Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Muskogee VA Medical Center, Muskogee, Oklahoma

Report No. 06-00896-212 **September 18, 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 March 20–24, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Muskogee VA Medical Center (VAMC, also referred to as the medical center). 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 300 employees. The Medical Center is under the jurisdiction of Veterans Integrated Service Network (VISN) 16.

Results of Review

The CAP review covered 14 operational activities. The medical center complied with selected standards in the following seven activities.

- Accounts Payable
- Accounts Receivable
- All Employee Survey
- Breast Cancer Management
- Contract Award and Administration
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care (EOC)

We made recommendations in 7 of the 14 activities reviewed. To improve operations, we made the following recommendations:

- Community Nursing Home (CNH) – Program oversight needs to be improved.
- Quality Management – Reporting of Peer Review results to Medical Executive Board needs to be improved.
- Improve physical controls and prescription documentation for controlled substances.
- Strengthen equipment accountability controls by adjusting Equipment Inventory Lists (EILs) timely and documenting equipment assignments accurately.
- Improve information technology (IT) security by updating virus protection files on wireless computers and restricting access to communications closets.
- Increase Medical Care Collections Fund (MCCF) collections by obtaining insurance information.

- Strengthen supply inventory management and reduce stock levels.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, Dallas Regional Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN 16 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 13–18 for the full text of the Directors' comments. Please note that the attachments referenced are not included in this report.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is a general medical and surgical facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics (CBOCs) in Tulsa and McAlester. The medical center is part of the South Central VA Healthcare Network that provides care to over 42,250 enrolled veterans in the 25 counties in its service area.

Programs. The medical center has 50 hospital beds which provide primary and consultative care in medicine, surgery, and mental health. Preventive and acute health care is provided through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation, oncology, dentistry, and geriatrics.

Affiliations and Research. The medical center has 28 academic affiliations including the University of Oklahoma-Tulsa Colleges of Medicine and Pharmacy, Oklahoma State University's College of Osteopathic Medicine, University of Tulsa, Southwestern Oklahoma State University, Connors State College, Bacone College, Northeastern State University, Indian Capital Technology Center, and numerous other colleges and universities with allied health programs.

Resources. The medical center's fiscal year (FY) 2005, medical care budget was $105.5 million. FY 2005 staffing was 688.3 full-time equivalent (FTE) employees, including 53 physician FTE and 178 nursing FTE.

Workload. In FY 2005, the medical center had 3,028 admissions and 306,170 total outpatient visits. The total of 31,558 unique veterans treated comprised a 3 percent increase from FY 2004.

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 benefit 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, quality management, 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 14 activities:

- Accounts Payable
- Accounts Receivable
- All Employee Survey
- Breast Cancer Management
- Community Nursing Home Contracts
- Contract Award and Administration
- Controlled Substances Accountability
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Equipment Accountability
- Information Technology Security
- Medical Care Collections Fund
- Quality Management
- Supply Inventory Management

The review covered medical center operations for FY 2005 and FY 2006 through March 24, 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 medical center (*Combined Assessment Program Review of the Muskogee VA Medical Center, Muskogee, OK*, Report No. 03-02374-017, November 7, 2003).

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

During this review, we also presented fraud and integrity awareness briefings for 300 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report we made 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 7–12). For those Audit activities not discussed in the report, there were no reportable deficiencies.

Results of Review

All Employee Survey – All Employee Survey Was Effectively Administered

Condition Needing Improvement. None. VHA administers an All Employee Survey (AES) every 3 years throughout the entire system to assess employee and organizational satisfaction. The Executive Career Field (ECF) Performance Plan for FY 2005 directs that the VISN will ensure the results from the 2004 AES are widely disseminated throughout the network.

The medical center met all requirements of Performance Measure 22 (Work Force Planning and Program Implementation), ECF Performance Plan for FY 2005. The AES site coordinator obtained survey results via the Proclarity website, and they were distributed throughout the facility by town hall and service level meetings.

