Department of Veterans Affairs
Office of Inspector General

Review of Recurring and Systemic Issues Identified During Combined Assessment Program Reviews at VA Facilities

January 1999 through August 2006

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VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

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Department of Veterans Affairs
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September 20, 2006

Memorandum to Secretary (00)

Review of Recurring and Systemic Issues Identified During Combined Assessment Program Reviews at VA Facilities, January 1999–August 2006

1. This report discusses recurring and systemic issues identified during the Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews impacting the effectiveness and efficiency of VA's delivery of health care and benefits to our Nation's veterans. The OIG established its CAP Program in January 1999 as a major program initiative to foster integrity, accountability, and excellence; and to recommend actions to address issues impacting VA's programs and activities—both on a facility-by-facility basis and nationally. The issues presented represent a compilation of CAP review results and highlight deficiencies frequently identified at VA facilities that, in our judgment, impact patient care; benefits administration; and financial, management, and administrative activities and programs. These issues continue to pose unnecessary risks to VA's stewardship of activities and programs and have continued potential for non-compliance with laws, regulations, and policies established to promote high-quality performance.

2. As a reflection of the CAP review program's success, we have examined a variety of risks and vulnerabilities and analyzed a wide range of issues impacting VA programs. Over time, we modified CAP review coverage to address new programs, emerging risks, and changing vulnerabilities. CAP program results have identified significant opportunities for VA to achieve operational efficiencies, realize cost savings, and prevent fraud in its programs. The OIG issued 296 CAP facility review reports from January 1999 through August 2006, including 230 Veterans Health Administration (VHA) health care facility and system reports and 66 Veterans Benefits Administration (VBA) regional office reports. In addition, we have also issued thirteen summary reports.

3. Because many of the same risks and vulnerabilities have continued to be identified during CAP reviews, this report highlights issues that VA should continue to address. Department managers should ensure that additional efforts are taken to strengthen management controls in the areas reported to provide better assurance of the success of its operations, activities, and functions. While facility managers have provided acceptable implementation plans and taken corrective actions in response to specific CAP review report recommendations, there is a need to institute comprehensive and rigorous oversight to realize continuing improvements.

4. The OIG is changing its approach for performing CAP reviews beginning in September 2006. The OIG Office of Audit's (OA) participation in CAP reviews will end to concentrate on performing national audits. However, OA will continue to review the systemic issues reported in CAP reviews to help determine actions needed to improve VA operations. This change will enhance the OIG's efforts to provide effective oversight and address the complexity and scope of VA's diverse mission, and help address issues involving the Veterans Integrated Service Networks (VISN) and more recent VBA business line consolidations.

5. The OIG Office of Healthcare Inspections (OHI) will continue to perform cyclical CAP reviews, and the OIG Office of Investigations will provide fraud and integrity awareness training for VA employees at VA health care facilities nationwide. This strategic change will help us provide a broader complement of value-added OIG services to VA management and enhance our efforts to be responsive to emerging issues. We will also continue to examine issues and allegations referred to the OIG by employees, patients, Members of Congress, or others and continue to follow-up on the significant issues identified during CAP reviews, including new areas of inquiry.

6. This report will be electronically disseminated to senior VA managers and remain available on our Web site: (http://www.va.gov/oig/52/reports/mainlist.htm.) This report makes no recommendations because recommendations were made in our individual CAP reports. However, a strong commitment is needed to demonstrate progress implementing and sustaining corrective actions and compliance with the guidance put in place to address many of the issues raised in this report in order to ensure broad-based improvements in the Department's activities and programs.

(original signed by:)
GEORGE J. OPFER
Inspector General

Introduction

Purpose

The purpose of this report is to provide information on recurring and systemic issues identified during the OIG CAP reviews from January 1999 to August 2006, including issues that impact patient care; benefits administration; and financial, management, and administrative controls. This report highlights areas where CAP review results showed persistent weaknesses and a need to strengthen management controls at VHA and VBA facilities.

Background

CAP reviews were initiated in January 1999 to evaluate the integrity, quality, efficiency, and effectiveness of programs and functions at VA facilities, and to identify opportunities for improvement in areas such as quality of care, management controls, program operations, delivery of benefits and services, and fraud detection and prevention. Initially, OIG conducted the CAP reviews at VA medical facilities. In fiscal year (FY) 2001, the CAP review program was expanded to include VBA facilities. The CAP reviews were established as joint operations with participation from the Offices of Audit, Healthcare Inspections, and Investigations. Through this program, teams of OIG auditors, healthcare inspectors, and investigators collaborated to assess key operations and programs at VA facilities.

These reviews have provided stakeholders with independent, timely, and periodic assessments of the effectiveness of various operational activities at VA facilities. In addition, CAP reviews have addressed issues that have a more immediate and visible impact on patients, visitors, and employees at VA facilities. During the CAP reviews, VA patients, employees, and managers have an opportunity to discuss concerns and issues with OIG staff.

CAP reviews performed at VA facilities: (1) evaluate how well VA facilities are accomplishing their missions of providing veterans high-quality medical and benefit services; (2) determine if management controls are in compliance with VA policies and other requirements, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse; and (3) provide fraud and integrity awareness training to promote VA employees' awareness of potential fraud as well as the requirement to refer suspected illegal activities to the OIG. In addition, CAP reviews examine issues or allegations referred by employees, patients, Members of Congress, and others.

A total of 296 CAP facility reports (230 VHA and 66 VBA) were issued from January 1999 through August 2006. In addition to the facility reports, 12 roll-up Healthcare Inspection reports (*See Appendix A for additional information on pages 23–34*) and 13 CAP review summary reports have been issued.

CAP review reports are available on the OIG Web site at http://www.va.gov/oig/52/reports/mainlist.htm.

Scope and Report Methodology

The scope of the information presented in this report encompassed a review of all CAP reports issued since the inception of the program. The CAP review reports analyzed included findings, conclusions, suggestions, and recommendations; and the scope of the reviews addressed programmatic and facility specific issues.

We identified CAP review results, which in our judgment impacted significantly on patient care, delivery of benefits, and the economy and efficiency of operations and determined which issues had the greatest impact on VA. We then selected those issues we considered to be systemic concerns that pose continued risks to VA programs and activities. Following are the systemic areas addressed in this report.

Veterans Health Administration:

Patient Care Issues

- Environment of Care
- Pharmacy Drug Controls and Security
- Part-Time Physician Time and Attendance
- Quality Management

Financial, Management, and Administrative Issues

- Contract Award and Administration
- Financial Management
- Government Purchase Card Program
- Information Security
- Inventory Management and Equipment Accountability
- Medical Care Collections Fund

Veterans Benefits Administration:

Benefits Administration Issues

- Compensation and Pension Claims Processing
- Fiduciary and Field Examination Program
- Vocational Rehabilitation and Employment Program

Financial, Management, and Administrative Issues

- Government Purchase Card Program
- Information Security and Security of Sensitive Records

Issues Identified at VHA Health Care Facilities

Patient Care Issues:

Environment of Care

We conducted environment of care (EOC) inspections during VHA medical facility CAP reviews from January 1999 through August 2006 and reported our findings in the individual medical facility reports. Over this period, we identified 119 facilities where improvements were needed in facilities' EOC. The purpose of our EOC inspections during CAP reviews was to determine if managers had established comprehensive EOC programs that result in a safe and clean environment. The majority of our findings concerned problems with safety, cleanliness, and sanitation. Facility managers concurred with our recommendations and took corrective actions.

On February 6, 2006, we issued a roll-up report, *Evaluation of Environment of Care in Veterans Health Administration Facilities*, (Report No. 04-03402-81), that included our findings from 40 CAP reviews for the period October 2003 through October 2004. We reported deficiencies at 19 of the 40 facilities. The most frequent deficiencies were in the categories of safety, cleanliness/sanitation, and infection control. Safety problems occurred as a result of management's failure to monitor staffs actions and update policies. Cleanliness and sanitation concerns were primarily due to a lack of general housekeeping and maintenance. All of the infection control issues were related to noncompliance with established policies and procedures. The EOC is crucial to achieving a safe patient care environment, reducing infection control risks, and improving patient care outcomes.

Because of the impact the health care facility EOC has on patient care, and the immediate and lasting impression EOC conditions make on patients, employees, and visitors to VA facilities, VHA must continually improve and sustain past improvements in this area. The OIG will monitor and report on the success of improvement actions in future CAP reviews and national audits, as needed, to ensure that VHA maintains a safe, secure, and sanitary environment in its health care facilities.

Pharmacy Drug Controls and Security

CAP review reports have contained recurring findings that show pharmacy drug controls, including accountability for controlled substances and pharmacy physical security, needed improvement at VHA medical facilities. We identified 175 facilities where improvements were needed in pharmacy physical security or controls over controlled substances and other drugs needed strengthening during CAP reviews from January 1999 to August 2006. The reviews showed that VHA facility staff have not consistently followed established procedures, including ensuring controls required by VA and other Federal authorities, and as a result vulnerabilities and risks have occurred VHA-wide.

