Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Lexington, Kentucky

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of Department of Veterans Affairs (VA) medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.

- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.

- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Introduction

During the week of June 3–7, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Lexington, KY, which is part of Veterans Integrated Service Network (VISN) 9. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to about 125 VAMC employees.

Results of Review

The QM program was comprehensive and provided effective oversight of patient care outcomes, but financial and administrative controls needed improvement. The VAMC Director, appointed in February 2002, faces significant challenges to improve VAMC operations, particularly matters pertaining to the relationship with the affiliated medical school.

One of the most significant affiliation-related problems was the absence of time and attendance controls for physicians in the VAMC's Medical and Surgical Services. The prior management had not required these services to comply with VA policy on physician timekeeping and had allowed the medical school to control physician duty assignments. As a result, the two services were overstaffed, while Primary Care Service did not have enough physicians and support staff to meet the growing workload. We recommended that the VAMC comply with VA policy on physician timekeeping, eliminate unneeded physician positions, and reallocate the resources associated with these positions to Primary Care or other VAMC activities that need resources. To further improve operations, the VAMC needed to:

- Require psychiatry residents to provide night and weekend coverage.

- Develop an agreement to obtain cardiac surgery services from the affiliated medical school.

- Properly control donations into and disbursements from General Post Fund (GPF) accounts.

- Reduce excess medical and prosthetics supply inventories and strengthen inventory controls.

- Improve facility cleanliness and correct other environment of care deficiencies.

- Strengthen administrative oversight of the Government purchase card program.

- Improve conscious sedation procedures and physician availability in the Endoscopy Suite.

- Ensure that patient waiting list data are accurate.

- Correct information technology (IT) security deficiencies.

- Improve procedures for managing violent patient behavior.

- Strengthen oversight of the Homemaker/Home Health Aide (H/HHA) Program.

- Properly account for research equipment.

- Improve security over controlled substances.

- Request a Veterans Health Administration (VHA) evaluation of Human Resources Management (HRM) activities.

VISN 9 and VAMC Lexington Director Comments

The VISN 9 Director and the VAMC Lexington Director agreed with the CAP review findings and provided acceptable improvement plans. (See Appendix C, pages 32-49, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. VAMC Lexington is a two-division tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at the community-based outpatient clinic in Somerset, KY. The VAMC is part of VISN 9 and serves a veteran population of about 89,000 in a primary service area that includes 37 Kentucky counties.

Programs. The VAMC provides acute medical, surgical, and psychiatric inpatient services at the Cooper Drive Division, which has 107 beds. Other Cooper Drive Division programs include primary and specialty care, ambulatory surgery, and women's health. The Leestown Division, located about 5 miles from the Cooper Drive Division, has 61 nursing home beds and provides nursing home care, primary care, and outpatient mental health care.

Affiliations and Research. The VAMC is affiliated with the University of Kentucky (UK) Colleges of Medicine and Dentistry and supports 88 residents in 22 medical and dental specialties. The VAMC also has program affiliations with 19 other institutions and provides training for 1,200 students in 50 allied health professions. In Fiscal Year (FY) 2002, the VAMC research program had 113 projects and a budget of $4.2 million.

Resources. In FY 2002, the VAMC's budget was $116 million, an 8 percent decrease from the FY 2001 budget of $126 million. Staffing through March 2002 was 1,276 full-time equivalent employees (FTEE), including 83 physician and 243 nursing FTEE. FY 2001 staffing was 1,289 FTEE, including 82 physician and 251 nursing FTEE.

Workload. In FY 2001, the VAMC treated 25,777 unique patients, a 5 percent increase from FY 2000. The FY 2001 average daily census (ADC) was 84 inpatients and 53 nursing home patients. In FY 2002 through March, the ADC was 79 inpatients and 52 nursing home patients. Outpatient workload totaled 249,907 visits in FY 2001, and the projected FY 2002 outpatient workload is 258,690 visits, a 4 percent increase.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care system operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 24 activities:

Agent Cashier	Medical and Prosthetic Supply Inventories
Controlled Substances Inspections	Part-Time Physician Time and Attendance
Endoscopy Procedures	Patient and Employee Satisfaction
Environment of Care	Patient Waiting Lists
Equipment Accountability	Pharmacy Security
General Post Fund Accounts	Physician Credentialing and Privileging
Government Purchase Card Program	Physician Productivity
Hazardous Materials Accountability	Procurement of Cardiac Surgery
Homemaker/Home Health Aide Program	Quality Management
Human Resources Management	Resident Irregular Hours Coverage
Information Technology Security	Supervision of Medical Students
Management of Violent Patient Behavior	Vendor Gratuities for Employees

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and quality of care. Survey results were discussed with VAMC management.