Facility analysis of the survey results included a review of all factors by each service, with staff selecting two areas from each section of the survey for improvement. The action plans, developed by the service line managers and designated work groups, have measurable objectives with identified timelines and milestones. The action plans were developed by the deadline of September 30, 2004. The AES coordinator distributed the action plans to the employees by hard copy and e-mail. Actions taken to improve the work environment were well documented.

Breast Cancer Management – Processes were Timely and Appropriate

Condition Needing Improvement. None. The medical center met the VHA performance measure for breast cancer screening, provided timely Radiology, Surgery, and Oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center exceeded the target level for all 4 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes.

Mammogram services were offered to the patients by fee-basis providers. Timely radiology, surgery, and oncology consultative and treatment services were provided to the patients by the medical center. An interdisciplinary treatment plan was developed, and providers promptly informed the patient of diagnosis and treatment options.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center exceeded the target level for all 4 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. This review included a case from 2004 in order to meet the 10 patient case review requirement.

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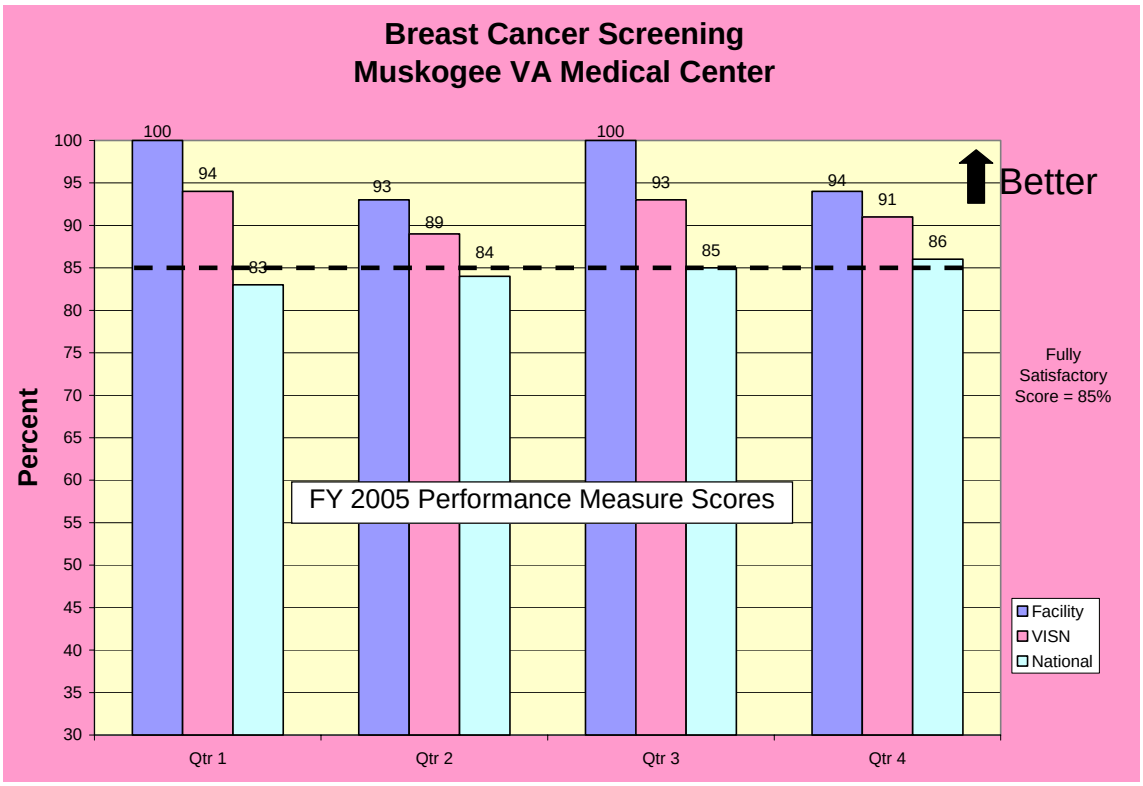

Patients appropriately screened	Mammography Results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
10/10	10/10	10/10	10/10	10/10

Diabetes and Atypical AntiPsychotic Medications – Patients Were Appropriately Screened and Managed

Condition Needing Improvement. None. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

Criteria. VHA clinical practice guidelines for the management of diabetes suggests that: a diabetic patient's hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, be maintained at less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl).

