Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA New Jersey Health Care System East Orange, New Jersey

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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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Contents

Page

Executive Summary i

Introduction 1

Health Care System Profile 1

Objectives and Scope of the CAP Review 2

Results of Review 4

Opportunities for Improvement 4

Quality Management Program 4

Breast Cancer Management 5

Community Nursing Home Program 6

Equipment Accountability 7

Service Contracts 10

Accounts Receivable 12

Information Technology Security 13

Environment of Care 14

Other Observations 15

Diabetes and Atypical Antipsychotic Medications 15

All Employee Survey 17

Appendixes

A. VISN Director's Comments 19

B. Health Care System Director's Comments 20

C. OIG Contact and Staff Acknowledgments 28

D. Report Distribution 29

Executive Summary

Introduction

During the week of April 17–21, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA New Jersey Health Care System (system) located in East Orange and Lyons, New Jersey. The purpose of the review was to evaluate selected system 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 235 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 3.

Results of Review

This CAP review focused on 11 areas. The system complied with selected standards in the following areas:

- All Employee Survey
- Diabetes and Atypical Antipsychotic Medications
- Radiology Services

We identified eight areas that needed additional management attention. To improve operations we made the following recommendations:

- Improve peer review and utilization management processes.
- Ensure that providers and patients are informed timely of mammogram and breast biopsy results, and monthly audits of view alerts are performed.
- Establish collaborative relationships with Veteran Benefits Administration (VBA) and the nursing home Ombudsman on behalf of community nursing home patients.
- Strengthen controls to account for and safeguard sensitive equipment.
- Improve contract administration and compliance with VA policy.
- Improve reviews, follow-up procedures, and timeliness on debts for current and former employees.
- Strengthen controls over information technology (IT) security.
- Ensure patient safety on the locked psychiatric unit.

This report was prepared under the direction of Ms. Katherine Owens, Director, Bedford Office of Healthcare Inspections.

OIG Comments

The VISN and the System Directors agreed with the CAP review findings and recommendations, and they provided acceptable improvement plans. See Appendix A, beginning on page 19, for the full text of the Directors' comments. We will follow up on implementation of planned actions until they are completed.

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

Introduction

Health Care System Profile

Organization. The system is an integrated organization consisting of two campuses located in East Orange and Lyons, New Jersey. The system also has community based outpatient clinics (CBOCs) in Brick, Elizabeth, Fort Monmouth, Hackensack, Jersey City, Morristown, New Brunswick, Paterson, and Trenton, New Jersey. It is under the jurisdiction of VISN 3 and serves a veteran population in 14 counties in central and northern New Jersey.

Programs. The East Orange campus is a tertiary care facility providing a full range of patient care services. Health care services are provided through medicine, surgery, psychiatry, long-term care, and primary care. The system also supports programs in physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

The Lyons campus is categorized as a specialty referral facility with the mission of providing psychiatric and long-term care.

Affiliations and Research. The system is affiliated with the New Jersey Medical School and the Robert Wood Johnson School of Medicine; and it supports over 400 residents, interns, and students. It also serves as a training site for general dentistry, oral surgery, nursing, audiology, psychology, and social work.

During fiscal year (FY) 2005, the system had 260 active research projects and 60 principal investigators. The total VA research funding for FY 2005 was $5 million, with $2.5 million in additional research support from the National Institutes of Health and from industry.

Resources. The system's budget for FY 2005 totaled approximately $314 million; the FY 2006 budget totaled approximately $335 million. FY 2005 staffing was 2,600 full-time employee equivalents (FTE); FY 2006 staffing was 2,580 FTE, which included 178 physician and 477 nursing FTE.

Workload. In FY 2005, the system treated over 59,000 unique patients. The average daily census for acute care beds was 126 in FY 2005. The average daily census for nursing home care beds was 248 for FY 2005. The outpatient workload for FY 2005 totaled 537,000 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, 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 QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. 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 activities:

Accounts Receivable	Environment of Care
All Employee Survey	Equipment Accountability
Breast Cancer Screening	Information Technology Security
Community Nursing Home Program	Quality Management Program
Diabetes and Atypical Antipsychotic Medications	Radiology Services
	Service Contracts

The review covered system operations for FY 2005 and FY 2006, through January 31, 2006; and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we interviewed 30 patients. The interviews showed a high-level of patient satisfaction, and we discussed the results with system managers.

We also presented three fraud and integrity awareness briefings for the system's employees. These briefings, attended by 235 employees, 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 make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Quality Management Program – Peer Review and Utilization Management Processes Needed To Be Strengthened

Condition Needing Improvement. The QM program was generally effective; however, clinical managers needed to strengthen peer review and utilization management (UM) processes.

Peer Review. Peer reviews are critical analyses of episodes of care that may involve clinical variations from accepted standards of practice. The reviews are conducted by clinicians of similar education, training, licensure, and clinical privileges as the providers involved in the episodes of care. The purpose of the peer review process is to identify issues, act upon them proactively, and ultimately improve the quality of patient care. A peer review committee (comprised of members of the medical and professional staff) administers the peer review process, documents its agreement or disagreement with the results of the peer reviews, and recommends improvement actions as needed.

Veterans Health Administration (VHA) regulations require that peer review committees report at least quarterly to the Executive Committee of the Medical Staff (ECMS). According to regulations, the report should include trends regarding the number of reviews, the outcomes by quality of care level,[1] the number of changes from one level to another, follow-up on action items, and recommendations that result from completed peer reviews. At the time of the CAP review, the system's Peer Review Committee was not reporting quarterly to the ECMS. Also, results of peer reviews were not trended over time for outcomes by level or by number of changes from one level to another. Additionally, justification for the changes in quality of care levels was not documented; committee minutes did not consistently identify corrective actions or recommendations that resulted from completed peer reviews.

Utilization Management. UM is the process of evaluating and determining the appropriateness of medical care services across the continuum of care to ensure the efficient and appropriate utilization of resources. Admissions and continued stays are compared to standardized criteria or clinical indicators that reflect the need for hospitalization or treatment. VHA regulations require that cases not meeting the standardized criteria be referred to a physician advisor as a third level reviewer.[2] At the

[1] Level 1 - most competent practitioners would have managed the case similarly; Level 2 – most competent practitioners might have managed the case differently; Level 3 – Most competent practitioners would have managed the case differently.

