Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Gastroenterology Service Issues at the VA Southern Nevada Healthcare System Las Vegas, Nevada

Report No. 08-01711-31 **December 2, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection at the VA Southern Nevada Healthcare System in Las Vegas, NV, at the request of Congressman Bob Filner, Chairman of the House Committee on Veterans' Affairs. The review was done to determine the validity of a number of allegations made by anonymous complainants regarding the system's gastroenterology (GI) services.

We substantiated that refurbished scopes were purchased and a scope broke during a GI procedure. However, we did not substantiate that: (a) the system had a high GI mortality rate, (b) nurses experienced retaliation for reporting substandard practices, (c) a GI provider was permitted to forgo documentation in VA patients' medical records, (d) GI providers reused syringes or exposed veterans to contaminated medication from vials while contractors of the system or (e) lucrative contracts were awarded to the GI provider group or that senior managers received kickbacks. We were unable either to substantiate or refute that GI equipment was improperly sterilized.

We recommended that a process be established to assure adequate inspection, maintenance, and replacement of patient care equipment. We recommended that controls be established to monitor and track all VA-owned equipment that is repaired by community vendors. We also recommended that when an employee recognizes Government property loss or damage, the employee promptly notifies the supervisor, who then notifies VA police. Additionally, we identified that VA acquisition regulations were not followed after the contract with the GI provider group expired in 2006.

We made three recommendations to ensure that the system takes actions to comply with the regulations pertaining to services provided by non-VA entities. The VISN and System Directors agreed with our findings and recommendations and submitted appropriate action plans. We will follow up on the planned actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Desert Pacific Healthcare Network (10N22)

SUBJECT: Healthcare Inspection – Gastroenterology Service Issues at the VA Southern Nevada Healthcare System, Las Vegas, Nevada

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding gastroenterology (GI) service issues at the VA Southern Nevada Healthcare System (the system). The purpose of the inspection was to determine the validity of the allegations and ascertain whether quality of patient care was affected.

Background

A. VA Southern Nevada Healthcare System Overview

Located in Las Vegas, NV, the system provides health care services to more than 35,000 veterans, with over 300,000 outpatient visits annually. In fiscal year 2003, the system's ambulatory care operation moved from a single location to 10 separate locations within Las Vegas. Outpatient care is also provided at community based outpatient clinics located in Henderson and Pahrump, NV**.** Inpatient services are provided at the Mike O'Callaghan Federal Hospital (MOFH), located at Nellis Air Force Base, as part of a VA/Department of Defense joint venture. The VA occupies 52 beds at the MOFH and provides medical, surgical, intensive, and psychiatric care**.** In addition, the system also provides psychiatric day treatment, readjustment counseling, and outreach for homeless veterans. The system is part of Veterans Integrated Service Network (VISN) 22.

B. Allegations

Anonymous complainants jointly wrote a letter to Congressman Bob Filner, Chairman of the House Committee on Veterans' Affairs, who requested an inspection. The letter states, "The veterans and your constituents need immediate assistance regarding the recent [Hepatitis C, Hepatitis B, and human immunodeficiency virus (HIV) *sic*] developments in Las Vegas." The complainants alleged:

- The system had a high mortality rate because of a GI provider who treated veterans for over 10 years.

- Nurses reported substandard GI practices to senior managers, yet clinical privileges and lucrative VA contracts were awarded to the GI provider group. These same nurses experienced retaliation or were forced to leave the system.

- The GI provider group's clinical director was not required to execute or sign progress notes for veterans receiving services.

- While the GI provider group was performing services at the system's South East Clinic (SEC), the practitioners were reusing needles and exposing veterans to contaminated medication from vials.

- GI equipment was not sterilized, and scopes were breaking inside veterans.

- Executive leadership covered up these events, closed the GI clinic at the system, and awarded the contract to the GI provider group.

- A clinical service chief purchased refurbished scopes that broke and caused veteran deaths.

- Senior managers were provided kickbacks in the form of compensation from the contracted GI provider group.

- The current public health crisis in Las Vegas could have been avoided if the system's senior managers had come forward 10 years ago.