From January through September 2005, OIG reviewed compliance with controls to account for prescription drugs and prevent or detect their theft or loss. This review summarized systemic

deficiencies identified during CAP reviews conducted at 22 VHA medical facilities. This work found that medical facility staff did not always follow controls intended to deter and detect theft of drugs, and that vulnerabilities existed that could facilitate drug theft. In addition, the results showed that some medical facilities can increase their use of automated inventory management systems to better control prescription drug inventories. We made numerous recommendations in the 22 CAP review reports to correct the conditions identified, and facility managers responded with acceptable implementation plans during the CAP reviews. However, to improve drug accountability and physical security, the following highlights significant improvement actions needing attention VHA-wide:

- Conduct all controlled substances inspections, reports, and related actions as required by VHA and the Drug Enforcement Administration.
- Follow requirements for conducting, recording, and resolving discrepancies in physical inventories of controlled and noncontrolled drugs.
- Ensure that staff use required automated drug accountability and inventory management systems.
- Comply with VHA policy for reporting suspected theft, diversion, or suspicious loss of drugs to VA Police and the OIG Office of Investigations.
- Ensure appropriate physical security and controls over access to drug storage areas, including use of required electronic intrusion systems.
- Provide training on drug accountability and inspections.

Part-Time Physician Time and Attendance

CAP review reports have had recurring findings that show part-time physician time and attendance controls needed improvement. From January 1999 to August 2006, we have identified 56 facilities that needed to strengthen controls over part-time physician time and attendance. We continue to see opportunities to strengthen management controls over this area. Managers did not have effective controls in place to ensure part-time physicians were on duty when required by employment agreements, physicians did not complete appropriate time and attendance records, timecards were not posted based on timekeepers' actual knowledge of physicians' attendance, desk audits were not conducted, and timekeepers did not receive annual refresher training.

To improve part-time physician time and attendance activities, CAP reviews have made numerous recommendations. The following recommendations, while reported in individual facility reports, are highlighted as significant improvement actions needed to strengthen controls for part-time physician time and attendance:

- Implement controls to ensure part-time physicians are on duty according to their employment agreements.

- Ensure part-time physicians complete appropriate time and attendance records.
- Ensure timecards are posted based on timekeepers' actual knowledge of physicians' attendance.
- Require that timekeeping desk audits are performed.
- Provide required annual refresher training to all timekeepers.

Our November 15, 2005, report, *Major Management Challenges Fiscal Year 2005*, (Report No. 06-00480-26), stated part-time physician time and attendance continues to be a management challenge in VA and references our April 23, 2003, report, *Audit of VHA's Part-Time Physician Time and Attendance*, (Report No. 02-01339-85). This audit also identified opportunities to ensure part-time physician time and attendance is properly managed VA-wide. The report recommended VA ensure part-time physicians are present during their scheduled tours of duty so that they meet their required VA employment obligations.

In May 2003, the Inspector General (IG) provided testimony to Congress regarding the results of this audit. He testified that VHA medical facility managers did not consistently ensure that part-time physicians were working the hours established by their VA appointments. As a result, part-time physicians' employment obligations were not met as required by their VA appointments. The IG stated that communication of expectations and responsibilities would significantly improve operations at the VA medical facilities. In response, VA management has taken action to effectively address the report recommendations by implementing new policy. However, we continue to receive and review allegations and complaints addressing this issue and based on recent CAP results, additional attention is needed to improve compliance with the new policy.

Quality Management

The OIG is mandated to provide oversight of quality management (QM) in VHA facilities. Our QM reviews provide a consistent and comprehensive approach to reviewing selected elements of the QM function. While we revise the QM review guide each year to reflect changes in relevant VHA and external requirements, QM reviews will continue to be an element of CAP reviews.

We have reviewed QM programs at medical facilities on CAP reviews performed between January 1999 to August 2006 and identified 128 facilities that needed to strengthen controls in this area. We reported our findings in the individual medical facility CAP reports. The purpose of our reviews was to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts; and if VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. The reviews have identified strengths and weaknesses in VHA guidance to the field as well as field compliance with VHA guidance and other external standards, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Medical facility managers concurred with our recommendations and took appropriate corrective actions. We issued two QM roll-up reports.

Our June 4, 2003, roll-up report, *Evaluation of Quality Management in Veterans Health Administration Facilities,* (Report No. 02-000026-106), included findings from 20 CAP reviews from October 2001 through September 2002. We concluded that all 20 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. However, we found areas needing improvement and made the following three recommendations to the Under Secretary for Health:

- Improve facility QM program effectiveness by ensuring that: all relevant areas and programs are included in the QM plan and program; managers and program coordinators receive training in data analysis and benchmarking; significant corrective actions are implemented and evaluated until issues are resolved; and practitioner-specific data are available for use at reprivileging.

- Emphasize the importance of senior managers' frequent, visible presence in clinical areas.

- Re-emphasize the requirement for detailed mortality and morbidity analyses and initiate internal review processes to ensure that managers perform the required analyses.

The Under Secretary for Health agreed with the recommendations and issued VHA Directive 2004-054, *Peer Review for Quality Management,* dated September 29, 2004, that addressed the issues in this report.

Our July 14, 2004, roll-up report, *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2003,* (Report No. 03-00312-169), included findings from 31 CAP reviews from October 2002 through September 2003. We compared our findings from the FY 2003 CAP reviews with the findings cited in the September 2002 report. We noted improvements in several areas; however, we continued to identify areas that needed improvement and made the following six recommendations to the Under Secretary for Health:

- Ensure all facilities have policies and have fully implemented processes for disclosure to patients who have been injured by adverse events.

- Develop and implement a standardized utilization management approach at all VHA facilities by a defined date.

- Ensure compliance with VHA regulations regarding patient complaints management, specifically data analyses and integration into facility QM reporting mechanisms.

- Ensure compliance with existing JCAHO requirements regarding medical record documentation reviews, specifically data analyses, reporting results in clinical forums, and implementing and evaluating action items.

- Ensure that clinical managers, program coordinators, and committee chairpersons responsible for QM-related monitors receive training in the following data management skills: analyzing critical data, benchmarking results, identifying specific corrective actions, defining effectiveness criteria for corrective actions, and implementing corrective actions and evaluating results until issues are resolved.

- Ensure that all clinical managers, program coordinators, and committee chairpersons responsible for QM-related monitors understand and fulfill the expectations to address all problem areas or opportunities for improvement until resolution.

The Under Secretary for Health agreed with our report recommendations and initiated a work group to review each of the recommendations and identify steps that might be taken at each organizational level to achieve more consistent compliance with established QM program goals. Further, VHA issued Directives 2005-049, *Disclosure of Adverse Events to Patients,* dated October 27, 2005, and 2005-009, *Utilization Management Policy,* dated March 7, 2005.

VHA managers should continue to strive to improve all aspects of medical facilities' QM programs, to ensure quality of patient care and comply with requirements of VA and medical oversight bodies including JCAHO. The OIG will monitor and report on QM in future CAP reviews.

Financial, Management, and Administrative Issues:

Contract Award and Administration

The CAP review reports have identified numerous instances in which contract award and administration needed improvement at VA facilities nationwide. VA needs to strengthen controls over facilities' contracting activities to enhance the economy and efficiency of procurement actions. From January 1999 to August 2006, we have identified 155 facilities that needed to improve various aspects of contract award and administration activities. We have also reported VA procurement practices, including contracting for health care services, as a serious management problem in annual reports of Major Management Challenges.

Areas needing improvement include: (1) strengthening VA controls throughout the life of the contracting processes to ensure that goods and services are needed and received timely; (2) ensuring accurate statements of requirements are prepared; (3) ensuring competition requirements are met; and (4) ensuring reasonable prices are paid, and goods and services meet quality standards. CAP reviews also identified a lack of acquisition planning, conflict of interest violations, poorly written solicitations, inadequate contract negotiations, and poor contract administration. In addition, the reviews found that required legal, technical, and preaward reviews for price reasonableness are not consistently obtained. In some cases, recommendations from the technical reviews were not implemented. The need to ensure these technical reviews occur is particularly important for non-competitive sole source procurements. Improvements are needed to ensure that VA's financial, performance, and contractual interests are adequately protected.

VA also needs to better leverage its substantial purchasing power and to improve the overall effectiveness of procurement actions and support. In addition, Contracting Officer's Technical Representatives (COTRs) need adequate training regarding their duties, responsibilities, and authorities before assuming responsibility to monitor contractor performance.

To improve contract award and administration activities, CAP review reports have included numerous recommendations. The following recommendations are highlighted as the most

significant improvement actions needed to strengthen controls in the contract award and administrative activities.

Preaward Contract Actions:

- Ensure competition requirements are met.
- Obtain legal and technical reviews prior to contract award, when required.
- Refer all sole-source contracts with affiliates or associated practice groups valued at $500,000 or more to the OIG for preaward audits.
- Strengthen controls to prevent potential conflicts of interest and seek VA Regional Counsel opinions.
- Ensure COs initiate background investigations for contractor personnel with access to VA computer systems and sensitive information prior to contractor performance.
- Ensure COTRs' training in duties and responsibilities, documentation of limited authority and delegation of certification responsibilities, and take action to ensure they properly monitor contracts.