[2] A UM specialist is considered the first-level reviewer and the attending physician is considered the second-level reviewer.

time of the CAP, patients who needed a third-level review were not consistently referred to a physician advisor.

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the System Director requires that: (a) the Peer Review Committee report quarterly to the ECMS, trend results of the peer reviews, document justification for quality of care level changes, and document improvement actions and recommendations that result from completed reviews; and (b) admission and continued stay cases that do not meet standardized criteria are referred to a physician advisor.

The VISN and System Directors agreed with the findings and recommendations. They reported that the ECMS added the Peer Review Committee to its agenda for quarterly reports. They also reported that the Committee has begun to trend results of peer reviews, document justification for quality of care level changes, and document improvement actions and recommendations. Additionally, the system developed a process to include a physician advisor to review UM cases that do not meet standardized criteria. The implementation plans are acceptable, and we consider the issues resolved.

Breast Cancer Management – Documentation of Provider and Patient Notification Needed To Be Improved and View Alert Audits Needed To Be Performed

Condition Needing Improvement. A review of 10 medical records for female patients who were screened for breast cancer showed that the patients received appropriate and timely care. However, clinical managers needed to improve documentation that providers and patients are timely notified of mammogram and biopsy results, establish monitoring processes to track notification, and conduct VISN 3 required monthly audits of view alerts for diagnostic test results.

Documentation. System patients who needed mammograms were referred to community agencies at VA expense. VHA regulations require that communication of suspicious or highly suggestive mammogram results be available to ordering providers within 3 working days.

A review of the medical records showed that in 3 of 10 cases with suspicious mammography results, there was no documentation to support that ordering providers were notified within 3 working days. Also, we did not find documentation that one patient was notified of a benign breast biopsy result. Additionally, at the time of the review, system managers had no tracking process in place to monitor the timeliness of provider and patient notification.

View Alert Audits. VISN 3 policy requires that monthly audits be done on view alerts placed in the computerized patient record system. The alerts notified providers of diagnostic test results. The purpose of the audits was to ensure that providers received,

read, and appropriately acted on the alerts. At the time of the review, these audits were not performed.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the System Director requires that: (a) mammography and biopsy results are documented in patients' medical records; (b) processes are established to track the timeliness of notification of mammogram results to ordering providers and patients; and (c) monthly audits of view alerts are completed to comply with VISN 3 requirements.

The VISN and System Directors agreed with the findings and recommendations. They reported that processes were developed to ensure that mammography and biopsy results are placed in patients' medical records, and providers are notified timely of test results; and that these processes will be tracked and trended. They also reported that IRM is developing a process to monitor view alerts monthly. Full implementation of all processes is expected by September 30, 2006. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Community Nursing Home Program – Collaboration with Veterans Benefits Administration and the Nursing Home Ombudsman Needed To Be Established

Condition Needing Improvement. Community nursing homes (CNH) are private or public nursing homes that contract with the VA to provide short and long-term care services to veterans. The goal of the CNH Program is to provide necessary services to match veterans' geographic preferences and health care needs and to optimize function and quality of life. According to VHA regulations, facilities with CNH programs must establish CNH review teams to perform necessary evaluations of nursing homes prior to contracts being established and also on an annual basis. They must also establish an interdisciplinary oversight committee to administer and monitor the program.

The system's CNH Program was well organized and the CNH Oversight Committee (previously called the Steering Committee) and review team provided excellent controls over the functions of the program. However, VHA regulations require that collaborative relationships with VBA and the State Ombudsman office be established and that CNH employees meet with representatives from each office at least annually.

The purpose for meeting with VBA representatives is to ensure that patients, especially those with fiduciaries, receive their benefits and that their money is appropriately allocated for their medical care. The purpose of meeting with an Ombudsman representative is to discuss topics of mutual concern and interest about the nursing homes that care for veteran patients. At the time of the review, annual meetings with representatives from these offices were not taking place.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the System Director takes action to establish collaborative relationships with VBA and the Ombudsman office and that CNH employees meet with representatives from each office at least annually.

The VISN and System Directors agreed with the findings and recommendations. They reported the CNH coordinator maintains frequent telephone contact with VBA and annual face-to-face meetings will be implemented. They also reported that multiple efforts to contact the State Ombudsman have been unsuccessful; however, they will continue to reach out and will formally invite them to participate in a meeting planned at least annually. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Controls To Account for and Safeguard Sensitive Equipment Needed To Be Strengthened

Condition Needing Improvement. System managers needed to improve procedures to ensure that sensitive equipment was properly accounted for and safeguarded. Sensitive equipment is defined as property, regardless of acquisition cost, that by its nature is subject to theft, loss, conversion to personal use; or which for some other reason, must be subject to more stringent controls than other property. During our review, we performed testing to determine whether sensitive IT equipment was being properly accounted for, safeguarded, disposed of, and recorded in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS), VA's property database. Acquisition and Materiel Management Service (A&MMS) did not have adequate controls in place to account for, receive, and track computer equipment. A&MMS management needed to ensure that AEMS/MERS was reliable and contained complete and accurate data for all items. Information Resource Management (IRM) Service staff needed to better track laptop computers loaned to VA employees, and A&MMS staff needed to account for computer equipment classified as out-of-service.

Sensitive IT Equipment Inventory Controls and Procedures. A&MMS management needed to update local inventory controls, procedures, and policies to receive, track, and account for sensitive IT equipment. The following issues required management attention:

- Sensitive IT equipment with an acquisition value less than $5,000, which includes most computer equipment, was not listed on an Equipment Inventory Listing (EIL) as required. As a result, all sensitive IT equipment was not accounted for during physical inventories. A&MMS staff should complete a 100 percent wall-to-wall inventory to identify all sensitive equipment, regardless of cost. This sensitive equipment should be listed on an applicable EIL and physically verified during the annual inventory process.