C. Timeline for Provision of GI Services

For more than 10 years, the system has had difficulty recruiting GI providers. Senior managers indicated that the availability of GI providers in the community is limited, and the system cannot offer salaries commensurate to the private sector. The system had an initial contract with the University of Nevada School of Medicine to perform GI services at the MOFH. Because of growing demand, the University subcontracted GI services with providers from the Endoscopy Center of Southern Nevada (ECSN). These providers were credentialed and privileged by the system and provided services at the MOFH.

In July 1997, the system's leased Ambulatory Care Center (ACC), located on Vegas Drive, was opened. In August 2000, the system contracted for the provision of GI services by the ECSN providers at the ACC. The VISN 22 Network Business Center (VISN 22 NBC) managed and facilitated the competitive bidding process for the contract. No further GI procedures were provided at the MOFH, with the exception of those needed during surgeries. Reportedly an average of seven GI procedures were performed daily at the ACC. A significant backlog existed due to staffing and the number of scopes available for procedures.

In early 2003, the ACC was closed due to structural faults, air conditioning problems, and general disrepair. The SEC, located on South Pecos Road, became the new site for GI services. In October 2006, GI services were suspended at this location. The SEC was limited by the facility's business occupancy agreement, which restricted the number of patients who could concurrently be under the effects of conscious sedation. As a result, the SEC could no longer meet GI patient workload demands. Additionally, the contract with the ECSN for the provision of GI services expired in April 2006, and extensions were in effect through December 2006. Senior managers reported that ECSN providers were not interested in negotiating a new contract and preferred to provide GI services under fee basis.[1] In November, the SEC was closed, and patients who had previously scheduled appointments received GI procedures from ECSN providers at the Shadow Lane location.

Beginning in January 2007, fee basis care was utilized for the provision of GI procedures. The ECSN and two other community GI provider groups provided GI services under this process. After initial and pre-procedure counseling and education at the system's Northwest Clinic, located on Fire Mesa Street, patients were seen in the fee basis provider's clinic location. Patients then returned to the Northwest Clinic after their procedures for follow-up.

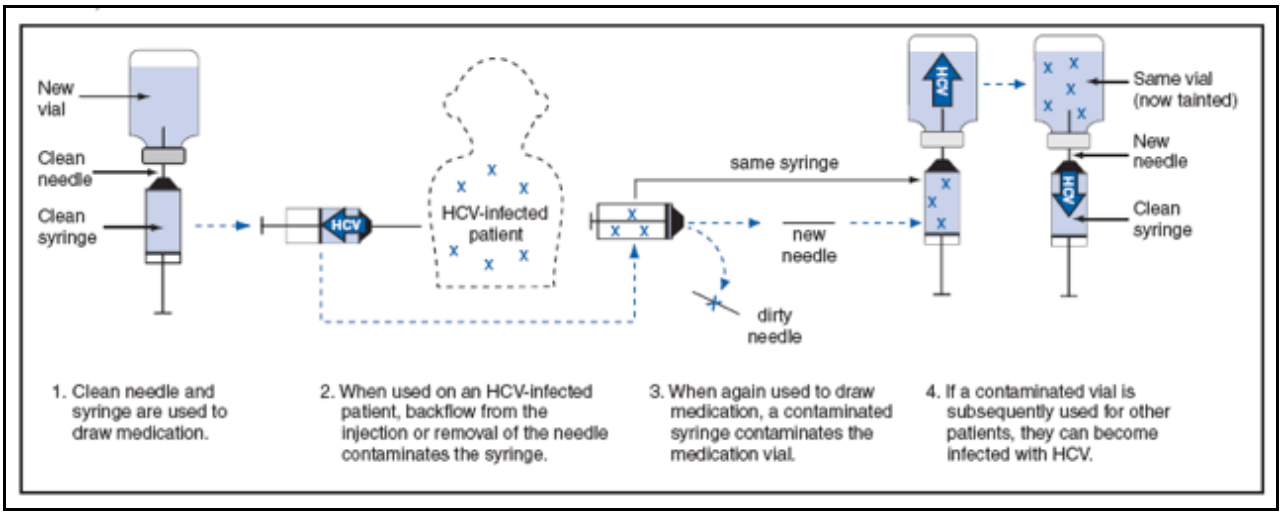
D. The System and Community Responses to a Cluster of Hepatitis C Cases