During the review, we also presented two fraud and integrity awareness briefings for VAMC employees. About 125 VAMC employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered VAMC operations for FYs 2000, 2001, and 2002 through May 2002 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective action is implemented. Suggestions pertain to issues that should be monitored by VAMC Lexington and VISN 9 management until corrective actions are completed.

Results of Review

Organizational Strengths

The QM Program Was Comprehensive and Provided Effective Oversight. The VAMC had an effective QM program to monitor quality of care using national and local performance measures, patient safety management, and utilization reviews. Comprehensive QM monitors were in place to improve patient care. QM findings were properly analyzed to detect trends, and actions were taken to address individual issues. QM administrative investigations and root cause analyses were conducted properly, and corrective actions were implemented. The QM program had an effective patient safety process, including an interdisciplinary team that met daily to review situations that could jeopardize patient safety. The team referred the concerns to the appropriate committee or service for further review and resolution. QM managers tracked mortality rates by inpatient unit, which gave them the ability to identify and investigate unexplained mortality increases. The VAMC's National Performance Measure scores met or exceeded VHA national results and goals for FY 2001 in all areas except smoking cessation for mental health patients.

Patients and Employees Were Satisfied with the Quality of Care. We interviewed 15 inpatients and 15 outpatients to obtain their opinions about the timeliness of service and quality of care. All 30 patients expressed satisfaction with their care and stated that they would recommend the VAMC's care to eligible family members or friends. Twenty-eight (93 percent) of the 30 patients rated the overall quality of care as very good or excellent. We distributed 385 employee satisfaction surveys to clinical employees, 244 of whom responded, although some did not answer all questions. Eighty-one percent of the respondents (187 of 230) rated the quality of care as good, very good, or excellent. Seventy-three percent of the respondents (160 of 219) believed patient care was the VAMC's first priority. The detailed results of the surveys were shared with VAMC managers.

During the review, we also evaluated several complaints and concerns referred to us by employees. We referred one issue pertaining to medical student involvement in patient care to VHA for evaluation.

Agent Cashier Operations Were Sound. All agent cashier funds were properly accounted for at both the Cooper Drive and Leestown Divisions. Physical security was adequate, employee duties were separated, agent cashier duties were transferred annually as required, and agent cashier audits were properly conducted.

Hazardous Materials Were Accounted For. VAMC staff had inventoried and properly accounted for all hazardous materials. Staff complied with VA policies on reporting, labeling, and storing hazardous materials. The VAMC Safety Officer ensured that all employees who worked with hazardous materials were adequately trained.

Opportunities for Improvement

Physician Time and Attendance – Physician Duty Assignments and Timekeeping Should Comply with VA Policy

Conditions Needing Improvement. The VAMC's Medical Service and Surgical Service did not comply with VA policy on physician time and attendance, and clinical management did not properly manage and supervise the physician staff in these two services. Instead, management allowed the UK medical school to decide physician assignments to duties such as clinic and operating room (OR) coverage. As a result, the school exercised too much influence on the physician resources of the two services, including setting physician staffing levels and determining staff composition.

VA Policy on Physician Time and Attendance. Like all other VA employees, physicians must be present for duty during the time for which they are paid, unless they are on leave or authorized absence. VAMCs typically have a physician staff made up of full-time and part-time physicians. At affiliated VAMCs, most physicians work part-time at the VAMC and part-time at the affiliated university hospital. These physicians are employed on VA appointments that require them to work for a specified number of hours during a 2-week, 80-hour pay period. (For example, a physician with a one-half time appointment would be required to work 40 hours per pay period.) VA policy allows part-time physicians to work either fixed tours of duty or flexible tours consisting of core and adjustable hours. Whether on fixed or flexible tours, part-time physicians must be on duty at the VAMC at the required times, or on approved leave. Timekeepers who prepare physician timecards should have personal knowledge that the physicians were present for the time shown on the timecards. Supervisors should not certify timecards unless they are sure the time and attendance information is correct.

Physician Time and Attendance Not Properly Managed. The VAMC did not manage its Medical and Surgical Services physician staffing properly and had not established the time and attendance controls required by VA policy. (This problem did not apply to Primary Care, Psychiatry, Radiology, or Anesthesiology Services, which had minimal part-time physician staffing.) To test physician time and attendance during CAP reviews, we normally interview timekeepers and use duty schedules and timecards to determine when physicians are supposed to be on duty. We then attempt to locate selected physicians to verify that they are either on duty or on approved leave. We could not perform this test for the Medical and Surgical Services because there were no duty schedules and timekeepers could not tell us which physicians were supposed to be on duty.