- Sensitive IT equipment procured locally by IRM Service was not received through the warehouse as required by VA policy. Warehouse staff stated that these purchases were delivered directly to IRM service. All sensitive IT equipment should be delivered to the warehouse and entered into AEMS/MERS by A&MMS staff. At this time, a local bar code label should be affixed to the equipment, initiating accountability controls.
- Data entered into the property database was not always complete for sensitive equipment. In some cases, A&MMS staff did not enter a location for delivered computer equipment because it had not been assigned to a using service or the intended location was unknown at the time of receipt. Accountability controls to track sensitive IT equipment would be improved if IRM staff informed A&MMS of locations and location changes for all computer equipment.

Sensitive IT Equipment Accountability. We reviewed a sample of 78 sensitive IT equipment items (total acquisition value = $108,882) from a total of 3,240 items (total acquisition value = $4,428,183) assigned to IRM Service. The acquisition value of the 78 items ranged from $1,000 to $2,575, and the recorded acquisition age ranged from 6 months to 21 years at the time of our review. We identified the following accountability discrepancies:

- Fifty-eight (74 percent) of the items (total acquisition value = $82,909) could not be located. These unaccounted for items included 24 computers, 29 printers, 2 monitors, 1 bar code reader, 1 scanner, and 1 fax machine.
- AEMS/MERS was unreliable because recorded sensitive IT equipment data was incomplete and inaccurate. For example: 33 items did not have a location, 7 items did not have an acquisition value, 6 items did not have an acquisition date, and 3 items did not have a serial number listed.

During annual inventories, responsible officials should physically verify all sensitive IT equipment listed on their EIL. They should also notify A&MMS staff of corrections to any incomplete or incorrect data listed in AEMS/MERS for all items listed on their EIL.

Loan Procedures for Laptop Computers. IRM service maintained loan documentation for laptop computers. The loan process for laptop computers allowed employees to borrow them for an indefinite period of time and did not require the computers to be brought into IRM service routinely. Consequently, laptop computers were not being inventoried or physically verified once the loan document was completed. We reviewed a sample of 20 laptop computers (total acquisition value = $54,478) listed in the current property database for physical verification and loan documentation testing. The acquisition value of the 20 computers ranged from $1,799 to $4,456, and the recorded acquisition age ranged from 2 months to 13 years at the time of our review. We identified the following discrepancies:

- Six (30 percent) of the laptop computers (total acquisition value = $16,108) could not be located, and loan documentation could not be provided.
- One laptop computer, which was physically located, was assigned to someone other than the employee listed on the current loan document, dated February 4, 2004. IRM staff stated that the employee who was supposed to have possession of the laptop transferred it to another employee in the same service without notifying IRM staff.
- One laptop computer was assigned to a doctor who was no longer employed on a full-time basis. A loan document, dated March 10, 2003, listed the period of loan to be indefinite. At the time of our review, the doctor only worked on a part-time basis and stated that the laptop computer was no longer needed; subsequently, it was returned to IRM service.

IRM staff should require that loaned laptop computers be returned annually for physical verification, at which time required security updates can be performed and an assessment of continued need for the equipment can be made.

Out-of-Service Equipment. A&MMS staff provided a report of all equipment listed in the property database as out-of-service. The list contained 459 items, with a total acquisition value of $1,870,589, of which 111 items (24 percent) were sensitive IT equipment. To assess accountability controls over sensitive IT equipment categorized as out-of-service, we reviewed a sample of 20 computers (total acquisition value = $35,378) for physical verification. We identified the following discrepancies:

- Five (25 percent) of the computers (total acquisition value = $7,696) could not be located. These unaccounted for items included three computers and one terminal acquired during Calendar Year (CY) 2004 and one computer acquired in CY 2001.
- The remaining 15 computers were physically verified during our review; however, we found that 6 of them were in service but inaccurately categorized as "out-of-service." IRM staff stated that these six items were sent out for repair and put back into service when they were returned, but the status in AEMS/MERS was not updated to in use status.

A&MMS staff should account for all sensitive out-of-service equipment, as well as update item categories where necessary. Items that cannot be located should be listed on a Report of Survey (ROS) in order to remove them from the property database.

Recommended Improvement Actions 4. We recommend that the VISN Director ensure that the System Director requires that: (a) a 100 percent wall-to-wall inventory is completed to identify all sensitive IT equipment on hand; (b) all sensitive IT equipment, regardless of acquisition cost, is listed on an applicable EIL and accounted for as part of the annual inventory process; (c) all sensitive IT equipment is delivered to the warehouse, at which time A&MMS staff enters complete accountability data into AEMS/MERS; (d) responsible officials physically verify all equipment listed on their EIL and notify

A&MMS of corrections to incomplete or incorrect data fields during annual inventories; (e) IRM staff physically verify laptop computers loaned to VA employees on an annual basis and determine if there is a continued need for the loan; and (f) A&MMS staff reviews the out-of-service equipment listing to ensure that it is accurate and being used for its intended purpose.

The VISN and System Directors agreed with the findings and recommendations. They reported that managers developed an IT equipment inventory plan that includes adding all sensitive items to the EIL and conducting initial and annual wall-to-wall inventories. They also reported that managers developed processes to ensure that IT equipment is delivered through the warehouse, IT equipment is verified by responsible officials and A&MMS is notified of discrepancies, there is documented justification of continued need for loaned laptop computers to VA employees, and that A&MMS reviews out-of-service equipment. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts – Contract Administration and Compliance with VA Policy Needed To Be Improved

Condition Needing Improvement. System managers needed to improve contracting activity performance by strengthening controls to ensure that contracting officers (COs) and contracting officer's technical representatives (COTRs) perform their responsibilities in accordance with the Federal Acquisition Regulation (FAR), the VA Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 5 contracts valued at $7.2 million from a total of 134 contracts valued at $70.7 million. The following issues, which are detailed in the Service Contracts Table below, required management attention:

CO Performance. COs did not take action to maintain complete files containing records of preaward and postaward administrative actions, or ensure COTRs received training before assuming responsibility for monitoring contractor performance.