On January 2, 2008, the Southern Nevada Health District (the health district) identified a cluster of two cases of acute Hepatitis C through routine disease investigation and surveillance activities. Both cases reported undergoing procedures at the ECSN. The Nevada State Epidemiologist was notified of the cluster upon discovery of the relationship between the two initial cases. On this same date, the health district contacted the Centers for Disease Control and Prevention (CDC), and the health district also notified the State Bureau of Licensure and Certification (BLC). A third case of acute Hepatitis C with a history of endoscopic procedures at the ECSN was identified. On January 9, the health district Outbreak Investigation Team (OIT) led an investigation, with technical assistance provided by the CDC. The investigation continued, involving clinical records reviews and interviews with current and former staff members, through January 17.

During the investigation, the team identified unsafe injection practices which placed patients at risk for exposure to bloodborne pathogens. CDC guidelines require "not to administer medications from a single syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single-use

[1] Fee basis care may be authorized to treat service-connected disabilities when VA has determined that available VA facilities do not have the necessary services required for treatment; the veteran is not able to access VA health care facilities based on geographic constraints or due to medical emergencies; or when it is economically advantageous to provide treatment using fee basis.

items; they should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient." With the first use, a needle or syringe should be considered contaminated after it has been used. If a syringe is to be used more than once, it should only be used on the same patient to dispense any remaining medication in the syringe, using aseptic technique to protect the needle or needleless device between uses. And, if a multidose vial is to be used for dispensing medication to multiple patients (or even the same patient on more than one occasion), both the needle and syringe used to access a multidose vial must be sterile. A needle or syringe that has been used to administer medication to a patient should never be used again to access a multidose vial. The illustration below depicts unsafe injection practices and disease transmission involving a patient with a Hepatitis C (HCV) infection.[2]



The OIT determined that these practices had been the standard practices of the clinic since March 2004. Clinic management provided a list of all patients seen at the ECSN between March 2004 and January 11, 2008, including name, address, telephone number, and accession date. This list included a total of 39,562 patients. The team verified that over 1,400 patients had addresses that were undeliverable. The team also began receiving reports from former patients who were not on the list. Because of this, a decision was made that it was necessary to alert patients through various forms of media, in addition to mail notification.

On February 1, 2008, one of the system's physicians evaluated a patient with acute Hepatitis C and no known risk factors. The patient had a colonoscopy in July 2007. On February 4, this physician informed the service chief and an infectious disease nurse, who was asked by the service chief to follow up with the health district. The health district confirmed that the patient was one identified as having a procedure at the GI provider clinic that was under investigation. Senior managers were quickly apprised of this

[2] CDC, *Morbidity and Mortality Weekly Report*, Vol. 57, No. 19, May 16, 2008.

information, and on February 6, immediately suspended all fee basis referrals to the ECSN facility.

On February 27, the system learned through a local press release, issued by the health district, that approximately 40,000 patients who were treated by ECSN providers at the Shadow Lane location may have been exposed to Hepatitis C. The release identified the re-use of syringes and the use of single dose vials of anesthesia medication on multiple patients as the potential sources of contamination. The health district identified six patients at that time who contracted Hepatitis C infections.

The system expedited the process of identifying and disclosing information to the veterans who had procedures at the ECSN. Because a total of 1,340 veterans were potentially exposed, Veterans Health Administration (VHA) policy[3] defines actions to be taken for a large scale disclosure of adverse events. Decisions regarding large scale disclosure of adverse events are made by the Principal Deputy Under Secretary for Health and may include consultation with VA Central Office's Clinical Risk Assessment Advisory Board. Per VHA policy, disclosure to veterans may entail any or all of the following:

- Institutional disclosure to affected veterans.
- Notification by mail or telephone to potentially affected veterans.
- Notification to facilities for required follow up with potentially affected veterans.