According to the VAMC's Chief of Staff (COS), the VAMC and the adjoining UK Medical Center (UKMC) were viewed as one hospital, with VA and UK medical and surgical physicians considered members of a pool of physicians who were available to provide care as needed at either the VAMC or the UKMC. The VAMC allowed the medical school to determine assignments and work schedules for all the pool physicians, including those on the VA payroll. This practice resulted in the following noncompliance with VA policy:

- **Physicians Not on VA-Approved Tours of Duty.** The Medical and Surgical Services did not have true rosters of VA staff physicians who worked normal tours of duty. The 2 services had 67 physicians on the payroll (6 full-time and 61 part-time, for a total of 37.5 FTEE). These physicians did not work fixed or flexible tours of duty as required by VA policy. Instead, they worked on alternating monthly rotations–one month at the VAMC and the next at the UKMC. When VA-paid physicians were working at the UKMC, the medical school was supposed to send substitute physicians to work at the VAMC. VAMC management relied on the school to send the substitutes and to make sure there were enough physicians available to meet the VAMC's patient care workload. Management told us that they generally knew which physicians were responsible for VA patients because the school issued a monthly physician assignment schedule showing coverage for both the UKMC and the VAMC. However, they acknowledged that this schedule was only a plan and did not necessarily reflect actual physician coverage at the VAMC.

- **Timecards Falsified.** The practice of the 1-month rotations led to the routine falsification of physician timecards. Management required timekeepers to complete timecards based on a fictitious tour of duty that showed physicians as present for duty at the VAMC when they were actually on 1-month rotations at the UKMC.

Because of this noncompliance with VA policy, management had no assurance that the VAMC received the physician services paid for. Management did not know whether the medical school always sent substitutes to replace VAMC physicians who had rotated to the UKMC or whether substitutes had experience and qualifications comparable to the physicians they replaced. The VAMC's practices had the following adverse effects:

- **Increased Physician Staffing Costs.** Because management did not properly control physician staffing, they could not reliably determine appropriate staffing levels. As a result, the VAMC incurred about $1.15 million in annual salary costs for physicians who were not needed in Medical and Surgical Services. (This issue is discussed in more detail on pages 6–8.)

- **Decreased Employee Morale.** Fiscal Service managers and Medical and Surgical Service timekeepers expressed serious concern about management requiring the falsification of physician timecards. Fiscal Service managers had tried to convince the former VAMC Director to comply with VA policy on physician timekeeping, but she had not taken any action. (The former Director retired in April 2001.)

VAMC management needed to gain control of Medical and Surgical Service physician staffing and implement timekeeping controls that fully comply with VA policy.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director implemented controls to fully comply with VA policy on physician time and attendance and the completion of physician timecards. The VISN Director and VAMC Director agreed and reported that VAMC physician time and attendance practices would be brought into compliance with VA requirements by the end of November 2002. Physicians will be placed on core or flexible time, and Fiscal Service staff had been instructed to conduct quarterly audits of

physician time and attendance. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Physician Productivity – Physician Staff Resources Should Be Reallocated To Better Meet the Primary Care Workload

Conditions Needing Improvement. VAMC management needed to reallocate underutilized physician staff resources from Medical and Surgical Services to Primary Care Service, which did not have enough physicians, nurses, and clerical staff to meet a growing workload. The 3 services had a total of 53.1 FTEE physicians (24.5 FTEE in Medical Service, 13.0 FTEE in Surgical Service, and 15.6 FTEE in Primary Care Service). To evaluate physician productivity, we analyzed patient care workload data for the month of March 2002 and interviewed clinical managers and staff to obtain their estimates of time spent on patient care, research, teaching, and administration.

<u>Low Patient Care Time for Medical and Surgical Service Physicians</u>. Sixty-seven individual physicians made up the 37.5 FTEE physician staff in Medical and Surgical Services. Measured by documented patient care time, the productivity of these 67 physicians was generally low. As Table 1 shows, in March 2002, 42 physicians (63 percent) spent less than 20 percent of their time in patient care, including 16 (24 percent) that did not spend any documented time in patient care:[1]

Table 1. Percent of Physician Time for Patient Care (March 2002)

Percent of Time for Patient Care	Number of Physicians Medical Service	Surgical Service	Combined
Over 50%	6	4	10
40-49%	2	1	3
30-39%	2	2	4
20-29%	3	5	8
10-19%	5	7	12
1-9%	9	5	14
0%	13	3	16
Total	40	27	67

Overall, only 22.3 percent of Medical Service physician time and only 35.5 percent of Surgical Service physician time was spent on patient care. (See Appendix A, pages 26-30, for more detailed information on the distribution of patient care time.) The following examples illustrate the problem of physicians who spent little or no documented time on patient care:

- A part-time endocrinologist was scheduled to work at the VAMC in March 2002 and had 90 work hours available after adjusting for leave. He reported no patient encounters or other patient care time for the month.