Postaward Contract Actions:

- Maintain required documentation files such as price negotiation memorandums in official contract files.
- Monitor contractor performance and ensure payments are made in accordance with contract terms, specifications, and acceptable levels of performance.
- Conduct regular supervisory contract file reviews to ensure compliance with regulations and policies, and to detect, correct, and prevent future contract deficiencies.

The OIG also issued a February 16, 2005, summary report, *Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions*, (Report No. 05-01318-85), that identified persistent weaknesses in contracting practices and opportunities to improve contract award and administration deficiencies including those identified during CAP reviews. This report presented results and recommendations for general contracting, contract pricing, conflict of interest, and other legal issues. The need for additional management attention to improve contract award and administration and all aspects of VA procurement processes is important because, in addition to affecting the price reasonableness of goods and services, the effectiveness of controls over these actions impact on whether the contracts are in the best interests of the Department.

The Department has implemented improvement actions in response to the numerous recommendations in our CAP review reports and other reports addressing contracting issues. VA issued Directive 1663, *Health Care Resources Contracting Buying*, dated August 10, 2006,

to address deficiencies in VHA's award and administration of sole-source contracts. In addition, the prior VA Secretary had established a Procurement Reform Task Force in response to OIG reported concerns, and VA has responded by working to implement the task force recommendations. However, recent CAP review reports continue to show that additional improvements are needed to improve contact award and administration throughout VA.

For more information see our reports:

- *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, (Report No. 04-01371-177), August 11, 2004.
- *Review of VA Implementation of the Zegato Electronic Travel Service*, (Report No. 04-00904-124), March 31, 2005.
- *Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study*, (Report No. 04-02330-212), September 30 2005.
- *Audit of VA Acquisitions for Other Government Agencies*, (Report No. 04-03178-139), May 5, 2006.

Financial Management

CAP review reports have contained recurring findings that indicated VA medical facilities' financial management controls need improvement. We have identified 80 facilities where financial management controls needed strengthening, including 44 facilities where facilities' agent cashier controls and activities needed improvements between January 1999 to August 2006. The primary areas that needed strengthening involved accounts receivable and agent cashier activities. The CAP reviews found that accounts receivable were not aggressively pursued for collection and that other debt collection actions needed improvement. Unannounced audits of the agent cashier were not conducted properly or timely, and physical security of the agent cashier needed improvement to protect cash assets at the facilities.

To improve financial management and controls, CAP review reports have made numerous recommendations, including the following:

- Aggressively pursue accounts receivable for collection, follow up on delinquent accounts receivable, and write off uncollectible receivables.
- Strengthen debt collection actions, including offsets against future obligations or other accounts and increase telephone contacts with insurers.
- Conduct unannounced audits of the agent cashier's cash advance at least every 90 days and ensure that agent cashier duties are properly segregated.

- Improve agent cashier physical security, including changing the combination to the agent cashier vault after changes in the agent cashier position and providing a security escort during cash replenishment trips.

VA facility managers have taken actions to implement the CAP review report recommendations, but stronger actions are needed by the Department to ensure that financial controls are effective and comply with VA requirements.

Government Purchase Card Program

We have reported VA procurement practices, including Government purchase card activities, as a serious management problem in recent annual reports of Major Management Challenges. The CAP review reports have identified numerous weaknesses in Government purchase card program controls VHA-wide, and there continues to be opportunities to strengthen management controls over purchase card program activities. We have identified 120 facilities that needed to improve controls over Government purchase card activities between January 1999 to August 2006.

Weaknesses in controls at VHA facilities, include instances of noncompliance with policies and procedures established for the program by VA and the Federal Acquisition Regulations (FAR). In addition, we continue to identify instances of inadequate training of cardholders and approving officials, untimely reconciliations and certifications of transactions by cardholders and approving officials, misuse of the cards, lack of segregation of duties, and numerous instances where purchases exceeded purchasing limits.

To improve Government purchase card program activities, CAP reviews have made numerous recommendations including the following improvement actions needed to strengthen related controls for the program:

- Ensure that all staff follow policies and procedures established for the program and comply with the FAR and VA regulations.

- Ensure adequate segregation of duties for cardholders, approving officials, purchase card coordinators, and dispute officers.

- Train cardholders and approving officials in performing program responsibilities.

- Ensure that cardholders and approving officials reconcile and certify purchase card transactions in a timely manner.

- Strengthen oversight, including supervisory reviews, to prevent misuse of purchase cards by VA employees.

- Implement controls to ensure cardholders do not exceed purchase limits.

The OIG also issued a national report on April 26, 2004, *Evaluation of the Department of the Veterans Affairs Government Purchase Card Program,* (Report No. 02-01481-135), that identified opportunities to ensure purchase cards were used properly VA-wide. The report

presented results and recommendations concerning purchase card fraud, improper and questionable purchase card transactions, and internal controls. The OIG concluded that VA management needed to strengthen internal controls and provide greater management oversight to ensure that the FAR and VA policies were effectively implemented to prevent and detect fraudulent, improper, and questionable uses of purchase cards.

VHA managers have implemented improvement actions in response to recommendations in our CAP review reports. The Department has also implemented improvement actions in response to the recommendations in the April 2004 report. For example, in 2005 VHA issued Handbook 1730.1, *Use and Management of the Government Purchase Card*, which updated and clarified procedures for the use of the purchase cards for VHA facilities and program offices.

VA's Office of Business Oversight (OBO) began using data mining techniques to identify potentially questionable purchase card transactions in FY 2005. The OBO provides status updates to the VA Chief Financial Officer (CFO) as well as Administration CFOs on a quarterly and annual basis, with overall program recommendations provided at the end of the fiscal year. In addition, the OBO has performed site reviews at VHA and VBA facilities and examined purchase card processes and procedures. Findings are summarized in an annual report, with program-wide recommendations directed to appropriate officials. Also, desk guides for cardholders, approving officials, and program coordinators have been signed and placed on the VHA's CFO Web site. Guides are also available for purchase card disputes and frauds, accruals, and audits. These are responsive improvement actions expected to improve controls over the purchase card program. However, based on recurring CAP review results VHA managers need to hold staff with purchase card responsibilities accountable for compliance with policies and procedures and ensure adequate supervisory reviews of facility transactions in order to reduce risks for misuse and overpayments.

Information Security

CAP review reports have had recurring findings that show information security needs improvement VHA-wide. We continue to see opportunities to strengthen management controls over information security activities. Between January 1999 and August 2006, the CAP reviews identified information technology (IT) and security deficiencies or security controls that needed strengthening at 176 VHA facilities reviewed. Some of these reviews were repeat visits to VHA facilities.

In CAP reviews, we have continued to make recommendations to improve security and contingency plans, control access to information systems, complete background investigations and annual security awareness training, and improve physical security controls. Further recommendations have been made including:

- Monitor access to key information systems and limit physical access to automated information security (AIS) resources to only those with legitimate needs.

- Implement security and contingency plans and conduct risk and vulnerability assessments.

- Improve physical security of IT and space, including addressing the need for ensuring environmental safeguards such as temperature and humidity controls.
- Ensure background investigations are conducted for VA and contractor personnel.
- Ensure timely termination of information system access for separated employees.
- Ensure all software program changes are adequately documented.
- Restrict off-duty users' access to VA computer systems and sensitive information.
- Provide annual security awareness training for all VA and contractor employees.
- Maintain documentation to provide assurance that all hard drives have been properly sanitized or destroyed prior to the disposition of computer equipment.
- Comply with VA policy regarding strong passwords.
- Store essential backup data in secure areas.

We have reported vulnerabilities in IT security controls in our Consolidated Financial Statements (CFS) annual audit reports since the FY 1997 audit and Federal Information Security Management Act (FISMA) audit reports since FY 2001, in addition to CAP review reports. Our September 20, 2006 report, *FY 2005 Audit of VA Information Security Program*, (Report No. 05-00055-216), also identified significant information security vulnerabilities that place VA at considerable risk. Most recently, our July 11, 2006 report, *Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans*, (Report No. 06-02238-163), reported that each year we continue to find repeat deficiencies and make repeat recommendations that remain unimplemented involving information security.

OIG officials testified before Congress in May and June 2006, reporting that we have conducted a number of audits and evaluations regarding information management security and IT systems, which have shown the need for continued improvements in addressing security weaknesses. We have also reported information security as a major management challenge for the Department in all Major Management Challenges reports issued from FY 2000 to the present. The recurring themes in these reports support the need for a centralized approach to achieve standardization, remediation of identified weaknesses, and a clear chain-of-command and accountability structure for information security.

As a result of our oversight, VA has implemented some recommendations for specific locations identified but has not made sufficient progress addressing corrections VA-wide. For example, in response to our FISMA audits, VA is developing policies and procedures for implementing a federated approach to managing IT security and resources and is in the process of addressing recommendations made during prior FISMA audits. However, we continue to find that corrective actions have not been applied at all VHA facilities nationwide, and CAP review results have continued to show that information security is a high risk area and additional management attention is needed in this area to ensure and sustain improvements. Individual VHA managers have agreed with our CAP review recommendations, and our follow-up process

confirms actions to resolve the specific conditions identified at these sites. However, more effort is needed to put security improvements in place that effectively eliminate the risks and vulnerabilities of unauthorized access and misuse of sensitive information and VA's information systems.