- *Required Preaward Administrative Actions.* The CO did not forward one contract valued at $2.0 million to the VA Office of Acquisition and Materiel Management for legal and technical review. A CO did not search the Excluded Parties Listing System (EPLS) database for one contract valued at $2.3 million to determine whether the prospective contractors were excluded from Federal contracts. Price Negotiation Memoranda were not prepared for three contracts valued at $5.0 million. Appointment letters designating COTRs were missing for two contracts valued at $2.4 million.
- *Required Postaward Administrative Actions.* COs did not conduct required postaward administrative actions including the initiation of background investigations of contract

personnel with access to VA computer systems for two contracts valued at $4.4 million.

- *COTR Training*. COs did not ensure that COTRs for five contracts valued at $7.2 million received training before assuming responsibility for monitoring contractor performance. The COTRs received training 4–15 months after the contracts were awarded. The training explains COTR duties, responsibilities, limited authority, and prohibited actions, which include the delegation of validation and certification responsibilities.

COTR Performance. For one contract valued at $1.3 million, the COTR inappropriately delegated responsibilities such as validating and certifying invoices for payment to other VA employees. The COTR for one contract valued at $1.4 million did not validate the line counts of the transcribed reports received from the contractor; instead, the COTR only validated that the reports were received from the contractor.

Service Contracts Table – Contract Administration Deficiencies

Contract Deficiencies	PET Scans $101,000	Radiology Physicians $2,043,000	Ophthalmology $2,372,000	Medical Transcription $1,439,000	Ambulette Service $1,263,000
Contracting Officer Responsibilities					
Legal/technical review not conducted		X			
EPLS database search not conducted			X		
Price negotiation memorandum not prepared			X	X	X
COTR appointment letter not issued	X		X		
Background investigation not conducted		X	X		
COTR not timely trained	X	X	X	X	X
COTR Responsibilities					
VA employees, other than COTR, validated services/certified payments					X
COTR not monitoring contract adequately				X	

Recommended Improvement Actions 5. We recommend that the VISN Director ensure that the System Director requires that: (a) contract reviews are conducted to ensure compliance with FAR, VAAR, and VA policy; (b) the required preaward and postaward administrative deficiencies are corrected, and controls and oversight are

strengthened to prevent deficiencies on future contracts; (c) background investigations are initiated on contracted personnel; and (d) training is provided to ensure COTRs understand their duties, responsibilities, and limited authority before assuming responsibility for monitoring contractor performance.

The VISN and System Directors agreed with the findings and recommendations. They reported that managers developed processes to ensure contract compliance with VA regulations, including preaward and postaward administrative actions. They also reported that employees from Network Acquisition and Logistics and from Human Resourses Management are developing processes to ensure that background checks on contracted personnel are completed, and COTR training is accomplished. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Controls on Current and Former Employee Debts Needed To Be Improved

Condition Needing Improvement. System managers needed to ensure that current employees were timely notified of debts owed, debts were accurately and timely established and followed up for collection, payments were posted correctly and promptly, and Fiscal Service staff was effectively trained in appropriate procedures. Fiscal Service staff needed to improve follow-up procedures on former employee debts by making telephone contact with all debtors and referring all delinquent debts to the Treasury Offset Program (TOP).

Current Employee Debt. The universe of current employee debts in the Financial Management System (FMS) as of January 31, 2006, included 19 debts valued at $99,156. We reviewed a sample of 10 current employee debts with a total value of $90,221 that ranged in age from 8 months to 6.5 years. VA policy requires that prompt and aggressive collection action and effective follow-up procedures are utilized. Debts owed by Federal employees may be collected by offset from current salary.

Fiscal Service staff was untimely in establishing or following-up on all 10 debts. There were additional and often multiple errors on individual debts for the majority of the debts. Dollar amounts were understated or overstated for 7 of the 10 debts: 3 debts had interest and administrative charges that should have been exempted; 2 debts had 3 payments incorrectly applied to the wrong bills; 1 debt required an increase of $100; and another debt was in error and should have been cancelled over 6 years ago. For three debts with salary offsets, payments were not posted to the debts until 6–8 weeks after the payments were made. Four addresses were incorrect or missing, and as a result, employees were not notified until 8–15 months after their debts were incurred.

Former Employee Debts. The universe of former employee debts as of January 31, 2006, included 19 debts valued at $137,424. We reviewed a sample of 10 former employee

debts valued at $134,301 that ranged in age from 10 months to 7.5 years. Two of the 10 debts reviewed were not being followed up for collection and had not been referred to TOP after 180 days delinquency as required by VA policy.

Recommended Improvement Actions 6. We recommend that the VISN Director ensure that the System Director establishes procedures to: (a) correct errors in current employee debts; (b) correct and improve current employee debt collection action by training all Fiscal Service staff regarding timeliness, accurate debt establishments and payment postings, interest and administrative charges and exemptions, and effective follow-up; and (c) make telephone contact with all former employee debtors and refer all delinquent debts to TOP.

The VISN and System Directors agreed with the findings and recommendations. They reported that Fiscal Services corrected employee debts, identified appropriate employees who require training, and communicated the importance of telephone contact with former employee debtors. Additionally, they reported that delinquent debts will be referred to TOP. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Information Technology Security – Controls Needed To Be Strengthened

Condition Needing Improvement. System managers needed to strengthen IT security. We evaluated IT security to determine whether controls and procedures were adequate to protect automated information systems (AIS) resources from unauthorized access, disclosure, modification, destruction, and misuse. The following issues required management attention.

Hard Drive Sanitation. VA policy requires that all sensitive information and data be removed from hard drives prior to the disposal of computer equipment. We selected 15 computers that had been turned in within the past 18 months, and requested documentation showing that the hard drives had been properly sanitized or destroyed. However, because IRM staff had removed the hard drives from the computers prior to disposal and not retained the local inventory numbers of the source computers, management could not provide the requested documentation. Without proper documentation, we could not be assured that these hard drives had been properly sanitized or destroyed prior to disposal.