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[1] In accounting for physician time, we included time provided by substitute physicians from the UKMC. The patient care time shown is the time documented in records such as the Patient Encounter Activity Report or the OR log.

- A part-time cardiologist had 126 work hours available. He reported 10 patient encounters, which equated to 5.0 hours of patient care time for the month (10 encounters × 30 minutes per encounter = 5.0 hours, or 4.0 percent of available time).

- A part-time neurosurgeon had 90 work hours available. She reported six patient encounters, which equated to 1.5 hours (6 encounters × 15 minutes per encounter = 1.5 hours). During the month, she performed three surgical procedures, which accounted for 10.3 work hours (based on time shown on the OR log plus 1 hour of preoperative and postoperative time per procedure). Her total patient care time for the month was 11.8 hours (13.1 percent of available time).

- A part-time internal medicine physician had 90 work hours available. She reported 78 patient encounters, which equated to 39 hours (78 encounters × 30 minutes per encounter = 39 hours) of patient care time for the month (43.3 percent of available time).

- A part-time orthopedic surgeon had 90 work hours available. He reported 59 patient encounters, which equated to 14.75 hours (59 encounters × 15 minutes per encounter = 14.75 hours). During the month, he performed six surgical procedures, which accounted for 17.9 work hours. His patient care time for the month was 32.7 hours (36.3 percent of available time).

Medical and Surgical Services Overstaffed. Based on our analysis of March 2002 workload data, we concluded that Medical and Surgical Services combined were overstaffed by about 7.3 FTEE physicians. In March, the 37.5 FTEE physicians had 5,400 available work hours after deducting leave. Of the 5,400 hours, 4,162 (77 percent) were accounted for as documented patient care time (1,450 hours), estimated inpatient care time (958 hours), or estimated research, teaching, and administrative time (1,754 hours). The remaining 1,238 hours (23 percent of available time) were not accounted for. This equated to 7.3 FTEE physicians. The salary and benefits costs associated with the 7.3 FTEE were about $1.15 million. (See Appendix A, pages 26-30, for more detailed information on our estimate of physician overstaffing.)

In our opinion, this overstaffing was directly attributable to the physician time and attendance practices in Medical and Surgical Services. Because of these practices, clinical management did not know how many physicians were on duty or how much care they were providing and, therefore, did not have reliable information for evaluating staffing levels and responding to changes in workloads. As a result, the two services had unproductive physician staff, while Primary Care Service, as shown below, did not have enough physicians and support staff to meet a growing workload.

More Staffing Needed for Primary Care. In March 2002, the 15.6 FTEE Primary Care physicians had 2,247 work hours available, of which 2,215 hours (98.6 percent) were spent on documented patient care (2,047 hours) and required administrative duties (168 hours). (We could not account for 32 hours.) Each Primary Care physician treated a daily average of 19 patients and was responsible for a panel of 1,200 patients, which met unofficial VHA guidelines for the size of patient panels.

Primary Care staffing was not adequate to meet the increasing demand for care. As of June 3, 2002, the VAMC had 1,621 patient-enrollees who had been waiting 30–180 days for their first Primary Care appointments. Based on panels of 1,200 patients, Primary Care needed 1.35 FTEE physicians to meet the workload associated with patients on the waiting list (1,621 patients ÷ 1,200 patients per panel = 1.35 FTEE physicians). According to the Chief of Primary Care Service, 1.35 FTEE physicians would require the support of 2.35 FTEE nurses and .88 FTEE clerical staff. Based on average salaries, the cost for the additional physician, nursing, and clerical staff would be about $337,000 a year.

The 1.35 FTEE physicians and the associated support staff represent the minimum additional resources needed for Primary Care. However, more resources may be needed to meet projected increases in workload. In June 2002, the Chief of Primary Care prepared a "Primary Care Waiting List Reduction Plan" which estimated that, based on the historical workload growth trend, the Service would need 4.0 FTEE additional physicians to reduce the waiting list and meet the increased workload expected by June 2003. The estimated cost of the 4.0 FTEE physicians plus 9.6 FTEE supporting nursing and clerical staff would be about $1.0 million, which is close to the amount spent on the 7.3 FTEE excess Medical and Surgical Service physicians.