Inventory Management and Equipment Accountability

CAP reviews have continued to show that VHA management needs to strengthen controls over the management of supply inventories, including medical, surgical, prosthetic, engineering, and other miscellaneous supplies. We identified 176 VHA facilities where improvements were needed to effectively manage inventories between January 1999 and August 2006. VHA policy establishes a 30-day supply goal for most items and mandates the use of the Generic Inventory Package (GIP) to manage medical, surgical, engineering, and miscellaneous supply inventories and the Prosthetics Inventory Package (PIP) to manage the prosthetic supply inventory.

Since their inception, CAP reviews have consistently found that VA medical facilities did not: (1) fully utilize GIP for all supply inventories; (2) regularly update GIP and PIP to ensure accurate inventory levels; (3) adequately train staff to use GIP and PIP; or (4) periodically perform physical inventories to verify GIP or PIP records. As a result, the medical facilities could not ensure that automated inventory records were accurate or supply levels were appropriate.

To strengthen controls over supply inventory management, we are highlighting the following significant recommendations made during CAP reviews:

- Require staff to accurately record inventory transactions in GIP and PIP and keep stock levels current.
- Monitor item usage rates, reconcile differences between actual and recorded stock levels, and adjust stock levels as appropriate.
- Perform periodic physical inventories.
- Reduce excess inventories.
- Train staff responsible for using and maintaining GIP and PIP, and provide refresher training as needed.

Recent Major Management Challenges reports also identified inventory management as a serious issue in VA. By improving inventory management nationwide, VA can potentially reduce excess inventories, ensure appropriate stock levels to meet patient needs, and prevent conversion problems for the future integrated financial and logistics system.

VHA officials have recognized the issues pertaining to inventory management, and have taken actions to effectively implement CAP review recommendations. Efforts that are underway include rewriting the *Inventory Management Handbook*, programming changes to GIP, monitoring reviews by the Chief Logistics Officer, and ongoing training for GIP and PIP users.

However, CAP review results continue to support that additional efforts are needed to strengthen inventory management controls.

CAP reviews also continued to show that VHA management needed to strengthen controls over equipment. During CAP reviews, we found that some VA medical facilities staff were not: (1) performing required physical inventories; (2) recording all equipment, including new or sensitive equipment, on Equipment Inventory Lists (EILs); (3) ensuring that EILs were complete and accurate; and (4) promptly reporting when equipment was lost, damaged, or destroyed.

To improve the equipment accountability at VA medical facilities, we made the following recommendations during CAP reviews:

- Maintain appropriate equipment inventory records, including updated lists to show the status and current locations of equipment items.
- Ensure that all sensitive equipment, such as firearms and IT equipment, is included on EILs.
- Require responsible VA employees to perform physical inventories of equipment in accordance with VHA requirements and timelines.
- Require inventory spot-checks for equipment, especially sensitive IT equipment.
- Establish procedures to ensure proper controls are followed and documentation is completed for equipment that is turned-in, transferred, destroyed, or disposed.
- Establish procedures for reporting equipment that is lost, stolen, or damaged, and remind all medical facility staff of the reporting requirement.
- Ensure that "Reports of Survey" are properly completed for missing equipment items.

Recent events concerning the loss of sensitive data in VA and other Federal agencies have contributed to the urgency of not only properly safeguarding sensitive data, but also the equipment that contains sensitive data. However, we continue to find instances where responsible medical facilities staff have not always implemented VA equipment accountability policies as required. As a result of CAP reviews, VA managers have taken actions to effectively implement CAP review recommendations. However, in our opinion, equipment accountability remains an ongoing compliance problem at many VA facilities.

Medical Care Collections Fund

CAP review reports have had recurring findings that show Medical Care Collections Fund (MCCF) needs improvement VHA-wide and we continue to see opportunities to strengthen management controls over collection activities. We identified 130 VHA facilities where improvements were needed to enhance MCCF collections or to strengthen controls over related billing activities from January 1999 to August 2006. CAP reviews have found various MCCF deficiencies at VA medical facilities, including not following policies and procedures governing means testing, not identifying veterans with health insurance coverage, inadequate medical

record documentation and coding, not billing for VA and fee-basis medical care in a timely manner, and not following up on delinquent bills. We have also identified and reported MCCF as a serious management problem in our Major Management Challenges Reports for the past several years. In fact, the FY 2005 report notes that CAP reviews examining MCCF activities found deficiencies at 19 of 21 facilities tested.

To improve MCCF activities, CAP reviews have made numerous recommendations. The following recommendations, while reported in individual facility reports, are highlighted as significant improvement actions needed to strengthen controls:

- Provide refresher training for employees responsible for administering means tests to veterans.
- Strengthen patient registration procedures to ensure insurance information is obtained at the time of treatment.
- Require that clinicians adequately document the care provided in veterans' medical records and that coders properly code the care provided.
- Bill insurance carriers for medical services provided in a timely manner.
- Ensure follow-up collection efforts for delinquent bills.

The OIG has also provided testimony to Congress regarding the MCCF program. On September 20, 2001, the Inspector General reported that audit results showed the potential for significant additional collections in the areas of insurance identification, medical record documentation, clearing billing backlogs, and collection of delinquent bills. On May 8, 2003, the Inspector General reported our *Audit of the Medical Care Collection* Fund, (Report No. 01-00046-65), which stated that an earlier OIG report resulted in identifying opportunities to increase collections in the areas of employee training, patient registration, medical record documentation, billing of insurance carriers, and follow-up with insurance carriers on delinquent accounts receivable. On July 21, 2004, the Assistant Inspector General for Auditing testified to Congress that, although VHA had increased collections, audit results showed that these conditions continued to persist based on the results of audits and CAP reviews.

VA management has taken actions to implement OIG recommendations. Collections have increased from $573 million in FY 2000 to over $1.8 billion in FY 2005. However, facility management still needs to strengthen billing procedures to avoid missed billing opportunities, improve the timeliness of billings, improve the accuracy of diagnostic and procedure coding; and aggressively pursue accounts receivable to ensure to the maximum extent possible, VA is properly compensated for the services provided to those veterans with private health insurance coverage.

Issues Identified at VBA Regional Offices

Benefits Administration Issues:

Compensation and Pension Claims Processing

CAP review reports have identified 63 instances (including repeat visits) where VA regional offices (VAROs) needed to improve compensation and pension (C&P) claims processing during the period June 2000 through August 2006. These included avoidable claims processing delays and/or procedural errors that affected workload completion and timeliness. VARO staff did not consistently identify hospitalized veterans whose benefits needed to be reduced, collect related overpayments, and process related C&P claims accurately and timely. In addition, several CAP reviews have identified the need to obtain and verify the accuracy of third-party signature authorizations for one-time retroactive payments. In OIG Semiannual Reports to the Congress from April 1, 2000, through March 31, 2006, we have reported that the processing of hospital adjustments needed improvement at all 42 sites where we had reviewed this issue.

CAP reviews also found problems with retroactive payments that were not timely or signed by employees with third-party signature authority. CAP reviews identified instances where supervisory reviews and directors' verification reviews of retroactive payments of $25,000 or more were not timely, documented, or lacked the required third approval signatures.

Our review of claims processing procedures showed that a number of factors had negatively affected several VAROs' ability to process C&P claims timely, including staffing issues and newly implemented regulations that require reworking of claims. To improve VARO claims processing, the following CAP review recommendations are highlighted as significant improvement actions needed to improve C&P claims processing VBA-wide:

- Improve monitoring of claims processing timeliness and aggressively follow up on processing delays.
- Provide training to VARO staff that includes emphasis on timeliness and accuracy in processing C&P claims.
- Promptly adjust benefit payments to veterans hospitalized at Government expense for a period of 90 days or more and initiate collection actions when necessary.
- Closely monitor one-time retroactive payments of benefits and ensure all required third-party authorization signatures are obtained.

The March 29, 2002 OIG report, *Special Review of VA Compensation and Pension One-Time Payments and Related Security Controls*, (Report No. 01-02957-075), also found that VAROs were not consistently complying with security control requirements related to C&P payments. This review identified unacceptably high rates of noncompliance with internal control requirements related to one-time payments (OTP) and C&P claim processing. For example, three-signature reviews had not been properly done for 41,149 of the 57,656 OTPs (71.4 percent) that were subject to these reviews. The report recommended that VAROs certify to VBA that

they have corrected Benefits Delivery Network (BDN) and claim folders security deficiencies identified during the review and annually recertify that they are in full compliance with BDN and claim folders security controls.

In addition, the *Major Management Challenges Fiscal Year 2005* report identified C&P claims processing timeliness as a serious weakness and VA management problem. This report concluded that although VA had made some progress in addressing its claims processing backlog that once peaked at over 600,000 outstanding claims, its efforts had been impeded by a variety of issues including the complexity of claims and the influx of veterans needing services and benefits from the war on terrorism. The report also stated that, although VA had established processing claims in a timely and accurate manner as a top priority, timeliness goals for completing rating actions for C&P claims had not been met.