Physical Security. VA policy requires that proper safeguards be in place to protect each facility's AIS resources from unauthorized access or destruction. This includes physical security of the computer room, telephone switch room, and all communication closets. The following physical security deficiencies were observed:

- The main doors leading into IRM offices at both the East Orange and Lyons facilities were unlocked even though keys controlled access. At the East Orange facility, the door leading into the network administration office, which is located adjacent to the computer room and separated only by a glass window, was also unlocked. These doors should be locked at all times to increase the protection of AIS resources from unauthorized access or destruction.
- At the Lyons campus, we found three communication closets that contained windows through which one could view their contents and also gain unauthorized access. Three other communication closets were unlocked. Also, one communication cabinet had wiring coming out from the bottom of the containment box, leaving it vulnerable to damage.
- The Morristown CBOC is located in a county building. Staff stated that the rear door leading into the CBOC must be left unlocked at all times because of a county ordinance. Although the door was located in a stairwell, one could easily gain access to the stairwell through a glass door located at the back of the building. Security could be strengthened by installing a motion detection alarm system in this area of the CBOC.
- The Lyons computer room was constructed inside an existing room. The room had two unprotected windows through which one could gain access from the outside. Once inside this room, one could gain access to the interior computer room through two unlocked doors.

Recommended Improvement Actions 7. We recommend that the VISN Director make sure the System Director takes action to: (a) ensure proper documentation is maintained to track and document the status of computer hard drives through final sanitation and disposition; (b) ensure that all IRM doors and the network administration office door remain locked at all times; (c) block and protect communication closet windows and exposed wiring identified at the Lyons facility, and ensure closets are kept locked; (d) install a motion detection alarm system at the back door of the Morristown CBOC facility; and (e) secure identified exterior windows at the Lyons campus computer room.

The VISN and System Directors agreed with the findings and recommendations. They reported that IRM managers developed processes to ensure documentation of hard drive status and to ensure that IRM doors at both campuses are locked at all times. Managers corrected the exposed wiring at the Lyons campus communication closet. Managers also installed a motion detector at the Morristown CBOC and secured exterior windows at the Lyons campus computer room. The implementation plans are acceptable, and we consider the issues resolved.

Environment of Care – A Safety Issue Was Identified

Condition Needing Improvement. The system's environment of care was clean and generally safe. However, one safety issue needed management attention.

On a locked psychiatric unit located on the Lyons campus, we found a standard window blind hanging at a window in the day room where patients were allowed to go unsupervised. The room was not monitored by surveillance cameras. The tensile strength of the strings holding the blind slats together could not be determined. This posed a potential safety risk because the strings could be removed by a patient and potentially used to inflict harm on self or others. Managers were unaware that the blind was on the unit, agreed that it presented a safety risk, and removed the blind while we were on site.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director requires that window blinds of this type not be placed on psychiatric units.

The VISN and System Directors agreed with the finding and recommendation. They reported that in addition to immediately removing the blind, they conducted environmental rounds to ensure that similar blinds were not used in other areas. The implementation plan is acceptable and we consider the issue resolved.

Other Observations

Diabetes and Atypical Antipsychotic Medications – Diabetes Screening Was Appropriate

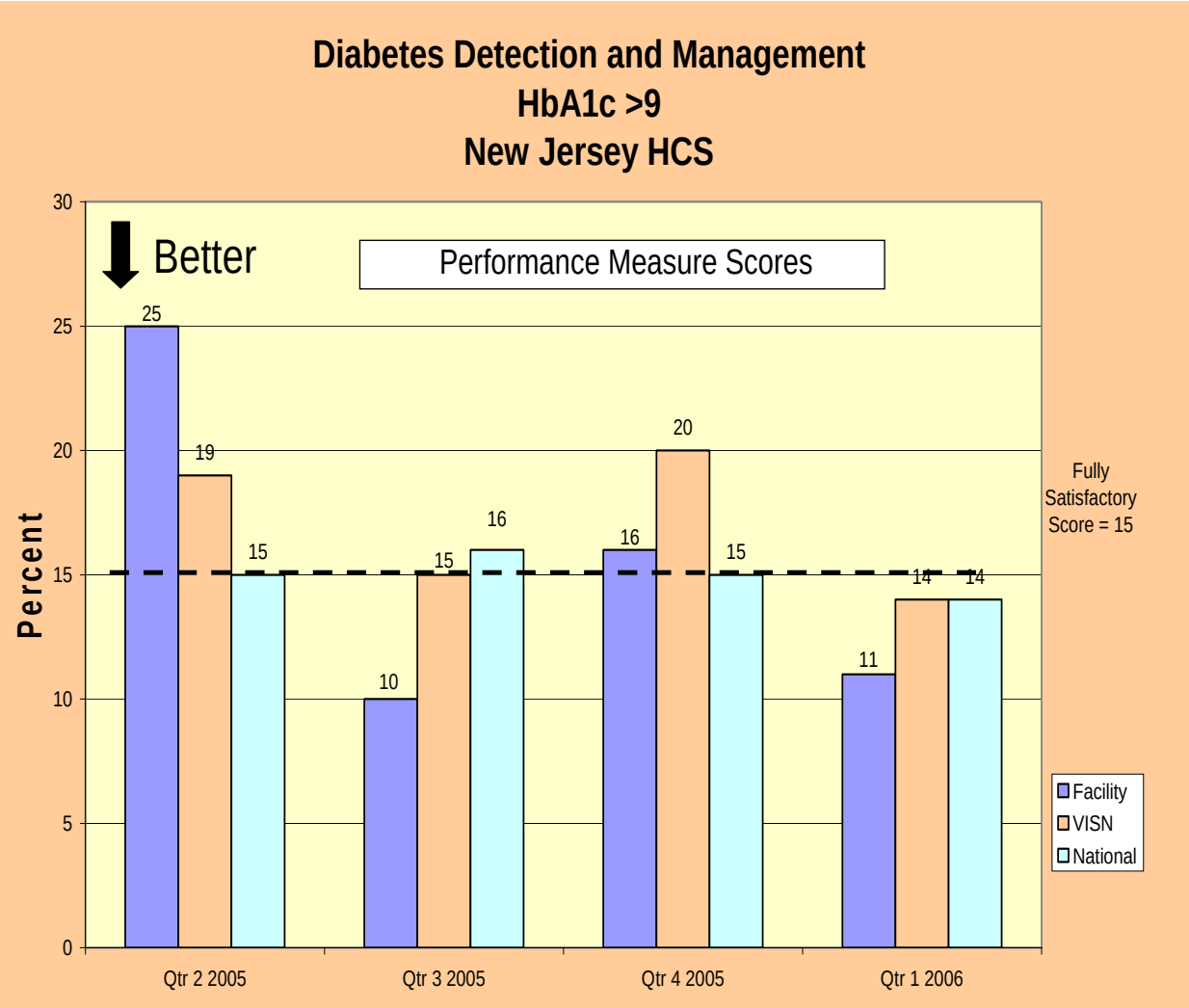
The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that diabetic patients' hemoglobin A1c (HbA1c) levels (the average blood glucose level over time) be obtained at least annually and be maintained at less than 9 percent to avoid symptoms of hyperglycemia (high blood sugar); that blood pressures be maintained at less than, or equal to, 140/90 millimeters of mercury (mmHg); and that low-density lipoprotein cholesterol (LDL-C) levels be maintained at less than 120 milligrams per deciliter (mg/dL). VHA clinical practice guidelines for the screening of patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) levels be obtained every 1–3 years.