To receive fully satisfactory ratings for the diabetes performance measures, the medical center must achieve the following quarterly scores:

- HbA1c greater than 9 percent (poor control) – 15 percent (lower percent is better)
- Blood Pressure less than or equal to 140/90mmHg – 72 percent (higher percent is better)
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent (higher percent is better)

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggests that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. A normal FBG is less than or equal to 110 mg/dL. Patients with FBG values greater than 110 mg/dL but less than 126 mg/dL should be counseled about prevention strategies (calorie-restricted diets, weight control, and exercise). A FBG value greater than or equal to 126 mg/ dL on at least two occasions is diagnostic for diabetes. Screening and counseling are not currently VHA performance measures.

Findings. We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. One of the 13 had diabetes. The review showed that the medical center met or exceeded VHA performance measures for diabetes management, and the 12 non-diabetic patients were appropriately screened for diabetes, and appropriately counseled about diabetes prevention.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
100 percent (1/1)	100 percent (1/1)	None (0/1)	100 percent (12/12)	100 percent (12/12)

Environment of Care – No Areas Needed Improvement

Condition Needing Improvement. None. Veterans Health Administration (VHA) policy requires a safe and clean healthcare environment. The medical center must establish a comprehensive environment of care program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards. To evaluate EOC, clinical and non-clinical areas are inspected for cleanliness, safety, infection control, and general maintenance. The medical center maintained a clean and safe environment with no reportable findings or recommendations.

Opportunities for Improvement

Community Nursing Home – Program Oversight Needed To Be Improved

Condition Needing Improvement. The medical center had incomplete information on the CNH website, which was established in November 2005 with CNH Team Coordinator access granted December 2005. All contracted nursing home information must be entered on the CNH website and updated quarterly by the coordinator. At the beginning of this CAP, only 3 of 20 contracted nursing homes were listed on the website. Fifteen more nursing homes were added during the site visit. The following week, information was amended to include the two remaining nursing homes. The CNH Coordinator could not provide documentation which demonstrated prior efforts to achieve this mandated task in a timely manner.

Documentation for the annual inspection of the community nursing homes was incomplete. An infection control checklist was implemented, but it was not completed for the previous annual inspections on four of five nursing homes that were reviewed. There were discrepancies identified on four of five patient charts during an annual inspection, with no documentation to demonstrate that these were corrected. The medical center revised the infection control checklist while inspectors were on site.

There was no documented evidence that Centers for Medicare and Medicaid Services Quality Measures were reviewed or monitored. The CNH Team Coordinator informed the healthcare inspectors that the quality measures were discussed during the Long Term Care Committee meetings, but these discussions were not documented. Two of the five nursing homes reviewed had no documented follow-up on corrective action plans for deficiencies. The two nursing homes had six or greater quality measures above state average. The state average for deficiencies in Oklahoma is nine. The two nursing homes inspected had 15 and 18 deficiencies respectively. The CNH Team Coordinator did not demonstrate or verify that corrective action plans were implemented for the deficiencies.

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) update the CNH website on a quarterly basis; (b) improve documentation of annual CNH inspections and review of quality measures; and (c) develop and document corrective action plans for deficiencies which are monitored by the CNH Team.