The Department has implemented improvement actions in response to the numerous recommendations in our CAP review reports. For example, VBA management has issued directions to improve procedures for extracting and acting on veteran hospitalization information. To improve controls over one-time retroactive payments, VBA implemented an electronic review system to verify the propriety of payments of $25,000 or greater.

VA credits improvements in reducing claims processing backlog to the reforms recommended by the Secretary's Claims Processing Task Force report of October 2001. The Task Force report also recommended measures to increase the efficiency and productivity of VBA operations, shrink claims backlog, reduce claims processing time, and improve the accuracy of decisions. In addition, the task force made 34 recommendations, and VBA defined 70 actions to accomplish those recommendations. As of August 2005, VBA reported that all task force recommendations had been implemented. However, while CAP review results show some improvements in controls over large retroactive payments, the reviews identify instances where controls over C&P claims processing needs improvement.

Fiduciary and Field Examination Program

CAP reviews have frequently identified deficiencies in Fiduciary and Field Examination (F&FE) program activities. Over the period June 2000 through August 2006, we reported deficiencies at 39 CAP review sites where we examined F&FE program activities. Significant systemic deficiencies were identified including inadequate follow-up on late fiduciary accountings, delays in performing required field examinations, and failure to obtain surety bonds for fiduciaries, when appropriate. In addition, field examiners did not always conduct thorough examinations or make appropriate recommendations or referrals, and coordination between VBA and VHA staff needed improvement.

CAP review reports have made many recommendations to strengthen F&FE activities and reduce the risk of theft or misuse of beneficiaries' funds. Key recommendations that address opportunities to improve systemic weaknesses impacting the F&FE program were to:

- Ensure that Legal Instrument Examiners promptly refer cases with late accountings to field examiners, the OIG, or the VA Regional Counsel, as appropriate.

- Ensure that field examiners perform field examinations within required timeframes, conduct thorough field examinations, and make appropriate recommendations or referrals.
- Ensure that F&FE staff meet with VA medical center staff to discuss and coordinate services provided to incompetent veterans.
- Ensure that F&FE management meets annually with appropriate VHA officials to coordinate services for incompetent veterans enrolled in the Residential Care Home (RCH) program.
- Provide training on bonding requirements, and ensure that F&FE staff require fiduciaries to obtain surety bonds, when appropriate.
- Ensure that F&FE staff follow up on delinquent fiduciary accountings and ensure that all F&FE data is accurately reported in the Fiduciary-Beneficiary System.

In July 2003, the Inspector General and Assistant Inspector General for Auditing testified before Congress reporting some of these same deficiencies in the F&FE activities. Also, our June 27, 2006, report, *Audit of Veterans Benefits Administration Fiduciary Program Operations*, Report (No. 05-01931-158), demonstrated the need to provide more effective program oversight. The audit complemented CAP review oversight and showed that VA needed to better protect the benefit payments and assets of incompetent beneficiaries by completing required field examinations, improving monitoring of fiduciaries who are required to submit periodic accountings, and ensuring that fiduciaries obtain appropriate surety bonds.

The Department has taken several actions in recent years to address the deficiencies we identified. The Legal Instruments Program Guide that had been used since 1981 was recently revised and updated, and a training conference for Legal Instruments Examiners was held in May 2006. Clarifying language concerning surety bonds has been added to the Fiduciary Program Manual, and an evaluation of the F&FE organizational structure and staffing levels has begun. However, since the number of weaknesses substantiated during CAPs remains high, more attention is needed to effectively address these deficiencies.

Vocational Rehabilitation and Employment Program

CAP review reports have had recurring findings that show VBA's Vocational Rehabilitation and Employment (VR&E) Program needs improvement VA-wide. From June 2000 through August 2006, we reported deficiencies at 39 CAP review sites where we examined VR&E program activities. The VR&E deficiencies reported at VAROs included inadequate monitoring of program participants and problems with timeliness of services, documentation, and data entry accuracy.

To improve VR&E activities, CAP reviews have made numerous recommendations including the significant improvement actions highlighted below:

- Provide timely application, evaluation, and planning services and reduce backlogs by timely notifying applicants of VR&E entitlement benefits.

- Ensure that VR&E records contain documentation on eligibility notifications, initial appointments, and decisions to grant benefits or change training objectives.

- Conduct periodic reviews to determine the correct status of participants, and promptly place participants who are not actively pursuing training into a discontinued status.

- Monitor data entered into AIS for accuracy, correct data as needed, and timely update veterans' status in VR&E records.

One of the goals of the OIG's *Strategic Plan 2005-2010* is to "Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing." The CAP reviews have addressed this goal, but the success of VBA-wide improvements in the VR&E program is not evident in overall CAP review results. With the exception of VR&E contracting practices, a national audit of this program has not been conducted in recent years. Based on CAP review results, a national audit is planned to begin in FY 2006.

Financial, Management, and Administrative Issues:

Government Purchase Card Program

CAP review reports have identified weaknesses in controls over the Government purchase card program activities VBA-wide and we continue to see opportunities to strengthen management controls over purchase card activities. From June 2000 through August 2006, we have reported deficiencies at 34 CAP review sites where we have examined Government purchase card program activities. Improved controls are needed so that VA can leverage its buying power to the maximum extent possible and obtain available discounts. VA procurement practices, including Government purchase card activities, have been reported as a serious management problem in our recent annual reports of Major Management Challenges.

CAP reviews have found various Government purchase card program weaknesses at VAROs, including insufficient supporting documentation, inappropriately splitting purchases, untimely reconciliations and certifications of transactions by cardholders and approving officials, inadequate segregation of duties, and a lack of training. In addition, we have identified instances where cardholders were authorized credit limits far in excess of their needs and requirements.

To improve the purchase card program, CAP reviews have made numerous recommendations. The following recommendations are highlighted as significant improvement actions needed to strengthen controls in the Government purchase card program in VA:

- Ensure that the staff follows VA policies and procedures established for the program.

- Set purchase card spending limits based on cardholders' actual procurement needs.

- Implement adequate segregation of duties for cardholders, approving officials, purchase card coordinators, and dispute officers.

- Maintain appropriate documentation for purchase card use, approvals, purchases, billing statements, reconciliations, and other purchase card activities.
- Ensure purchase cardholders do not split purchases and/or exceed the assigned spending limits of their warrants.
- Ensure cardholders and approving officials reconcile and certify purchase card transactions in a timely manner.
- Train cardholders and approving officials in performing assigned responsibilities.

The OIG issued a national report in April 26, 2004, *Evaluation of the Department of the Veterans Affairs Government Purchase Card Program,* (Report No. 02-01481-135), that identified opportunities to ensure purchase cards were used properly VA-wide. The report presented results and recommendations in the areas of purchase card fraud, improper and questionable purchase card transactions, and internal controls. At that time, VA management needed to strengthen internal controls and provide greater management oversight to ensure that the FAR and VA policies were effectively implemented to prevent and detect improper and questionable uses of purchase cards, including fraudulent use.

In 2005, VBA reported that they had continued to emphasize to VARO staff the importance of following the guidance set forth in VBA Handbook 4080, *Management of the Government Purchase Card*. The handbook, which incorporated prior OIG recommendations and suggestions, was released to VAROs in June 2004. It includes a purchase card checklist as well as an approving official's review guide to aid in monitoring cardholders' purchase card use. VARO managers efforts have improved controls over purchase card activities, but additional efforts are needed to ensure compliance with applicable policies and procedures and to ensure timely supervisory review of purchase card activities.

Information Security and Security of Sensitive Records

CAP review results have repeatedly continued to demonstrate that information security weaknesses persist and that information security needs improvement at VBA facilities nationwide. We continue to identify opportunities to strengthen management controls over information security activities. Between June 2000 and August 2006, we identified IT and security deficiencies during 49 VARO reviews conducted. Some of these reviews were repeat visits to regional offices.

These CAP reviews have also continued to identify instances where sensitive claims files were not properly identified and secured. In addition, BDN access was not always limited to employees with legitimate need, employees' personal claim files were not always secured and electronically locked, and AIS physical security needed improvements. We continue to make recommendations to properly identify and secure sensitive claims files, including all identified veteran-employees' relatives; electronically lock sensitive files in BDN; ensure that BDN commands provided to VBA employees are necessary; ensure that employees' claims folders are electronically locked; and improve AIS physical security.

While VARO managers agreed with these CAP review recommendations, and the OIG follow-up process confirmed that actions were taken to resolve the specific conditions identified at these sites, we continue to find that corrective actions are not successful in improving conditions nationwide. Further, we continue to identify these conditions during site visits; and, therefore, we consider these weaknesses to be systemic.

To improve information security, CAP reviews have made numerous recommendations. The following recommendations, while reported in individual VARO reports, are highlighted as significant improvement actions needed to strengthen controls in information security:

- Add veteran-employees' relatives to the sensitive file list and electronically lock their files in BDN.
- Provide the VARO staff the required computer security awareness training.
- Ensure that employees' claims folders are electronically locked.
- Ensure that BDN commands provided are necessary.
- Identify and secure sensitive claims files.
- Improve AIS physical security.