We reviewed a random sample of 13 patients who were taking one or more atypical antipsychotic medications for at least 90 days. Two of these patients had diabetes. The review showed that one of the two diabetic patients did not have HbA1c or LDL-C levels measured since July 2004. At that time, the levels showed that the patient's blood glucose and cholesterol were in control. We found that the patient did not keep a scheduled primary care appointment in 2004 and had not rescheduled the appointment. However, the patient did keep mental health appointments, and mental health clinicians agreed that they needed to ensure that the patient received appropriate monitoring.

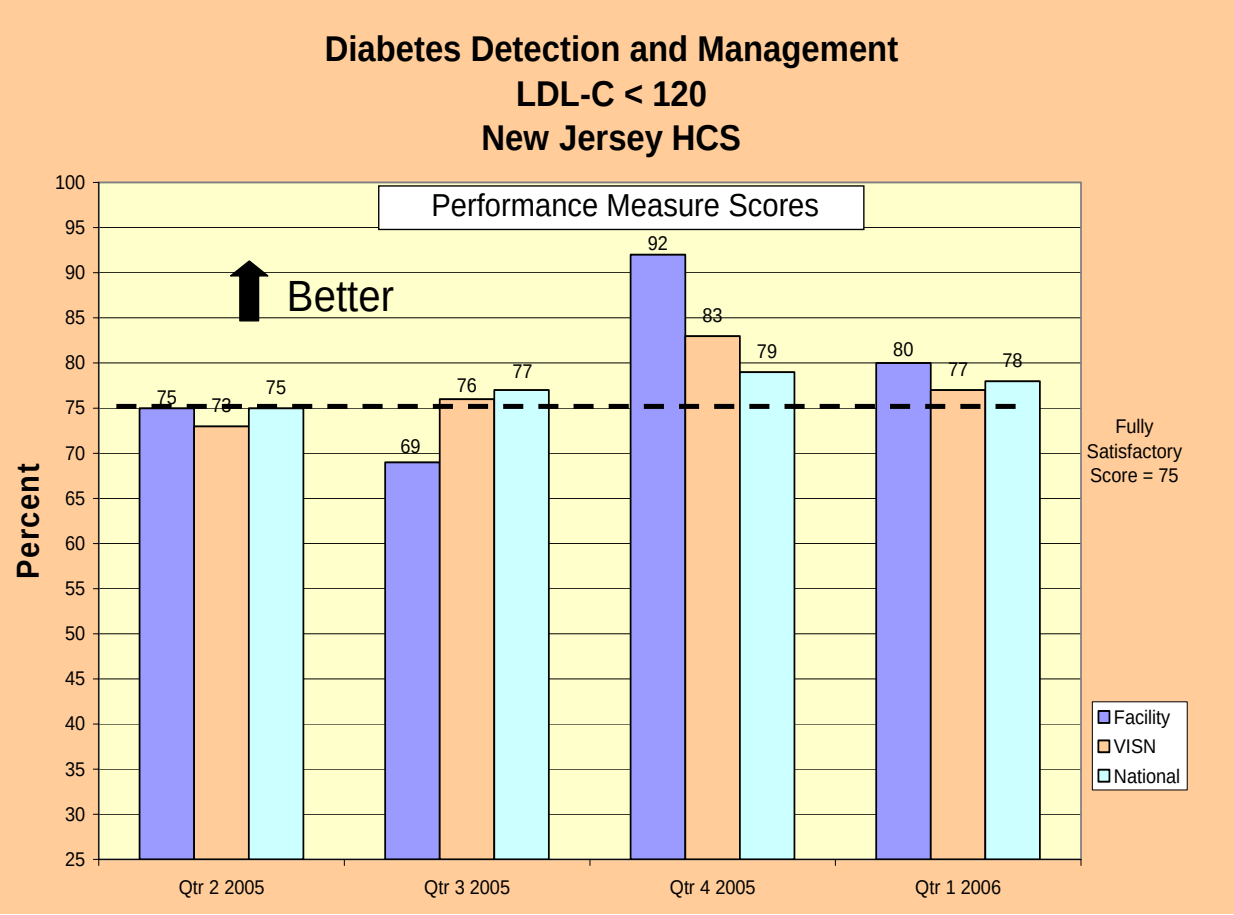
We reviewed the system's HbA1c performance measure scores for FY 2005 through the first quarter 2006. Satisfactory scores for HbA1c measurement were obtained for 2 of the last 4 quarters (Graph 1).

Graph 1



We reviewed the LDL-C performance measure scores for FY 2005 through the first quarter of FY 2006. The system met or exceeded the fully satisfactory level for this performance measure in 3 of the last 4 quarters (Graph 2).

