur **Target Completion Date:** Completed – April 2006

In April 2006, improved auditing tool is in place to monitor monthly documented visits in the Computerized Patient Record System (CPRS) by the VA Loma Linda Social Worker and Community Health Nurse.

(b) Concur **Target Completion Date:** Completed June 2006 and Ongoing

Routinely reporting audit tool findings at monthly Geriatrics Extended Care (GEC) Oversight Committee and monthly Review Team Committee meetings.

(c) Concur **Target Completion Date:** Completed June 2006 and Ongoing

Report audit tool findings at the Medical Center's performance Improvement Council (PIC) meetings on a quarterly basis.

(d) Concur **Target Completion Date:** Completed June 2006 and Ongoing

Copies of the monthly GEC Oversight Committee and Review Team meeting minutes are furnished to the Chair of Medical Center Performance Improvement Council.

(e) Concur **Target Completion Date:** September 30, 2006

VA Loma Linda Social Worker and Community Health Nurse will plan early visits of nursing homes to cover those timeframes when they have planned leave.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds
2	Reduce excess medical and prosthetic supply inventories.	$669,021

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Janet C. Mah (310) 268-4335
Acknowledgments	Julio Arias Daisy Arugay Andrew Hamilton Tamara Jacobson Rosetta Kim Andrea Lui Shoichi Nakamura Michelle Porter Maurice Smith Julie Watrous Jeff Wieters

Appendix E

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