CAP reviews have also found various security of sensitive records deficiencies at VAROs, including instances where VAROs did not perform semiannual audits and physical inventories of sensitive claims folders, electronically lock veteran-employees' and their relatives' claims folders, and implement control logs for staff to sign when locked claims folders are removed and returned to storage locations. To improve VARO security of sensitive records, CAP reviews have made numerous recommendations. While these recommendations have been reported in VARO CAP review reports, we are also emphasizing and highlighting the following significant improvement actions needed to strengthen VARO controls over sensitive records because these sensitive files are considered to be at high risk for fraud:

- Conduct audits of sensitive claims folders to ensure they are securely maintained at proper locations.
- Limit access to keys for rooms storing sensitive claims folders to authorized staff and use a centralized log system to control and monitor access to claims folders.
- Coordinate with the appropriate VARO of jurisdiction to obtain all employee-veterans' claim files for that office.
- Electronically lock all claims folders for veteran-employees and their relatives.

VA management has taken action to improve VARO security of sensitive records. During 2005, VA's OBO initiated research on physical security controls over hardcopy and electronic files related to the C&P program. This research included observing VARO facility access vulnerabilities as well as control and accountability over claims folders. The OBO has indicated

it will include physical security controls as a formal objective of their C&P reviews and will report any findings to VARO directors with recommendations for corrective actions. This action is expected to help strengthen controls over the security of sensitive records.

As we indicated previously in this report's section on VHA IT security issues, significant information security vulnerabilities and weak controls over security continue to place VA at continued and unnecessary risk of unauthorized access and misuse of sensitive information. Also, we have reported vulnerabilities in IT security controls in our Consolidated Financial Statements audit reports since the FY 1997 audit, FISMA audit reports since FY 2001, and CAP review reports. The magnitude of these risks is impeding VA from effectively carrying out its mission of providing health care and delivering benefits to our veterans and their beneficiaries. CAP review results underscore the need for continued improvements in addressing security weaknesses.

Our September 20, 2006 report, *FY 2005 Audit of VA Information Security Program*, (Report No. 05-00055-216), and our July 11, 2006 report, *Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans*, (Report No. 06-02238-163), noted that each year we continue to identify repeat deficiencies and repeat recommendations that remain unimplemented. For example, we recommended in FY 2002 and again in FY 2006 that one VARO complete required semiannual reconciliations of locked files (employee-veteran claims files), confirming that our FY 2002 recommendation had not been implemented effectively.

OIG officials' testimony before Congress in May and June 2006 noted we have conducted a number of audits and evaluations on information management security and IT systems that have shown the need for continued improvements in addressing security weaknesses. We have also reported information security as a major management challenge for the Department in all Major Management Challenges Reports issued for the last six years. The recurring themes in these reports support the need for a centralized approach to achieve standardization, remediation of identified weaknesses, and a clear chain-of-command and accountability structure for information security.

As a result of our work, the Department has implemented some recommendations for specific VBA locations identified but has not made corrections VA-wide. In response to our FISMA audits, VA is currently developing policies and procedures for implementing a federated approach to managing IT security and resources, and is still in the process of addressing recommendations made during prior FISMA audits. VARO managers have agreed with our CAP review recommendations, and our follow-up process confirms actions to resolve the specific conditions identified at these sites. However, we continue to find that corrective actions are not applied at VBA facilities to correct conditions nationwide. Additional management attention is needed to effectively address the systemic issues identified.

Appendix A

OIG HEALTH INSPECTION REPORTS ADDRESSING SIGNIFICANT AREAS REVIEWED DURING COMBINED ASSESSMENT PROGRAM REVIEWS

The following areas were also evaluated during CAP reviews. In response to the OIG reports discussed below, facility and national recommendations are in place or there are implementation plans in progress that are expected to address the weaknesses identified. However, these areas still will require rigorous oversight by Department officials to ensure national compliance VHA-wide and to sustain improvements impacting patient care.

Colorectal Cancer Detection and Management

We evaluated the effectiveness of colorectal cancer detection and management during 25 CAP reviews at VHA medical facilities from January through October 2005, and reported our findings in the facility CAP review reports. The purpose of our reviews was to determine whether VHA clinicians appropriately screened patients for colorectal cancer, provided diagnostic evaluations and treatment efficiently, effectively managed patients with positive screening results and/or active symptoms, properly notified patients of their cancer diagnoses, and coordinated care among all involved disciplines. The majority of the recommendations concerned the need for improvement in timeliness from presentation of symptoms or positive screening results to diagnosis. Facility managers agreed with our recommendations and took corrective actions.

On February 2, 2006, we issued a roll-up report, *Colorectal Cancer Detection and Management in Veterans Health Administration Facilities*, (Report No. 05-00784-76), that included our findings from the first 10 of the 25 medical facility CAP reviews. We concluded that clinicians needed to better manage patients with symptoms or positive screening results. We made three recommendations to the Under Secretary for Health:

- Establish appropriate metrics to evaluate and improve the timeliness of colorectal cancer diagnosis.
- Implement prioritization processes to ensure high-priority patients receive diagnostic colonoscopies according to their clinical needs.
- Implement a consistent notification requirement for patients undergoing colorectal cancer diagnostic testing, including timeliness and documentation.

In response to our findings, the Under Secretary for Health plans to update the Colorectal Cancer Screening Information letter to include a clarification of prioritization processes to ensure that high-priority patients receive diagnostic colonoscopies according to their clinical needs. This information letter will be reissued as a directive which will also include specific requirements for patient notification of colorectal cancer screening results, including a timeline and documentation standards.

Appendix A

Community Residential Care Program

We inspected Community Residential Care (CRC) programs from April through October 2003, during 9 of the 18 CAP reviews at VHA medical facilities that had formal CRC programs, to determine whether VHA medical facilities inspect their CRC homes in accordance with VA policy; veteran patients are appropriately assessed, placed, and followed up in CRC homes; CRC caregivers are qualified to meet patients' needs; and incompetent patients' care is coordinated with VBA. VHA medical facility Directors agreed with our findings and took appropriate corrective actions for the individual CAP review reports issued.

On May 3, 2004, we issued a roll-up report of our findings, *Veterans Health Administration's Community Residential Care Program,* (Report No. 03-00391-138), from nine CAP reviews. We concluded that improvements were needed to strengthen VHA's CRC program and enhance controls. We made 11 recommendations to the Under Secretary for Health:

- Issue standardized procedures for the collection and reporting of CRC workload, staffing, and cost data.
- Conduct annual fire and safety inspections of CRC homes per Chief Network Officer Interim Letter 10N-2000-02.
- Conduct interdisciplinary CRC inspections in accordance with VHA Manual M5-Part III.
- Conduct and document interdisciplinary patient assessments for all patients referred for CRC placement.
- Provide CRC caregivers instructions for managing patient care needs at the time of placement, and after hospitalizations and clinic visits, and document these discussions in the medical records.
- Assess patients' suitability and integration into the CRCs within 1 month of placement, conduct monthly follow-up visits thereafter, and document the patients' medical records to reflect functional and behavioral status, changes in health or mental health needs, and appropriateness for continued placement.
- Provide CRC caregivers with annual training.
- Conduct CRC caregiver screenings to rule out VA employees.
- Revise policy to require CRC caregiver background clearances for participation as a VA-approved CRC home.
- Conduct and document annual discussions with VBA field examination supervisors regarding incompetent CRC patients, and take actions as appropriate.

- Document that patients and families sign statements of agreement when accepting referrals to CRC services and programs not approved by VA.

The Under Secretary agreed with our findings and recommendations and provided acceptable improvement plans. VHA developed CRC Handbook 1140.1, *Community Residential Care Program*, which replaced VHA Manual M-5 Part III CRC Program Manual. The new CRC handbook addresses most of the recommendations, requires data collection and reporting, and defines expectations for facility inspections, patient assessments, information sharing, and follow-up visitation schedules. It further discusses requirements for CRC program staff training and clearances, annual meetings with VBA, and the process to follow when placing patients in non-VA community settings. VHA is in the process of changing a regulation to require annual inspections of CRC homes. The revised regulation is expected to take effect in FY 2007.

Controlled Substances Prescribed to Patients in Mental Health and Behavioral Sciences Programs

We reviewed Mental Health and Behavioral Sciences (MH&BS) physicians' prescribing practices at nine VHA medical facilities during CAP reviews from October 2000 through March 2001 and reported our findings in the individual medical facilities' CAP review reports. The purpose of the review was to evaluate prescribers' management of long-term use of controlled substances for patients in VHA MH&BS programs. We found that, generally, facility managers needed to improve utilization of pain treatment alternatives to long-term narcotic use, prescribers were not always documenting consideration of therapeutic alternatives to long-term narcotic use, or that they negotiated treatment contracts with patients. Facility managers agreed with our findings and took appropriate corrective actions.

On April 16, 2002, we issued a roll-up report of our findings, *Controlled Substances Prescribed to Patients in Veterans Health Administration Mental Health and Behavioral Sciences Programs*, (Report No. 01-00026-18), from the nine CAP reviews. We concluded that the quality of care in VHA mental health programs could be improved if there was more consistency among providers in managing long-term narcotics for MH&BS patients with pain. We made three recommendations to the Under Secretary for Health:

- Require mental health providers, treating patients requiring narcotic prescriptions for prolonged periods, to explore alternatives to treating them for pain, refer patients to available alternatives when appropriate, and document these clinical decisions.