Graph 2



The 11 patients who did not have diabetes were appropriately screened, and 9 patients were appropriately counseled about diabetes prevention. Psychiatry clinical managers ensure that psychiatric patients are enrolled in primary care. Because many mental health patients have difficulty maintaining healthy lifestyles and are at risk for developing diabetes and cardiovascular complications, follow-up in primary care is essential.

All Employee Survey - Improvement Plans Were Developed and Implemented

The Executive Career Field (ECF) Performance Plan for FY 2005 required that VISN directors ensure dissemination of the results of the 2004 All Employee Survey (AES) throughout their networks during the FY 2005 rating period. In addition, VISNs were required to analyze the 2004 AES results and help facilities formulate improvement plans

to address deficient areas. These plans were to include timelines and milestones that would effectively measure improvements.

The VISN and the system met the requirements of the ECF Performance Plan. The medical center's AES site coordinator distributed survey results by posting results on the system's website, and supervisors discussed results in service meetings. Additionally, system managers conducted town hall meetings. Managers developed measurable improvement plans based on an analysis of survey results. In an effort to improve the work environment and the overall quality of care, system managers initiated focus groups involving patients, employees, and volunteers. Additionally, managers contracted with a non-profit organization to implement the "Planetree Program," a program designed to develop and implement patient-centered care in healing environments. To find more about this program you can visit their website, www.planetree.org.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2006

From: Director, New York/New Jersey Veterans Healthcare Network (10N3)

Subject: CAP Review, VA New Jersey Health Care System,

To: Inspector General (50)

Thank you for your draft report of the Combined Assessment Program review which was conducted at the VA New Jersey Health Care System April 17 - 21 2006. I have reviewed your findings and concur with the recommendations and corrective actions submitted by the VA New Jersey Health Care System.

(original signed by:)
James Farsetta, FACHE

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2006

From: Director, VA New Jersey Health Care System

Subject: CAP Review**,** VA New Jersey Health Care System

To: Director, New York/New Jersey Veterans Healthcare Network (10N3)

Enclosed please find our response to the OIG CAP Review of the VA New Jersey Health Care System, April 17-21 2006.

I concur with the findings and submit actions to address each recommendation.

(original signed by:)
Kenneth H. Mizrach

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

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

OIG Recommendation(s)

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the System Director requires that: (a) the Peer review Committee report quarterly to the ECMS, trend results of the peer reviews, documents justification for quality of care level changes, and documents improvement actions and recommendations that result from completed reviews; and (b) admission and continued stay cases that do not meet standardized criteria are referred to a physician advisor.

Concur **Target Completion Date:** 09/30/2006

(a) The Peer Review Committee has been added to the standardized ECMS agenda for quarterly reports. Trended results will be included as recommended. Justification for quality of care level changes has been added for capture at each meeting and will be available for tracking and trending, as have recommendations/actions for completed reviews.

(b) The requirement for inclusion of referral to a physician advisor has been reviewed with the Care Management staff who are completing admission and continued stay reviews. Follow up to insure that the requirement is met will be conducted by the Lead Quality Management Specialist for UR, including validation of the process and tracking and trending results of interactions with the physician advisors. This will be included in UR reports beginning in September.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the System Director requires that: (a) mammogram and biopsy results are documented in patients' medical records; (b) processes are established to track the timeliness of notification of mammogram results to ordering providers and patients; and (c) monthly audits of view alerts are completed to comply with VISN 3 requirements.

Concur **Target Completion Date:** 09/30/2006

(a) and (b) All mammogram results are forwarded to the Mammography Coordinator who insures that results are forwarded to radiology for scanning and notifies the ordering provider via email that results have arrived and are available for review. Breast biopsy reports are currently scanned in and attached to the mammography report; however discussions are underway to determine the most appropriate location in CPRS for these reports. The Mammogram Coordinator will monitor the provider notification via an Access Database program developed to track the process. Additionally, the VA-WH Mammogram Review Results clinical reminder has been activated, notifying providers that results are available for review and allowing documentation of notification of the patient. This will allow complete tracking of the notification process. Mammography contracts are currently under review and have not been finalized, but the mechanism and timeliness of reporting both normal and abnormal results to patients and ordering providers will be specified in the contract.

(c) IRM Service is developing a process to monitor View Alerts on a monthly basis. Results will be reported to Service Chiefs and at the ECMS.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the System Director takes action to establish collaborative relationships with VBA and the local Ombudsman office, and that CNH employees meet with representatives from each office at least annually.

Concur **Target Completion Date:** 09/30/2006

The Community Nursing Home Coordinator has had a consistent relationship with VBA representatives in the past. In addition to regular phone contact, a face-to-face meeting will be planned to thoroughly discuss all issues related to veterans' benefits. This meeting will occur at least annually and more often if needed.

Multiple efforts have already been made to contact the Office of the Ombudsman, without success. We will continue to reach out to them and will formally invite them to participate in a meeting so that topics of mutual concern and interest about the nursing homes can be discussed. This meeting will be planned at least annually and more often if indicated. It is noted that difficulty in obtaining a response from the Ombudsman appears to be a national issue that Central Office is also attempting to address.

Recommended Improvement Actions 4. We recommend that the VISN Director ensure that the System Director requires that: (a) a 100 percent wall-to-wall inventory is completed to identify all sensitive IT equipment on hand; (b) all sensitive IT equipment, regardless of acquisition cost, is listed on an applicable EIL and accounted for as part of the annual inventory process; (c) all sensitive IT equipment is delivered to the warehouse, at which time A&MMS staff enters complete accountability data into AEMS/MERS; (d) responsible officials physically verify all equipment listed on their EIL and notify A&MMS of corrections to incomplete or incorrect data fields during annual inventories; (e) IRM staff physically verify laptops loaned to VA employees on an annual basis and determine if there is a continued need for the loan; and (f) A&MMS staff reviews the out-of-service equipment listing to ensure that it is accurate and being used for its intended purpose.