To improve physician productivity and service to veterans, management needed to eliminate unneeded Medical and Surgical Service physician positions and shift the resources associated with these positions to Primary Care Service or other activities that need more resources. This would expand the opportunity to serve veterans and better utilize $1.15 million in salary costs.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director: (a) eliminated unneeded physician positions in Medical and Surgical Services and (b) reallocated the resources associated with those positions to Primary Care Service or other VAMC activities that needed resources. The VISN Director and VAMC Director agreed and stated that 2.0 physician FTEE would be reallocated to Primary Care Service by December 31, 2002, and that additional physician FTEE would be reallocated as timekeeping were resolved and more accurate measurements of physician workload became available. To better match surgeon staffing to workload, the VAMC plans to contract for surgical physician FTEE instead of staffing Surgical Service with VA physicians. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.[2]

Resident Coverage – Psychiatry Residents Should Provide Coverage At Night and On Weekends

Conditions Needing Improvement. VAMC management needed to ensure that the UK medical school provided psychiatry resident coverage during irregular hours (nights and weekends) as required by the resident disbursement agreement with the school. In Academic Year 2002–2003, the VAMC had three psychiatry residents, one each at Post-Graduate Year levels 1, 2, and 3 (annual salary and benefits cost = $136,523). Under the terms of the resident disbursement

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[2] In October 2002, after we had completed this report, VAMC management provided new information that raised additional issues about physician workloads and the medical record documentation of physician involvement in patient care. We are reviewing these matters and may issue a separate report if warranted.

agreement, residents were supposed to provide coverage at the VAMC 24 hours a day, 7 days a week. Despite the agreement, the school had not allowed psychiatry residents to provide irregular hours coverage at the VAMC. Instead, these residents worked only a normal tour of duty, 8:00 a.m. –5:00 p.m. Monday through Friday. Although school officials would not allow VA-paid residents to provide irregular hours coverage at the VAMC, they sometimes required these residents to provide this coverage at the UKMC and expected them to be available for this duty as needed. If the residents could provide coverage at the UKMC, there was no reason why they could not do the same at the VAMC.

According to VAMC clinical management, the lack of irregular hours coverage was detrimental to patient care. Residents normally deal with matters such as patient restraint and medication changes. Because residents were not available, ward nurses had to telephone VAMC staff psychiatrists at home to obtain guidance on these patient care issues. According to the Chief of Psychiatry Service, this procedure was not a good substitute for having a resident on the psychiatric wards.

The VAMC needs, and is entitled to receive, the irregular hours coverage it has paid for, especially since VA-paid residents are providing this coverage at the UKMC. VAMC residents should be required to work the same irregular hour tours as residents assigned to the UKMC (such as every third night). The two institutions should work together to ensure that both have adequate resident coverage. Because the institutions are collocated, it may not be necessary to have a resident on duty at the VAMC during all irregular hours if residents at the UKMC can quickly go to the VAMC when necessary.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director made arrangements with the UK medical school to obtain adequate psychiatric resident coverage during irregular hours. The VISN Director and the VAMC Director agreed and informed the UK medical school that the provisions of the resident disbursement should be adhered to. As of July 1, 2002, the medical school began providing psychiatric resident coverage 24 hours per day, 7 days per week. The recommended improvement action has been implemented, and we consider the issue resolved.

Procurement of Cardiac Surgery – A Written Agreement with the Medical School Should Be Developed

Conditions Needing Improvement. The VAMC needed to develop a written agreement clearly delineating the terms under which the UK medical school would provide cardiac surgery for VA patients. In September 1997, the VAMC entered into a Memorandum of Understanding (MOU) with UK to obtain cardiac surgery services. Under the MOU, the school agreed to provide emergency cardiac surgery services at no cost to the VAMC or its patients. According to VAMC management, the school was willing to do this because it needed VA patients in order to have enough workload to maintain the accreditation of its cardiac surgery program.

The MOU allowed the school to charge VA or the patient for non-emergency cases. However, the school classified all VA patients as emergencies (and therefore non-billable under the terms

of the MOU). As a result, VAMC management did not expect to pay for any portion of cardiac surgery procedures. However, throughout the 2-year term of the MOU (September 1997–November 1999), the UK physicians' billing group, the Kentucky Medical Services Foundation (KMSF), billed the VAMC for certain services, such as anesthesia and laboratory tests. (The VAMC was not billed for major costs such as use of the UKMC surgical suite, surgical supplies, and the services of cardiac surgeons, nurses, and other support staff.) The VAMC disputed, but ultimately paid, the $208,000 billed by KMSF.