The system mailed letters recommending and offering screenings for Hepatitis C, Hepatitis B, and HIV. These screenings were in accordance with recommendations by the CDC and the health district. Additionally, the system established a help line to provide additional information. The table below summarizes the screening status of veterans referred to the ECSN Shadow Lane location.

Screening Status of Veterans Referred to the Shadow Lane Location	
1256	Veterans screened by a system provider, at other VA facilities, or by a local community provider for Hepatitis C, Hepatitis B, or HIV
35	Deceased
32	Closed administratively. The system made three or more attempts to contact the veteran utilizing certified mail and telephone without success.
9	Referred, but did not have a procedure at the site.
4	Veterans plan to address their concerns and risk factors with their primary care provider at next scheduled visit.
4	Declined testing

[3] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

On June 5, the health district completed an investigation of an acute case of Hepatitis C associated with ECSN providers at the Burnham Avenue location. The health district determined the acute case was linked to the center, but there was not sufficient information at that time to determine the likely source of disease transmission. The health district sent letters to patients of that clinic, encouraging them to discuss their risk for disease transmission with their physician and to pursue testing for Hepatitis C, Hepatitis B, and HIV.

As of August 15, the system identified 481 veterans who were treated by ECSN providers at the Burnham Avenue location. Of the 481 veterans, 341 have been tested for Hepatitis C, Hepatitis B, and HIV. Ten of the 341 veterans are now deceased. The table below summarizes the number of veterans from both ECSN locations who tested positive after screening.

Shadow Lane and Burnham Avenue ECSN Locations			
	Pre-Existing Infection	Newly Diagnosed	Total
Hepatitis C	43	4	47
HIV	2	1	3

From both locations, 47 total cases since screening began tested positive for Hepatitis C. Four of the 47 were new cases. Three cases of HIV were identified, with one being a new case.

The health district and BLC are providing technical bulletins and educational materials to medical facilities and providers in an effort to educate the healthcare community and prevent similar incidents from happening in the future.[4]

Scope and Methodology

Because of the ongoing investigations regarding the cluster of Hepatitis cases at ECSN facilities in Las Vegas, we limited the scope of our inspection to addressing the complainants' allegations regarding the provision of GI services by ECSN while they were under VA contract and working onsite at VA owned or leased facilities. We conducted onsite inspections May 20–23 and June 2–6, 2008, and conducted follow-up telephone interviews as needed. We reviewed VHA policies, system policies, contract and fee basis files, credentialing and privileging folders, quality management documents, Tort claims, peer reviews, patient incident reports, VHA issue briefings, and other documents. We completed a focused review of medical records of 134 patients who

[4] See http://www.southernnevadahealthdistrict.org/outbreaks/index.htm for further information.

received procedures from ECSN providers under fee basis. We interviewed senior and mid-level managers and employees.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.[5]

Inspection Results

Issue 1: Gastroenterology Service Provision at the System

Mortality Rate. We did not substantiate that the system had a high mortality rate because of a GI provider who had treated veterans for over 10 years. We reviewed root cause analyses (RCAs) and patient incident reports that recorded incidents sustained during GI procedures. None of the incidents reflected deaths directly related to a GI procedure, although we found two deaths that occurred shortly after the procedures. In both cases, documentation shows the causes of deaths were related to other medical complications.

Retaliation and Staff Turnover**.** We did not substantiate that nurses experienced retaliation or were forced to leave the system for reporting substandard practices. We interviewed nurse managers and nurses, and we reviewed exit statements submitted by nursing staff who separated from the system. We found that each of these employees separated from the system voluntarily for personal reasons. The only complaint offered by interviewees related to GI services was displeasure with senior managers' decision to close the SEC.

Credentialing and Privileging**.** We reviewed C&P files of 19 providers who performed GI services at the SEC. The specific types and numbers of providers were as follows:

South East Clinic Providers	
Gastroenterologist	13
Anesthesiologist	3
Physician Assistant	2
Certified Registered Nurse Anesthetist	1

Five providers were system employees. The remaining 14 were contractors from the GI provider group. The system's Professional Standards Board made recommendations to senior managers for each individual provider's practice.