Quality Management – Reporting of Peer Review Results to Medical Executive Board Needed To Be Improved

Condition Needing Improvement. We found the Peer Review Committee (PRC) did not report to the Executive Committee of the Medical Staff (ECMS) on a quarterly basis as established in Medical Center Memorandum 11-13. Our review of the ECMS meeting minutes revealed there was no systematic approach to reporting the cases that had been peer reviewed by the PRC. Reports were submitted twice between March 2005 and February 2006.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires all cases brought to the PRC meetings for discussion and review are reported quarterly to the ECMS.

Controlled Substances Accountability – Controls Needed To Be Strengthened

Condition Needing Improvement. Management needed to improve outpatient pharmacy security and ensure that written prescriptions for Schedule II controlled substances include all required information. Required 72-hour controlled substances inventories were performed, and controls over drugs maintained in the pharmacy vault were effective. The controlled substances inspectors were trained and monthly inspections of controlled substances included excess, outdated, and unusable substances awaiting destruction. However, we identified two areas that needed improvement.

Security Specifications Not Met. Management needed to ensure that physical security for dispensing areas was met. We inspected the outpatient pharmacy dispensing areas at the medical center and the Tulsa outpatient clinic and found that the walls and windows protecting the two dispensing areas did not meet the required specifications. Medical center management cited their desire to maintain a face-to-face relationship with patients as the reason that the walls and windows did not meet the required specifications. However, they agreed to upgrade the dispensing areas to meet specifications so long as they could station pharmacy technicians outside of the dispensing areas to receive prescriptions through a pass-through window and distribute the prescriptions to patients over a counter. This change would allow medical center and outpatient clinic personnel to maintain face-to-face contact with patients while still meeting VA requirements.

Prescriptions Not Properly Completed. Management should ensure that written prescriptions for Schedule II controlled substances contain all of the required information. VHA policy requires that prescriptions contain the full name and address of the patient; include the name, address, and Drug Enforcement Administration registration number of the practitioner; and be signed and dated. We reviewed 17 written prescriptions for completeness and found that 11 (65 percent) did not contain patients' full names and none contained addresses. Pharmacy Service management told us that

practitioners could not always get to a computer to look up the full names and addresses of the patients when writing the prescriptions. However, they agreed that physicians should put the patients' full names and last four digits of the patients' social security numbers on the prescriptions and the pharmacy could attach address labels to the backs of the prescriptions. These procedures would meet VHA requirements.

Recommended Improvement Action 3. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) walls and windows in outpatient pharmacy dispensing areas meet VA security specifications and (b) prescriptions for Schedule II controlled substances include all of the required information.

Equipment Accountability – Controls Needed To Be Strengthened

Condition Needing Improvement. Medical center management needed to improve procedures to ensure that nonexpendable and sensitive equipment is properly accounted for and safeguarded. VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded on Equipment Inventory Listings (EILs). Acquisition and Materiel Management Service (A&MMS) personnel are responsible for coordinating the inventories, notifying all services when inventories are due, following up on incomplete or delinquent inventories, and adjusting EILs when discrepancies are identified. Although the medical center had made improvements in equipment accountability procedures since the last CAP review, improvements were still needed.

As of December 31, 2005, the medical center had 68 active EILs including 6,428 equipment items with a total acquisition value of $21.7 million. We identified two equipment accountability issues that required corrective actions.

EILs Not Adjusted Timely. A&MMS personnel did not adjust EILs at the time that equipment was turned in or reported lost or missing. VA policy requires that adjustment vouchers be prepared to adjust overages and shortages identified during EIL inventories or whenever equipment items are added, turned in, or reported as lost or missing. Because A&MMS personnel did not prepare adjustment vouchers timely, equipment items continued to appear on EILs even though previous EILs had been annotated to show that the equipment was missing or had been turned in.