In November 1999, the VAMC and the medical school replaced the MOU with a clinical services contract. The COS told us he understood that the contract only covered non-emergency cardiac surgery and that the school had agreed to the same terms as the original MOU–that is, the UKMC would consider all VA referrals as emergency cases and not bill the VAMC for any costs. However, the contract did not differentiate between emergency or non-emergency surgery but did contain a schedule of charges for various services such as preoperative and postoperative care and professional fees. Because of the confusion over the contract terms, KMSF billed for services from November 1999 until February 2002. The VAMC refused to pay these charges and on February 7, 2002, cancelled the contract.

Since February 2002, the VAMC has continued to obtain cardiac surgery services from the UKMC without a written agreement. According to the COS, all patients needing cardiac surgery have been sent to the UKMC, where the surgery has been done at no cost to the VAMC, Medicare, patients, or the patients' insurance company. However, absent a formal agreement, several medical/legal issues are unclear–for example, are the referred patients VA patients or UKMC patients and who is responsible for follow-up care?

As of June 2002, KMSF had not billed the VAMC for any cardiac surgery services provided after February 2002, and this arrangement appeared to be mutually beneficial to the VAMC and the medical school. To prevent further misunderstandings and avoid potential adverse legal consequences, VAMC management should establish a clearly defined sharing agreement with the medical school describing the terms and conditions under which referrals will be made.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director developed a written agreement with the UK medical school to obtain cost-effective cardiac surgery. The VISN Director and the VAMC Director agreed and stated that they were negotiating a contract with the UK medical school that would be in accordance with Government contracting regulations. The targeted date for implementing the contract is December 2002. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

General Post Funds – Donations into and Disbursements from GPF Accounts Should Be Properly Controlled

Conditions Needing Improvement. The former VAMC management had not established adequate controls on some GPF accounts. Employees were allowed to: (1) accept GPF donations without proper approval, (2) improperly accept honoraria and deposit these funds into

GPF accounts, and (3) use GPF account funds for purchases that appeared to be for personal benefit.

VA Policy on GPF Accounts. General post funds are donated funds. VA policy allows VA facilities to accept donations from individuals, corporations, and other institutions for VA-approved research and for activities that benefit patients. VAMCs should require prospective donors to provide letters specifying how they wish the funds to be used. If a donor is unwilling or unable to specify the intent of a donation, then the VAMC should deposit the donation in a general purpose GPF account. The VAMC Director or a designee should review proposed donations to ensure they are appropriate and can be properly accepted. Donations for research should be reviewed by the VAMC Research and Development (R&D) Committee, as well as by the VAMC Director.

Donated funds are deposited into GPF accounts that can be set up to hold single donations (such as a donation to a specific research project) or multiple donations (such as numerous donations for patient recreation activities). Each GPF account is typically considered a separate fund control point, with a fund control point official appointed to approve disbursements from the account. (For example, the Chief of Voluntary Service might be appointed as fund control point official for a patient recreation GPF account.)

Fiscal Service should monitor GPF accounts to ensure that funds are properly accounted for and that expenditures are for the intended purposes. The R&D Committee should monitor research GPF accounts to ensure that researchers use donated funds as intended.

Four GPF Accounts Not Properly Managed. As of April 2002, the VAMC had 30 GPF accounts with balances totaling $923,456. Based on a limited review of GPF account records and discussions with Fiscal Service staff, we concluded that 26 of the accounts had adequate Fiscal Service oversight. We reviewed the remaining four accounts more extensively because Fiscal Service staff expressed concern that the former VAMC Director had not reviewed the account donations and had allowed certain employees to use the accounts funds without adequate oversight. The balances of these four accounts totaled $153,864. Two of the four accounts had only one deficiency–the former VAMC Director had not reviewed and approved the donations. Otherwise, the donations into and the disbursements from these two accounts were appropriate. However, as discussed below, there were significant deficiencies in the management of the other two accounts, which were designated as GPF 154 (titled with the names of two VAMC researchers) and GPF 125 (titled "Education"). The balances for these two accounts totaled $138,904.