[5] http://www.ignet.gov

Additionally, verifications of education and training, licensure, and National Practitioner Data Bank[6] (NPDB) queries were documented in provider files in accordance with VHA policy. We were informed by the Chief of Staff that after quality data is reviewed at the time of reprivileging, the tool used to summarize the data is not retained. Quality data collected is provider-specific and includes drug utilization, utilization management, infection control, blood utilization, surgical case review, risk management, mortality/morbidity review, medical record review, and customer service. The Chief of Staff and Quality Management staff confirmed that there were no ECSN providers with unusually high mortality rates. This information was available at the time of reprivileging for each of the ECSN providers.

Documentation of Gastroenterology Procedures**.** We did not substantiate that the GI provider group's clinical director was permitted by the system to forego documentation in VA patients' medical records. We interviewed nurse managers, nurses, and technicians and none of these employees recalled the GI provider group's clinical director performing procedures at the SEC during its operating years. Many of the staff reported they had never met the group's clinical director. Furthermore, the clinical director has no responsibility to document in a patient's medical record unless they are the patient's treating physician.

We obtained a list of 1,340 patients who had received GI services by ECSN providers at the Shadow Lane location through fee basis. We randomly selected 134 patients and reviewed their medical records to determine if documentation from the ECSN providers for scheduled GI procedures was present. Of the 134 medical records reviewed, we found that the ECSN clinical director was the treating physician for 21 patients. The clinical director appropriately documented these patients' procedures.

Clinical Practices in the System's Own Gastroenterology Clinic. We did not substantiate that the practice of reusing syringes and single use supplies existed while the system contracted with ECSN. We interviewed managers, physicians, nurses, and technicians. All of these employees informed us that they had not engaged in these practices or witnessed this by their colleagues. Managers stated that the system GI staff were vigilant and would have promptly reported any clinical practice concerns they witnessed. Furthermore, we were informed that sufficient supplies were available, and if others were needed, Supply, Processing, and Distribution employees promptly delivered them.

Scope Maintenance. We substantiated that a particular brand of scopes used for GI procedures had been problematic since 1993. Problems included issues with the camera, fiber optic lighting system, viewing, and rigidity. The frequency of use and cleaning

[6] The NPDB is primarily an alert or flagging system. The information contained in it is intended to direct discrete inquiry into and scrutiny of specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is an important supplement to a comprehensive and careful review of a practitioner's professional credentials.

process also contribute to a scope's lifetime. The reported industry standard is that scopes used 2–3 times per day will have an expected lifetime of 3–5 years.

Staff informed us that when a scope needed repair the process was to contact Biomedical Engineering, which would, in turn, contact a community repair vendor to pick up the scopes from the system's warehouse logistics office. The vendor generally completed the scope repair in approximately 1 week. The repaired scope would then be returned to the SEC by Biomedical Engineering staff. We determined that this process was not consistently followed. Due to the frequency of scope problems and the need to maintain an adequate number of operational scopes for daily procedures, SEC staff began directly contacting the community repair vendor for service. In addition, SEC staff requested and received loaner scopes from the community vendor. Biomedical Engineering staff were often not included in or aware of the conversations between the SEC staff and the community vendor. Consequently, there was not a reliable monitoring process to track the physical location of the scopes and those scopes that were most problematic.

We learned that in 2004 three scopes were missing. VHA policy[7] requires that any employee who detects a loss of, or observes damage to, Government property will immediately make an oral report to the supervisor, who in turn will advise the local police authority, VA or otherwise, and formalize the findings on VA Form 1217, Report of Survey. The VA police will include all information relative to the preliminary investigation conducted by the supervisor or their subordinates. Reports of Survey were initiated for each missing scope, but they were never recovered. Contrary to VHA policy, we learned through interviews with staff and managers that the system's Chief of Police was not informed, and there were no police reports filed on any of the occasions when the scopes were initially determined missing.