In May and October 2005, medical center management hired new A&MMS personnel who were assigned the responsibility for equipment accountability. Prior to that time, the positions had been vacant for several months. In addition, previous A&MMS personnel had not completed EIL inventories or made adjustments for at least 1 year. In December 2005, the new A&MMS personnel, along with responsible officials in each service, conducted a wall-to-wall inventory of all equipment. They identified 1,253 equipment items with a total estimated acquisition value of $1.3 million that were listed on EILs but

could not be located. These items were purchased between 1987 and 2003 and had depreciated in value. Medical center management made the decision to delete all missing equipment from the EILs at one time because the discrepancies dated back at least 3 years, the true disposition of the equipment was not known, and no evidence of fraud, waste, or abuse was found. Adjustments to the EILs were completed in February 2006. Not adjusting inventory records in a timely manner compromises the integrity of inventory records and increases the risk of theft. At the time of our review, A&MMS personnel had instituted procedures that should ensure that inventory records are adjusted timely when items are turned in or reported as lost or missing.

EIL Data Not Accurate. To determine if nonexpendable and sensitive equipment was properly accounted for and recorded on EILs, we reviewed a sample of 23 items listed on 11 separate EILs. We were able to locate all 23 items. However, on one EIL the name of the VA police officer assigned one handgun was incorrect, and the name of the officer assigned another handgun was not shown on the EIL. A&MMS personnel told us that the EIL was incorrect because VA Police Service had not informed A&MMS when the handguns were reassigned.

Recommended Improvement Action 4. We recommend the VISN Director ensure the Medical Center Director requires that: (a) A&MMS personnel adjust EILs promptly when discrepancies are identified or when items are turned in or reported as lost or missing and (b) EILs accurately reflect equipment assignments.

Information Technology Security – Controls Needed To Be Strengthened

Condition Needing Improvement. We evaluated IT security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, or misuse. The medical center had implemented effective controls to ensure that sensitive information is removed from computers prior to disposal and that IT users have appropriate computer access and privileges. Medical center personnel addressed computer service continuity through comprehensive contingency plans and local policies. They also implemented a cyber security training program that had a 100 percent compliance rate for FY 2005. However, controls needed to be strengthened in two areas.

Files Not Updated. Information Resources Management (IRM) personnel had not installed updated virus protection files on 4 of the medical center's 30 wireless laptop computers. In addition, the medical center did not have procedures to ensure that all wireless computers received Windows updates. IRM personnel told us that they regularly performed virus protection and Windows updates for network computers. However, computers that were not connected to the network when updates were performed did not receive the updated files. As a result of our review, IRM personnel

established procedures so that all wireless computers that are not connected to the network at the time of scheduled updates will immediately receive the updated files the next time they access the network.

Access to Communications Closet Not Properly Restricted. Access to one communications closet was not properly restricted. VA policy requires that physical security controls restrict the entry and exit of unauthorized individuals from IT areas containing wiring, telephone and data lines, backup media and source documents, and any other elements required for the system's operation. We inspected 15 communications closets and found that 1 closet had a wall that did not extend from the floor to the ceiling. As a result, unauthorized individuals had access to computer switches that controlled network operations.

Recommended Improvement Action 5. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) all wireless computers on the network receive virus protection and Windows update files in a timely manner and (b) all communications closets be constructed in a manner that limits access to authorized personnel.

Medical Care Collections Fund – Identification of All Insured Veterans Would Increase Collections

Condition Needing Improvement. Medical center management needed to improve compliance with medical center procedures for identifying veterans with health insurance coverage. Under the MCCF program, VA is authorized to bill health insurance carriers for certain costs related to the treatment of insured veterans. Successful recovery of costs requires that medical center staff accurately identify veterans with insurance.

Medical center procedures require that insurance information be obtained at the time of treatment. Clinic staff should ask veterans if they have insurance or if their coverage has changed and obtain copies of the veterans' insurance cards. We observed check-in procedures in five clinics and found that the intake clerk in one clinic did not comply with the requirement to inquire about insurance coverage. Medical center management was unsure why the clerk had not inquired about insurance coverage but agreed that the clerk should have inquired.