Concur **Target Completion Date:** 03/2007

(a), (b) A detailed 10 step IT equipment inventory plan has been developed and will be tracked by the Associate Directors. It includes (1) adding all sensitive items not previously considered accountable to the EIL (target date: July 31 2006) and an initial and annual wall to wall inventory (counting) of all equipment (December 31, 2006 and annual) as well as completion of any required Reports of Survey and full EIL reconciliation (March 2007).

(c) All IT equipment is now delivered through the warehouse at which time A&MMS staff enters complete accountability data into AEMS/MERS.

(d) A process has been established for IT responsible officials to physically verify equipment on listings and notify AMMS of discrepancies. A final completion/reconciliation of the EIL will be done once the wall to wall inventory is completed.

(e) A process of monthly verification of laptops loaned to VA employees and justification of continued need for the loan has been established.

(f) A&MMS has established a quarterly review process to review out of service equipment listing to ensure that it is accurate and being used for its intended purpose.

Recommended Improvement Actions 5. We recommend that the VISN Director ensure that the System Director requires that: (a) contract reviews are conducted to ensure compliance with FAR, VAAR, and VA policy; (b) the required preaward and postaward administrative deficiencies are corrected and controls and oversight are strengthened to prevent deficiencies on future contracts; (c) background investigations are initiated on contracted personnel; and (d) training is provided to ensure COTRs understand their duties, responsibilities, and limited authority before assuming responsibility for monitoring contractor performance.

Concur **Target Completion Date:** 09/30/2006

(a) & (b) A checklist has been added to every contract file specifically detailing the items required for each contract. The contract specialist responsible for the contract will ensure each item is present and reflected on the checklist. Inclusive of this checklist will be pre and post award requirements. In addition, an internal board within Network Acquisition & Logistics has been established that will be responsible for checking contracts for compliance on a quarterly basis. All findings and corrective action will be documented.

(c) Network Acquisition & Logistics in conjunction with Human Resources Management Program is currently in the process of developing a flow chart detailing the necessary steps and responsibilities of all parties involved to initiate background checks on contracted employees. All contracted employees will have a background check initiated by September 30, 2006

(d) On March 21, 2006, a new online COTR training module had been developed by Acquisition Training & Career Development Division of the Office of Acquisition & Materiel Management Service. This new online training details the various responsibilities of the COTR. VISN 3's Network Acquisition & Logistics has informed and made available the training website to the facilities. All VANJHCS COTRs will be required to complete this training by September 30, 2006.

Recommended Improvement Actions 6. We recommend that the VISN Director ensure that the System Director establishes procedures to: (a) correct errors in current employee debts, (b) correct and improve current employee debt collection action by training all Fiscal Service staff regarding timeliness, accurate debt establishments and payment postings, interest and administrative charges and exemptions, and effective follow-up, and (c) make telephone contact with all former employee debtors and refer all delinquent debts to TOP.

Concur **Target Completion Date:** 09/30/2006

(a) Fiscal Service has reviewed the current employee debts in the accounts receivable package residing in VistA. As a result of this review, Fiscal Service has made corrections to debts as required; this includes but is not limited to, input of current addresses on the bills, re-computing of original debt amount since this information may be inaccurate due to having been input by the service where the indebtedness generated. In addition, any bills that required interest and admin costs to be exempted had the appropriate action taken.

For debts that did not have interest or admin costs applied, Fiscal Service is checking with other facilities on any difficulties they may have experienced with the process when bills are being established and audited. When the problem is identified action will occur to correct interest or admin costs.

(b) Fiscal Service determined that three accountants, one accounts receivable technician, and all payroll technicians require training on the accounts receivable package in VistA and all regulations provided in the 4800 series Handbook. This training will be completed no later than September 30.

(c) Fiscal Service has communicated to staff that deals with the accounts receivable activity the importance of phone follow-up as well as written. When calls are made by fiscal staff they will be documented in the comment log to record this follow-up process. In addition, any debts that are not in a suspended status or on hold will be referred to TOP at the timeframe stated in VA regulations.

Recommended Improvement Actions 7. We recommend that the VISN Director make sure the System Director takes action to: (a) ensure proper documentation is maintained to track and document the status of computer hard drives through final sanitation and disposition; (b) ensure all IRM doors and the network administration office door remain locked at all times; (c) block and protect communication closet windows and exposed wiring identified at the Lyons facility, and ensure closets are kept locked; (d) install a motion detection alarm system at the back door of the Morristown CBOC facility; and (e) secure identified exterior windows at the Lyons computer room.

Concur **Target Completion Date:** 09/30/2006

(a) IRM staff members follow written procedures for the tracking and documentation of the status of computer hard drives through final sanitation and disposition. Documentation positively linking removed, destroyed hard drives with the PCS from which they were removed is now maintained. This resolves this issue.

(b) IRM doors were locked immediately and have been maintained locked. This resolves the issue identified. Additional measures are being taken, to facilitate the convenient entry of authorized individuals to the area, which is to equip the doors with buzzers for admission to the area. This will be completed by June 30.

(c) Exposed wiring identified in communication closets has been corrected. Staff members have been reminded to leave closets locked, according to policy. Exterior windows are being identified, and a vendor source selection is taking place to facilitate resolving this deficiency. The target date for completion of the project is August 11, 2006.

(d) The VANJHCS will install a motion detector at the back door by June 30 2006.. The door remains locked at this time.

(e) The identified exterior windows at the Lyons campus computer room will be secured as part of the project mentioned above. A vendor source selection is taking place to facilitate resolving this deficiency. The target date for completion of the project is August 11, 2006.

Recommended Improvement Action 8. We recommend that the VISN Director ensures that the Medical Center Director take actions to be sure that window blinds of this type are not placed on psychiatric units.

Concur **Target Completion Date:** Completed

The window blinds in the identified area were immediately removed and rounds were conducted to ensure that no other area had a similar problem. The blinds will be replaced by suicide-resistant drapes.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, Director Bedford Office of Healthcare Inspections (781) 687-2317
Acknowledgments	Annette Acosta Stephen Bracci John Cintolo David Irwin Mathew Kidd James McCarthy Patricia McGauly Jeanne Martin Sunil Sen-Gupta Jacqueline Stumbris

Appendix D

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