Equipment Sterilization. We were unable to substantiate or refute that GI equipment was improperly sterilized. During interviews, we learned that system staff followed a process for scope cleaning. At the conclusion of each procedure, staff wiped the scope, rinsed it in a disinfectant, and processed it through a sterilization machine. This process was consistent with industry standards for sterilization. We also reviewed GI procedure log books maintained by system employees. The log books included in sequential order the patient, scope identification number, provider and support staff involved in the procedure, sterilization machine identification number, sterilization cycle number, and any pertinent comments such as problems with the scope or to note that the disinfection solution was changed. However, because we did not directly witness the sterilization process while ECSN providers were contracted by the system, we could not definitively verify that proper sterilization techniques were used after each procedure.

[7] VA Handbook 7125, to be used with VA Directive 7125, *Supply and Procurement – General Procedures*, November 17, 1994.

Refurbished Equipment. We substantiated that refurbished[8] equipment was purchased. While GI services were performed at the ACC, managers described that scopes were breaking down frequently and nearing the end of their useful life. After the move of GI services to the SEC in 2003, managers determined the number and types of scopes needed to meet the patient workload, including replacement of the old scopes. The system was authorized $250,000 for the VISN 22 NBC to facilitate this acquisition. Senior managers acknowledged that the scopes acquired for GI procedures at the SEC were "reconditioned." Interviewees reported that the VISN 22 NBC staff defined reconditioned as those used in a single-use demonstration or returned to the vendor after minimal use and restored to factory standards.

At the request of senior managers, an independent team from another VA performed an assessment in 2004 of the system's GI program, based on review of complications during GI procedures and resulting root cause analyses. One of the aspects the team examined was equipment used during GI procedures. The team determined that records of maintenance and repair for cautery equipment used during procedures were difficult to obtain. Through interviews and review of preventive maintenance records, the team concluded that cautery equipment used was unreliable. The team recommended the removal of suspected and actual malfunctioning cautery equipment and the enhancement of an equipment maintenance, repair, and replacement program. Our findings regarding scope maintenance, repair, and replacement indicate that this remains problematic.

Broken Equipment. We substantiated that a scope broke during a GI procedure. On August 12, 2005, a patient was undergoing a colonoscopy at the SEC when the provider withdrawing the scope noted complete separation of the rubber sheath of the bending tip from the instrument. A patient incident report was completed, and further investigation was conducted. The patient was sent to the Post Anesthesia Care Unit, further examined and monitored, and discharged home without any signs of bleeding or pain. Immediately after the incident, Biomedical Engineering staff removed the damaged scope and had it inspected by an independent company. The staff was advised by Legal Counsel on September 9, 2005, to have all reconditioned scopes inspected by an independent company. These scopes were removed.

Issue 2: Contract Irregularities and Kickbacks to Senior Management

We did not substantiate that lucrative contracts were awarded to the GI provider group or that senior managers received kickbacks from the contracted group. The VISN 22 NBC, in collaboration with system senior managers, facilitated the process for contracting the provision of GI services for the system. Senior managers wrote a comprehensive statement of work defining expectations of the contractor. The VISN 22 NBC appropriately solicited bids, including notes to offerors; intent of the contract, schedule of

[8] We were unable to make a distinction between "refurbished" and "reconditioned" scopes. The complainants were anonymous, so additional information could not be obtained.

services, and prices/costs; and the description/specifications/work statement. The VISN 22 NBC received three bidders, and system senior managers appointed a panel to review the applicants, using criteria based on the system's needs. Based on this review and subsequent recommendations to the VISN 22 NBC, the GI provider group was awarded the contract. The contract was written to allow for a specified number of option year renewals. Because the complainants were anonymous, we were unable to ascertain their definition of lucrative with respect to the overall contract costs. Given the limited number of GI providers in the Las Vegas community, the financial terms of the contract and option year extensions did not appear to be out of line.