Donations Not Reviewed and Approved. The former VAMC Director had not reviewed the donations into GPF accounts 154 and 125. The two employees who controlled research account GPF 154 had accepted donations that appeared to be for their discretionary and unrestricted use. One of the employees had received five such donations:

In September 2001, the UK medical school donated $100,000 in the name of one of the employees. The VAMC agent cashier accepted the funds and transferred them into GPF 154. The VAMC did not obtain a donation letter explaining the intended purpose of the donation. However, we found an internal medical school memorandum indicating that the funds were

intended for use at the employee's "sole discretion for unrestricted divisional development and research purposes." During the 4-year period 1999-2002, a corporation made four donations totaling $16,500 to the medical school for the employee. The school deposited the funds with the agent cashier, who transferred them to GPF 154. The VAMC did not obtain donation letters for any of these donations. However, the corporation's letters to the school indicated that the funds were for the employee's unrestricted use in his research activities.

None of these five donations were reviewed by the former VAMC Director or the R&D Committee. For these donations, management should have contacted the donors and asked them to provide donation letters explaining how they wanted the funds to be used. Although donations may be accepted for use by individual researchers, these donations should not be for the researcher's unrestricted use. Instead, the VAMC should ask donors to delineate how they wish the funds to be used, such as for a specific research project, a particular type of research, or general expenses related to the researcher's VA-approved research activities. This is necessary so that Fiscal Service and the R&D Committee can provide oversight to ensure that donated funds are used for valid research purposes.

The other employee who controlled GPF 154 also accepted a donation that should have received closer scrutiny. This employee donated funds to his own research account:

The employee and his wife were officers and sole shareholders in a private corporation that provided research technology for drug and animal testing. In December 2000, the corporation (over the wife's signature) made a $75,587 donation to GPF 154. The corporation provided a donation letter that stated: "These funds are to be used exclusively for [the employee's] use in execution of research pertaining to [corporation] designated protocols and for his other research activities."

Neither the former VAMC Director nor the R&D Committee had reviewed the donation letter or approved the donation. This donation should have been carefully reviewed to make sure that the funds would be used for VA-approved research and not for unapproved research that would benefit the corporation.

GPF 125 held 24 donations totaling $22,087 that had not been reviewed and approved by the VAMC Director. These donations were received from 24 different donors and were apparently intended for VAMC educational programs. The VAMC's Education Service received the donations and had them deposited into the GPF account without obtaining donation letters. Because the exact intent of the donations was not known, Fiscal Service could not properly monitor the use of the funds. For these donations, the VAMC should have obtained donation letters stating whether the donors wanted the funds to be used for general educational activities or for specific educational purposes.

Improper Honoraria Deposited in GPF Accounts. Government ethics regulations prohibit employees from soliciting funds from private sources and from accepting honoraria for giving speeches or presentations related to their Government duties. Our review found that four VAMC physicians and one VA Regional Counsel attorney had accepted improper honoraria, and deposited these funds into GPF 125:

- In 2000 and 2001, two physicians solicited a total of $5,500 from pharmaceutical companies and deposited these funds into GPF 125.

- During 1999-2002, two other physicians and the Regional Counsel attorney accepted eight honoraria totaling $7,500 for presentations about VAMC activities that they managed or advised as part of their Government duties. The employees had the honoraria deposited to GPF 125. The Regional Counsel attorney, who was responsible for advising VAMC employees on Government ethics questions, acknowledged that she and the two physicians should not have accepted the honoraria. In addition to violating Government ethics rules, these employees raised further questions of propriety by depositing the funds in a GPF account that facilitated potential personal use of the funds. If the money was used for personal benefit, it might be considered personal income by Federal and State authorities, with income tax implications. As described below, some of these funds were used to purchase items that appeared to be for personal use.

Questionable Purchases Made From GPF Accounts. Three of the four employees who deposited honoraria into GPF 125 were allowed to control these funds and to purchase items that appeared to be for their personal use and not for VAMC educational activities, which was the apparent purpose of GPF 125. Most of the expenditures from GPF 125 appeared to be for valid educational purposes (for example, handout materials for patient wellness training and manuals for cardiac life support training). However, from January 1999 until March 2002, the 3 employees used GPF 125 funds for 71 purchases (total cost = $31,297) that appeared to be for personal use. Purchases included personal computers kept at home, palm pilots, professional journals, professional organization dues, and tuition for classes to maintain board certification. The questionable purchases occurred because the fund control point official had not been properly trained and was not aware of his responsibility to approve all account expenditures.