Recommended Improvement Action 6. We recommend the VISN Director ensure that the Medical Center Director requires that intake clerks follow medical center procedures to obtain and update veterans' insurance information at the time of treatment.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened and Stock Levels Needed To Be Reduced

Condition Needing Improvement. The medical center needed to maintain accurate inventory records in the Supply Processing and Distribution (SPD) activity and reduce stock levels of medical supplies. VHA policy requires that medical facilities use the automated Generic Inventory Package (GIP) and Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, GIP and PIP data showed that the medical center's supply inventory included medical items valued at $93,597, prosthetics items valued at $61,225, and engineering items valued at $69,954.

Inaccurate Inventory Records. To assess the accuracy of GIP and PIP data, we inventoried 34 line items—20 medical, 4 prosthetics, and 10 engineering line items—with a recorded value of $23,424. Except for one discrepancy, an overage of $25, we found that inventory records for prosthetics and engineering line items were accurate. However, stock levels for five medical line items in the SPD activity were inaccurate, with two shortages valued at $401 and three overages valued at $578. The actual value of the 20 medical line items inventoried was $15,962, which was 1 percent higher than the recorded value of $15,785. Applying this 1 percent to the total medical inventory, the restated value would be $94,533 ($93,597 x 1.01), which was $936 more than the recorded value. The inaccurate inventory records occurred primarily because SPD personnel and nursing staff did not promptly or accurately record receipts and distributions of supplies.

Excess Medical Inventory Stock. The medical center needed to reduce stock levels of medical supplies. To determine if medical stock levels could be reduced while still meeting the medical center's needs, we compared the quantities on hand to usage data for 20 medical line items. We found that the medical center needed to reduce stock levels for 6 (30 percent) of the 20 line items. The value of the excess stock was $2,051, which was about 13 percent of the actual value ($15,961) of the 20 line items we inventoried. Based on the restated value of the medical inventory, the estimated value of excess stock was $12,289 ($94,533 x 13 percent). Overstocking ties up money in stock and increases the risk of damage, outdating, contamination, or obsolescence of inventory items.

Recommended Improvement Action 7. We recommend the VISN Director ensure the Medical Center Director takes action to: (a) ensure that SPD personnel and nursing staff promptly and accurately record receipts and distributions of medical supplies and (b) reduce medical stock levels to the minimum needed to meet the medical center's needs.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 31, 2006

From: VISN Director

Subject: **Muskogee VA Medical Center Muskogee, Oklahoma**

To: Assistant Inspector General of Healthcare Inspections

VISN 16 concurs with the Medical Center's response.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 31, 2006

From: Medical Center Director

Subject: **Muskogee VA Medical Center Muskogee, Oklahoma**

To: Assistant General for Healthcare Inspections

Please find our response below.

Medical Center Director's Comments to Office of Inspector General's Report

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the medical center Director takes action to (a) update the CNH website on a quarterly basis; (b) improve documentation of annual CNH inspections and review of quality measures; and (c) develop and document corrective action plans for deficiencies which are monitored by the CNH Team.

Concur **Target Completion Date:** July 2006

(a) The CNH website was updated in March 2006. The website will be updated on a quarterly basis by the Community Care Coordinator and the Home Based Primary Care Program Manager will monitor the website on a quarterly basis to ensure compliance.

(b) The CNH inspection form for infection control was revised March 2006 to reflect a yes, no and comment regarding each question and discussed at the time of exit from the CNH.

(c) Community Care Coordinator will review all of the discipline's inspection forms to ensure completeness and identify any deficiencies prior to exit with the CNH administrative staff. The Community Care Coordinator will monitor the program to ensure documentation of the deficiencies found at the CNH inspections and will coordinate and document follow up corrections to the Long Term Care Committee July 2006.

This action plan will be an ongoing process. Recommend that action 1 be closed.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director require all cases brought to the PRC meetings for discussion and review are reported quarterly to the ECMS.