We found that the system's former Chief of Medicine and Primary Care entered into a Memorandum of Understanding (MOU) with the following private vendors for services to be provided at non-VA facilities:

- Gastroenterology Center of Nevada, entered into on March 19, 2007
- Digestive Disease Center, undated
- Physician Billing Services Anesthesia, entered into on April 26, 2007

The MOUs contain requirements, negotiated prices, and other terms and conditions that obligate VA to pay for services provided by these private entities. The former Chief of Medicine and Primary Care had no authority to enter into these agreements. There is no legal authority for anyone, other than a warranted contracting officer, to enter into a contract or other agreement for healthcare services. Although VA Acquisition Regulation 801.670-3 gives authority to the Chief of Staff and physician responsible for the ambulatory care function to authorize medical, dental, and ancillary services under $10,000 per authorization, the authorization applies only when the service is not available from an existing contract and appears to be limited to individual episodes of care. The MOUs were clearly for multiple patients over a long period of time with a dollar value in excess of $10,000.

We did not find any indication to support that senior managers accepted kickbacks from the contracted group. We interviewed current and former senior managers, mid-level managers, and employees. There was not a single inference that the contracting process resulted in illegal employee gains in the form of compensation or special favors.

Conclusions

We concluded that the GI providers performed their duties in accordance with VHA and system standards while they were contractors of the system. Once the contract ended and GI services were provided by ECSN staff through fee basis at their own clinic locations, there was no longer daily direct VA staff oversight of the providers' performance. This included oversight of basic clinical practices that were determined by the health district's OIT to be factors directly linked to those patients who acquired infections. We identified

an opportunity for the system to improve processes for the inspection, maintenance, and replacement of patient care equipment. The system needed to ensure controls are established to monitor and track all VA-owned equipment that is repaired by community vendors. Employees who recognize Government property loss or damage must follow VHA policy requiring notification of the supervisor, who then notifies VA police. Additionally, because the system did not follow VA acquisition regulations for services provided by private entities after the ECSN contract expired, controls must be established and education provided to ensure future compliance.

Recommendations

Recommendation 1. We recommended that the System Director requires that a process be established to assure adequate inspection, maintenance, and replacement of patient care equipment.

Recommendation 2. We recommended that the System Director requires that controls be established to monitor and track all VA-owned equipment that is repaired by community vendors.

Recommendation 3. We recommended that the System Director requires that VHA policy is followed regarding notification of the supervisor and VA police when an employee recognizes Government property losses or damages.

Recommendation 4. We recommended that the VISN Director ensure that the System Director identifies all MOUs and other fee basis agreements entered into on behalf of the Government by someone other than a warranted contracting officer and if found, work with the VISN Head of Contracting Activity (HCA) to have them ratified.

Recommendation 5. We recommended that the VISN Director ensure that the HCA, System Director, and senior managers work together to identify the needs of the system, develop contract requirements, and properly award contracts to obtain necessary healthcare services.

Recommendation 6. We recommended that the System Director requires that program managers and employees are aware that fee basis services to be provided at non-VA facilities must be purchased through contracts awarded by a warranted contracting officer.

Comments

The VISN and System Directors agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13-17, for the

full text of their comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 7, 2008

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **Healthcare Inspection – Gastroenterology Service Issues at the VA Southern Nevada Healthcare System, Las Vegas, Nevada**

To: Director, Chicago Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. This memo is in response to the October 20, 2008 Draft OIG Report No. 2008-01711-HI-0114 on the subject above.

2. We concur with all findings and recommendations as identified in your Draft report. We also concur with the actions identified in the attached Director's comments provided by the VA Southern Nevada Healthcare System Director in Las Vegas, Nevada.

3. If you have any questions please contact me at 562-826-5963.

(original signed by:)

Ronald Norby

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 6, 2008

From: Director, VA Southern Nevada Healthcare System (593/00)

Subject: **Healthcare Inspection – Gastroenterology Service Issues at the VA Southern Nevada Healthcare System, Las Vegas, Nevada**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. This memo is in response to the October 20, 2008, VA OIG Draft Report No. 2008-01711-HI-0114 on the subject above.

2. We concur with all recommendations identified in the report. Attachment 2 identifies VASNHS Director's comments to include corrective actions to address the recommendations.

3. A VISN 22 Director response is included for your concurrence and forwarding to the Director, Chicago Office of Healthcare Inspections. The final response is due to the Director, Management Review Service (10B5) no later then November 7, 2008.

4. If you have any questions please contact me at (702) 636-3010 or my Associate Director, Ann Marie Feistman, at (702) 636-3011.