- Re-assess existing mechanisms for providing mental health providers an organized method of interdisciplinary treatment consultation to most appropriately treat patients needing long-term pain management, and modify monitors as appropriate.

- Re-visit the comprehensiveness of pain management education provided to MH&BS patients with chronic pain conditions ensuring curriculums include advising patients and families of other treatment options, and risks of dependencies that may occur from long-term use of controlled substances and other related mental health medications.

The Under Secretary for Health agreed with our recommendations. Corrective actions included requiring all medical facilities to establish pain management oversight committees to coordinate monitoring efforts, development of a variety of education and training programs, and development of clinical practice guidelines for management of long-term opioid use.

Emergency Preparedness

We reviewed emergency preparedness programs during CAP reviews at 12 VHA medical facilities from November 2004 through February 2005, and included our findings in the facility CAP review reports. The purpose of the reviews was to determine whether VHA facilities had comprehensive, effective emergency preparedness programs, employees had appropriate emergency preparedness training, and VHA buildings' heating, ventilation, and air conditioning systems complied with National Institute for Occupational Safety and Health (NIOSH) guidelines. We found that medical facilities generally complied with VHA directives, NIOSH guidelines, and JCAHO standards. However, emergency preparedness education and training was not consistently provided to facility employees and physical security needed improvement. Medical facility managers agreed with our findings and took corrective actions.

On January 6, 2006, we issued a roll-up report of our findings, *Emergency Preparedness in Veterans Health Administration Facilities*, (Report No. 04-03266-51), from the 12 VHA medical facilities. We concluded that VHA had properly addressed emergency preparedness at the national level. However, improvements were needed to decrease VHA facility vulnerability to increased facility damages and increased injuries or death to employees and patients. We made five recommendations to the Under Secretary for Health:

- All employees receive regular and role-specific emergency preparedness training.
- All facility emergency plans address personal protection equipment, staff training, and sheltering in place.
- Facility Hazard Vulnerability Analyses reflect actual facility risks.
- OIG high-risk laboratory safety recommendations are implemented.
- Building security vulnerabilities are assessed and prioritized, and corrective or mitigating actions are implemented, as feasible.

The Under Secretary for Health agreed with our recommendations. Actions taken included: developing a Web-based training program including elements of comprehensive emergency management, the role of personal protection equipment, evacuation, and sheltering in place; emphasizing compliance with existing policies in regard to securing high-risk laboratories; issuing Web-based education by the VA Office of Research and Development; requiring VISN Safety Managers review of the hazard vulnerability assessments during the Annual Workplace Evaluation at each facility; and requiring each facility certify compliance with recommendations from the OIG report.

Appendix A

Homemaker and Home Health Aide Program

VHA's Homemaker and Home Health Aide (H/HHA) Programs were inspected at 17 VHA medical facilities during CAP reviews from October 2001 through September 2002, and we reported our findings in the facility reports. The inspections were performed to determine whether H/HHA programs were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost effective, and met customer expectations. While we found deficiencies with patient selection and program management at some facilities, patients generally told us they were satisfied with H/HHA services. VHA facility managers agreed with our recommendations and took appropriate corrective actions.

On December 18, 2003, we issued a roll-up report of our findings, *Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program*, (Report No. 02-00124-48), at the 17 VHA medical facilities. We made two recommendations to the Under Secretary for Health to strengthen the H/HHA program:

- Issue a policy to replace expired VHA Directive 96-031, and provide additional guidance requiring that: patients receive thorough initial interdisciplinary assessments prior to placement in the program, patients receiving H/HHA services meet clinical eligibility requirements, and benchmark rates for these services are established.

- Seek a VA General Counsel opinion as to whether a veteran's special monthly compensation or pension status can be considered when prioritizing need for services and determining frequency of authorized H/HHA visits. If VA General Counsel determines that this consideration is appropriate, we recommend that policy reflect this change.

The Under Secretary for Health agreed with our recommendations and issued VHA Handbook 1140.6, *Purchased Home Health Care Service Procedures*, dated July 21, 2006. This handbook includes guidance on assessments/reassessments, clinical admission criteria, referrals, and care plans. It also addresses administrative functions to include program monitoring and oversight, administrative eligibility and costs, and waiting list management. VA General Counsel issued an opinion ruling against consideration of special compensation when prioritizing the need for services.

Management of Moderate Sedation

We reviewed medical facility moderate sedation programs during 30 CAP reviews at VHA medical facilities from February through September 2004, and included our findings in the facility CAP review reports. The purpose of the review was to determine whether patients who received moderate sedation during invasive procedures performed outside the operating room (OR) received a commensurate level of care as patients who have procedures in the OR. We made recommendations for corrective actions at 20 of the 30 facilities. The majority of the recommendations were in the following program areas: cardiopulmonary resuscitation (CPR) training, moderate sedation training, clinical privileges, pre-sedation assessments and re-

evaluations immediately prior to sedation, and trending and analysis of adverse events. Facility managers concurred with all the recommendations and took corrective actions.

On November 1, 2005, we issued a roll-up report, *Evaluation of Management of Moderate Sedation in Veterans Health Administration Facilities,* (Report No. 04-00330-15), that included our findings from the 30 CAP reviews performed. We concluded that the administration of moderate sedation outside the OR by non-anesthesia clinicians was generally safe and effective; however, we found areas that needed improvement. Four recommendations were made to the Under Secretary for Health:

- Develop and implement VHA policy for the administration of moderate sedation outside the OR that includes specific standards of practice and the required JCAHO elements.
- Ensure compliance with current VHA Directive 2002-046, *Staff Training In Cardiopulmonary Resuscitation And Advanced Cardiac Life Support, Acute Care Strategic Healthcare Group (111),* regarding cardiopulmonary resuscitation training.
- Ensure that all clinicians administering moderate sedation maintain current training and clinical privileges/scopes of practice.
- Ensure moderate sedation adverse events are reported, trended, and analyzed in conjunction with OR anesthesia adverse events, and the data is used to improve performance.

The Under Secretary for Health developed and implemented a comprehensive policy directive, VHA Directive 2006-023 *Moderate Sedation by Non-Anesthesia Providers,* dated May 1, 2006, that includes specific standards of practice and the requirements set forth by JCAHO. This policy includes guidance to ensure that local facilities comply with staff training for CPR and that all clinicians administering moderate sedation outside the OR maintain current training and clinical privileges/scopes of practice.

Management of Patients with Pressure Ulcers

We reviewed pressure ulcer prevention and management during 24 CAP reviews at VHA medical facilities from November 2004 through May 2005, and reported our findings in the CAP facility reports. The purpose of the review was to determine if clinicians provided comprehensive pressure ulcer prevention and assess whether management provided pressure ulcer education to clinicians, patients, and external caregivers, including assessing whether managers collected and analyzed pressure ulcer data and evaluated the financial impact of pressure ulcers. We made recommendations for corrective actions in identifying at-risk patients, performing reassessments, performing treatments as prescribed, and providing patient and staff education. Facility managers concurred with all the recommendations and took corrective action.

On March 22, 2006, we issued a roll-up report that included our findings, *Management of Patients with Pressure Ulcers in Veterans Health Administration Facilities,* (Report No. 05-00295-109), from the 24 CAP reviews. We concluded that although considerable research

has been devoted to pressure ulcer prevention and treatment, many VHA medical facilities had not implemented a comprehensive skin care program that provides clinicians and managers with the appropriate resources, tools, and guidelines to deliver optimum pressure ulcer care. We made one recommendation to the Under Secretary for Health:

- Ensure that comprehensive guidance regarding pressure ulcer prevention, management, and education is implemented.

The Under Secretary for Health issued a handbook entitled *Assessment and Prevention of Pressure Ulcers*. The handbook addresses the provision of a standardized evidence-based approach to the assessment and prevention of pressure ulcers, the use of the Braden Scale for initial and ongoing assessment, the provision of a standardized minimum documentation requirement for assessing and preventing pressure ulcers and provision of patient, family, and caregiver education concerning ulcer prevention and management. In addition, VHA plans to develop a directive that will include a reporting structure and define the measures for incidence, prevalence, and cost factors associated with pressure ulcers.

Management of Violent Patients

We inspected the procedures in place to manage violent behaviors during CAP reviews at 13 VHA medical facilities from October 2002 through April 2003 and reported our findings in individual medical facility CAP review reports. The purpose of this review was to determine the effectiveness of VHA's program to identify violent patients and to reduce the risk to employees, patients, and others visiting VHA medical facilities of encountering threatening and violent patient behaviors. While we found opportunities for improvement in the management of violent patient events, we also found that several components for successful violence prevention programs were in place. VHA facility managers agreed with our recommendations and took appropriate corrective actions.