Concur **Target Completion Date:** 4/17/06

Peer Review information was presented to ECMS at the April 2006 meeting. The action plan for peer review to be presented to ECMS quarterly will be an ongoing process. Recommend that action 2 be closed.

Recommended Improvement Action 3. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) walls and windows in outpatient pharmacy dispensing areas meet VA security specifications and (b) prescriptions for Schedule II controlled substances include all of the required information.

Concur **Target Completion Date:** 4/1/07

(a) A design has been implemented to ensure compliance with the VA security specification for the walls and windows in outpatient dispensing areas. Target completion date is April 1, 2007.

(b) Beginning 4/7/06 patients' full name and address was placed on all Schedule II prescriptions. Chief of Pharmacy monitors the Schedule II prescriptions on a monthly basis and will report findings to the Pharmacy and Therapeutic Committee starting July 2006. This action plan will be an ongoing process. Recommend that action 3, (b) be closed.

Recommended Improvement Action 4. We recommend the VISN Director ensure the Medical Center Director requires that: (a) A&MMS personnel adjust EILs promptly when discrepancies are identified or when items are turned in or reported as lost or missing and (b) EILs accurately reflect equipment assignments.

Concur **Target Completion Date:** 6/23/06

(a) A&MMS developed a policy, MCM 90-5, Report of Survey Procedure, published February 7, 2006 prior to the Combined Assessment Program Review in March 2006. Please see attachment 4. A&MMS completed all necessary actions to ensure the intent of the above cited recommendations were met prior to the departure of the audit team in March 2006. A&MMS leadership will continue to comply with the implemented policies and procedures that address timely processing of turn-ins and accuracy of EILs.

(b) A&MMS has monitored the EILs assigned to police officers to ensure compliance and prepared a written report to the Associate Director. This action plan will be an ongoing process. Recommend that action 4 be closed.

Recommended Improvement Action 5. We recommend the VISN Director ensure that the Medical Center Director requires that: (a) all wireless computers on the network receive virus protection and Windows update files in a timely manner and (b) all communications closets be constructed in a manner that limits access to authorized personnel.

Concur **Target Completion Date:** 5/30/06

(a) When Laptop computers are turned on, the necessary antivirus & Windows software are installed immediately. This action plan will be an ongoing process.

(b) Hard ceilings or extended walls were installed to ensure security of communication closets. Recommend that action 5 be closed.

Recommended Improvement Action 6. We recommend the VISN Director ensure that the Medical Center Director requires that intake clerks follow medical center procedures to obtain and update veterans' insurance information at the time of treatment.

Concur **Target Completion Date:** 8/30/06

A policy will be developed to ensure that patients' insurance information is updated.

Recommended Improvement Action 7. We recommend the VISN Director ensure the Medical Center Director takes action to: (a) ensure that SPD personnel and nursing staff promptly and accurately record receipts and distributions of medical supplies and (b) reduce medical stock levels to the minimum needed to meet the medical center's needs.

Concur **Target Completion Date:** 4/6/06

(a) After-hour access to SPD is made only by the on-duty Nurse Manager and the VA Police Officer. Signatures of both parties accessing the area are recorded and all items removed are identified using appropriate nomenclature, quantity, and location of intended use.

(b) This has resulted in the SPD inventory reflecting full compliance in the areas of excess stock on hand and long supply from April 2006 through June 2006. Please see attachment 10. This action plan will be an ongoing process. Recommend that action 7 be closed.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
7	Reducing stock levels would make funds available for other uses	$12,289
	Total	$12,289

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Linda G. DeLong, Director Dallas Regional Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Shirley Carlile Clenes Duhon John Houston Heather Jones Karen Moore Chau Pham Wilma Reyes Sally Stevens Joel Synderman Marilyn Walls

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 16
Director, Muskogee VA Medical Center

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate
  Tom Coburn
  James Inhofe
U.S. House of Representatives
  Dan Boren

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