(original signed by:)

John B. Bright

Attachments:

1. VISN 22 Director Response Letter
2. VASNHS Director Comments
3. OIG Draft Report Transmittal Letter
4. OIG Draft Report - Healthcare Inspection – Gastroenterology Service Issues at the VA Southern Nevada Healthcare System (VASNHS), Las Vegas, Nevada

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

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

OIG Recommendations

Recommendation 1. We recommended that the System Director requires that a process be established to assure adequate inspection, maintenance, and replacement of patient care equipment.

Concur **Target Completion Date: Complete**

Corrective actions have been completed for Recommendations 1, 2, and 3 noted under Action Plan below. Recommend closure of Recommendations 1, 2, and 3.

We concur that recommendations 1, 2, and 3 were warranted at the time of the events noted in this report; however, corrective actions to address these findings were implemented and effective processes have been in place since March 2006. We continue to monitor the effectiveness of the corrective actions. No further incidences have occurred; therefore, no additional action is indicated at this time. Corrective actions implemented include but are not limited to the following: 1) Implementation of the Medical Equipment Management Plan which includes all VHA equipment management requirements as outlined in the VHA Handbook 7125; this plan is reviewed and updated annually; 2) Weekly Leadership EOC Rounds implemented in FY 2006; 3) Quarterly EOC Medical Equipment Report submitted to Environment of Care Committee; 4) Annual Workplace Evaluation (AWE) – no equipment management findings noted FY06 – FY08; 5) Vendor Control Requirements procedure is in place (all Vendors must sign in-out with Security and Engineering); 6) VA Chief of Police hired in October 2007; 7) Report of Survey's were completed for any missing or damaged government property and Police Reports completed and reported; 8) Mandatory staff training and facility policies are in place related to processes for management of faulty equipment MCM 02-06-103 ELECTRICAL SAFETY; and MCM 02-07-58 Protection of Government and Private Property notification processes for lost or damaged government equipment.

Recommendation 2. We recommended that the System Director requires that controls be established to monitor and tract all VA-owned equipment that is requested by community vendors.

Concur **Target Completion Date: Complete**

Response is addressed under Recommendation 1.

Recommendation 3. We recommended that the System Director requires that VHA policy is followed regarding notification of the supervisor and VA police when an employee recognizes Government property losses or damages.

Concur **Target Completion Date: Complete**

Response is addressed under Recommendation 1.

Recommendation 4. We recommended that the VISN Director ensure that the System Director identifies all MOUs and other fee basis agreements entered into on behalf of the Government by someone other than a warranted contracting officer and if found, work with the VISN Head of Contracting Activity (HCA) to have them ratified.

Concur **Target Completion Date: December 31, 2008**

The VASNHS Chief of Staff will work with the senior clinical managers to identify all MOUs and other fee based agreements entered into on behalf of the government by someone other than a warranted contracting officer. Once identified, the documents will be evaluated to identify any unauthorized commitments. If so, all will be forwarded to the VISN Contracting Officer for ratification.

Recommendation 5. We recommended that the VISN Director ensure that the HCA, System Director, and senior managers work together to identify the needs of the system, develop contract requirements, and properly award contracts to obtain necessary healthcare services.

Concur **Target Completion Date: December 31, 2008**

The VASNHS Chief of Staff will work with senior managers to identify system needs based on current use of fee basis services (high dollar cost and/or high volume). The Chief of Staff will prioritize those that are recurring needs and develop contracts based on the prioritizations. This process will be conducted in collaboration with the VISN 22 Contracting

Office. Further, a template will be developed that can be used to assist managers with the development of the statement of work and facilitate the contracting process.

Recommendation 6. We recommended that the System Director requires that program managers and employees are aware that fee basis services to be provided at non-VA facilities must be purchased through contracts awarded by a warranted contracting officer.

Concur **Target Completion Date: December 31, 2008**

We have advised program managers and employees that MOUs are not to be negotiated. We are working with Contracting Officers and General Council to assure that all healthcare provided at non-VA facilities to veterans is administered in accordance with applicable statutory authority.

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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