On May 3, 2004, we issued a roll-up report of our findings, *Healthcare Program Evaluation—Veterans Health Administration's Management of Violent Patients,* (Report No. 02-01747-139), at the 13 VHA medical facilities. We concluded that VHA could improve its patient violence prevention program and made four recommendations to the Under Secretary for Health:

- Establish interdisciplinary response teams in each facility specifically trained in violence management, and ensure that the teams appropriately respond to all emergency calls.

- Develop a consistent method of identifying and reporting violent incidents, and ensure complete information is available to employees who are responsible for analyzing and trending this data, and recommending corrective strategies.

- Establish interdisciplinary committees charged with the responsibility of reviewing and tracking violent incidents for the purpose of developing violence management and preventive strategies.

- Develop guidelines for the appropriate use of automated warning flags, ensure that they are applied consistently throughout VHA, and ensure that all employees have access to computer systems that will flag patients' records when there are histories of violence. Patient records that are flagged should be systematically reviewed by interdisciplinary committees to establish the need for continued use of flags for each patient. Additionally, until the VA-wide flagging system is fully operational, individual facilities should explore methods to develop local employee alert systems.

The Under Secretary for Health agreed with our recommendations and implemented a patient record flagging system as part of the computerized patient record system and established Disruptive Behavior Committees at VHA medical facilities.

Medical Record Privacy

We evaluated VHA policies and procedures related to security and privacy of veterans' medical records during CAP reviews at 12 VAMCs between February and November 2001, and we included our findings in the individual medical facility CAP review reports. These reviews were conducted to determine whether medical record privacy policies and procedures at VAMCs included adequate employee training and security measures to protect against misuse or unauthorized disclosure of patient health information. Medical facility managers agreed with our findings and took corrective actions.

On December 24, 2002, we issued a roll-up report of our findings, *Evaluation of Veterans Health Administration Medical Record Security and Privacy Practices*, (Report No. 01-01968-41), at the 12 VHA medical facilities. We concluded that VHA had established appropriate guidelines regarding the security of electronic data. However, the implementation of information security programs varied across the medical centers included in this review. Some VAMCs were diligent in their compliance with VHA directives, while others did not appear to understand the full scope of their responsibilities to protect the confidentiality of medical information. We made the following recommendations to strengthen VHA's medical record privacy policies and procedures and promote the confidentiality of patients' medical information:

- Position computer monitors such that patient information is not visible to unauthorized persons in the area and purchase computer privacy screens for those monitors that cannot be adequately repositioned.

- Provide locked containers or shredders in employee work areas for the disposal of sensitive patient information.

- Monitor restricted medical record access logs on a regular basis.

- Require employees to justify access to restricted records.

- Revise policies to include sanctions for improper access of restricted records and disseminate information to employees on the consequences of violating policy.

- Implement an incident reporting system to identify and record violations, assess damage, and report incidents to Veterans Affairs Central Incident Reporting Capability.

- Improve employee awareness of incident reporting procedures through training initiatives.

- Appoint full-time or primary-duty Information Security Officers who have the required technical training in AIS.

The Under Secretary for Health agreed with our findings and issued VHA Handbook 1605.1, *Privacy and Release of Information,* dated December 31, 2002, that addresses the issues in this report.

Pain Management

We reviewed VHA's pain management initiative at 13 medical facilities during CAP reviews from October 2000 through March 2001, and reported our findings in the medical facility CAP review reports. The purpose of the review was to determine whether pain management initiatives had been implemented in medical and surgical settings at VHA medical facilities, and to determine whether pain interventions were timely and adequate, as reflected in documented follow-up pain measures. We found that, generally, VHA medical facilities had made significant strides in implementing the pain management initiatives, however, the extent of implementation varied. Medical facility managers agreed with our findings and recommendations and took corrective actions.

On June 10, 2002, we issued a roll-up report of our findings, *Veterans Health Administration Pain Management Initiative,* (Report No. 01-00026-101), at the 13 medical facilities. We concluded that VHA had developed a comprehensive initiative to address pain management issues. However, we found that the extent and quality of implementation varied extensively from facility to facility. Managers needed to continue efforts to implement or improve several processes to strengthen pain management initiatives. We made five recommendations to the Under Secretary for Health:

- Re-emphasize components and standards established by VHA directive on pain management and by JCAHO, and ensure that all facilities have established current pain management policies to improve program performance.

- Ensure that facility managers fully implement pain management education and training programs in all VHA clinical settings, and that this education and training is documented in employee records in a manner that reflects the course content or key elements of the instruction.

- Ensure that all facility managers are providing education and training pertaining to dependency, potential addiction, pain medications, and their effects, appropriate titration, side effects, and benefits.

- Ensure that facility managers ensure clinicians assess and document 5th vital sign information whenever vital signs are taken for all patients, document assessments of patients' prior experiences with pain, and document descriptions of how effectively patients' medications controlled their pain.

- Ensure that facility managers require clinicians to document patients' prior pain treatment experiences, and educate patients and family members during hospitalization and upon discharge.

The Under Secretary for Health agreed with our recommendations. Actions included issuing VHA Directive 2003-021, *Pain Management*, dated May 2, 2003, requiring all medical facilities establish pain management oversight committees to coordinate program development and monitoring; mandating annual pain management education and to reflect that training in education records; adding the 5th vital sign to computerized patient record system vitals sign requirements; and amending VHA policy to include requirements for documenting patient's pain management experiences and education patients and families both during hospitalization and at discharge about pain management.

Patient Transportation Services

We reviewed patient transportation services during 14 CAP reviews at VHA medical facilities from October 2003 through January 2004 to determine if: VHA facilities complied with VA and VHA policies and Federal regulations governing patient transportation, VHA facilities had effective internal controls to ensure safe patient transportation, and opportunities existed to improve patient safety by strengthening patient transportation services programs. Medical facility directors agreed with our findings and took appropriate corrective actions.

On August 4, 2005, we issued a roll-up report of the findings, *Inspection of Veterans Health Administration Patient Transportation Services*, (Report No. 04-00235-180), from the 14 CAP reviews. We made nine recommendations to the Under Secretary for Health to ensure that deficiencies and vulnerabilities identified were corrected.

- Improve initial and follow-up screenings of motor vehicle operators and volunteer drivers.

- Ensure annual safe driving training is provided to all employees and volunteer drivers and publish policy regarding mandatory training requirements to include instruction in handling medical emergencies.

- Ensure drivers' compliance with all aspects of VHA's Employee Safety Alert regarding transportation in 15-passenger vans.

- Ensure patient safety is maintained through the consistent practice of securing patient care equipment, other cargo, and vehicles and ensure that security of patients in vehicles is reviewed, policies are established, and observed.

- Publish policy describing required equipment needed in vehicles used to transport patients. This policy needs to specify that cellular phones and 2-way radios operate independent of the vehicle's battery and provide communication coverage throughout the patient transport.

- Provide guidance to VA facilities regarding employee escorts for patients with special medical or mental health needs and ensure that incidents occurring during trips are reported to appropriate clinical staff and documented in the patients' medical records.

- Ensure contracts for transportation services require that vendors clarify that their drivers have been screened, trained, and are competent to safely transport VA patients and that medical centers ensure that initial and follow-up certifications are received and retained.

- Ensure VA managers consider the use of volunteer drivers in emergency planning.

- Require that transportation incidents and accidents are reported to VHA headquarters managers and program officials.

The Under Secretary for Health plans to develop a directive to provide consistent guidance to the medical facilities in areas such as the screening of drivers, driver training and screening requirements, vehicle safety, and the reporting of vehicle accidents and incidents; however, the action is still pending.

Procedures for Communicating Abnormal Test Results

We completed a review of the adequacy of VHA's communication practices for conveying abnormal test results to treatment providers and patients at 16 VHA medical facilities during CAP reviews from April through October 2001, and reported our findings in the VA medical facility CAP review reports. This review was conducted to determine if the practices enabled providers to make informed decisions and ensured patients were provided appropriate care. Medical facility management agreed with our findings and took appropriate corrective actions.

On November 25, 2002, we issued a roll-up report of our findings, *Summary Review Evaluation of Veterans Health Administration Procedures for Communication Abnormal Test Results*, (Report No. 01-01965-24), at the 16 VHA medical facilities. We concluded that although most facilities had adequate diagnostic services policies that address procedures for communicating abnormal test results, national guidelines needed to be strengthened to ensure consistent application. We made four recommendations to the Under Secretary for Health:

- Develop system-wide policies requiring timely communication of abnormal test and procedure results to providers and patients, and document these notifications in medical records.

- Ensure that diagnostic clinicians document on their test reports when they notify providers of abnormal results.

- Emphasize to providers the importance of complete documentation when they notify patients of abnormal test results, including documentation of any follow-up actions.

- Ensure that managers evaluate the effectiveness of their view alert systems.

The Under Secretary for Health agreed with our recommendations and issued VHA Directive 2003-043, *Ordering and Reporting Patient Test Results*, dated August 6, 2003, that delineates national abnormal test result reporting policies. VHA issued a revision to Handbook 1106.1, *Pathology and Laboratory Medicine Service Procedures*, dated June 4, 2003, that establishes policy for reporting abnormal test results and issued Care Management software to provide clinicians with an electronic "to do" list to assist in monitoring results from diagnostic testing.

Appendix B

OIG Contact

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Appendix C

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