Stronger GPF Controls Needed. To address the problems discussed above, VAMC management needed to implement effective controls that will bring GPF accounts into full compliance with VA policy on approving donations and monitoring expenditures. Fiscal Service should ensure that donation letters are obtained in all cases and that donations are approved by the VAMC Director (and the R&D Committee for research donations). Management should appoint fund control point officials for all GPF accounts and ensure that these officials are trained on GPF policies and procedures. Fiscal Service should also monitor GPF accounts to ensure that disbursements are appropriate. Until these controls are implemented, there will be a continued risk that donated funds will be improperly accepted and/or used for inappropriate purposes. In addition, the VAMC Director needed to consult with Office of General Counsel ethics officials in VA Central Office to determine whether any of the honoraria received should be returned to payers and whether administrative action should be taken against the recipients of the honoraria.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the VAMC Director: (a) implemented controls to bring GPF accounts into full compliance with VA policies on accepting donations and monitoring expenditures; (b) provided training on GPF policies and procedures for fund control point officials and all other staff involved in administering GPF accounts; (c) issued guidance reminding employees about Government ethics rules on soliciting and accepting honoraria; and (d) determined, in conjunction with Office of

General Counsel ethics officials, whether any of the honoraria received should be returned to the payers and whether administrative action should be taken against recipients of the honoraria.

The VISN Director and the VAMC Director agreed, and stated that a new VAMC policy incorporating controls, processes, and procedures for GPF accounts would be in place by October 31, 2002. VAMC employees will receive training and guidance on GPF account administration and honoraria by October 31, 2002. VAMC management contacted the Office of General Counsel for guidance on the possible return of honoraria and on whether administrative action should be taken against the recipients of the honoraria. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Conditions Needing Improvement. The VAMC needed to reduce excess inventories of medical and prosthetics supplies. VHA policy states that VAMCs should maintain supply inventories at levels that will meet current operating needs. Inventories above those levels should be avoided so funds are not tied up in excess inventory. VHA policy states that inventory levels for medical and prosthetics supplies should not exceed a 30-day supply.

Medical Supplies. VAMCs are required to use VA's automated Generic Inventory Package (GIP) to manage medical supply inventories. Supply, Processing, and Distribution (SPD) Section staff did not routinely update GIP when supplies were issued from the inventory. Because of this, the GIP data was inaccurate, and the SPD staff could not use it to manage the inventory. To follow up on the inaccuracies we identified in the GIP data, the SPD Section performed a wall-to-wall inventory and found that it had about $230,000 in inventory that exceeded a 30-day supply.

Prosthetics Supplies. Prosthetics Service maintained inventories of 119 different types of surgical stents (devices used to internally support veins and arteries to prevent blockage). The inventories of all 119 types of stents had more than a 30-day supply. The value of this excess inventory was about $270,000. This inventory had accumulated because the VAMC had allowed physicians to order stents based on their preferences for particular types and manufacturers. As physicians changed their preferences, existing supplies went unused. To address this problem, the VAMC should use the existing supply of stents to the extent clinically feasible and should establish controls to preclude ordering more stents than needed.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the VAMC Director implemented controls to: (a) reduce excess medical and prosthetics supply inventories, (b) effectively use GIP to manage SPD inventories, and (c) preclude ordering more stents than needed. The VISN Director and the VAMC Director agreed and reported that excess inventory was being reduced through (i) full implementation of GIP, (ii) staff reorganization to provide additional staff to manage inventory levels, and (iii) use of consignment agreements for stents. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Environment of Care – Patient Safety and Confidentiality, Pest Control, and Cleanliness Should Be Improved

Conditions Needing Improvement. Our inspection of the VAMC found numerous environment of care deficiencies that needed to be addressed:

Patient Safety. At the Leestown Division Nursing Home Care Unit (NHCU), we found scissors, blade shavers, toenail clippers, carpentry tools, liquid bleach, laundry soap, and window cleaner in unlocked and unattended areas of the Rehabilitation and Occupational Therapy Sections. Potentially dangerous objects and substances should be stored out of reach of patients, particularly those who might accidentally harm themselves.

Patient Confidentiality. In several different patient care areas at the Cooper Drive Division, we found unsecured documents containing confidential patient information, including names, social security numbers, drugs prescribed, and procedure outcomes. On equipment in the hall of the sleep study area, we found a clipboard with documents showing the results of a patient's sleep study. We also found three computers turned on and unattended, with patient information readily accessible.

Pest Control. The VAMC needed to intensify efforts to control pests. Dead insects (cockroaches, flies, and beetles) were found in light fixtures and on windowsills in clinical areas at both divisions. At the Leestown Division NHCU we found live ants in a microwave oven used to heat patient food. Fruit flies were found in hallways and patient rooms at both divisions.

Facility Cleanliness. The general cleanliness of the VAMC needed improvement. At the Cooper Drive Division, dust had accumulated on bathroom air vents, walls around toilets in many inpatient units were urine-stained, baseboards were dirty and stained, and inpatient lockers were dirty. The floors along baseboards in hallways had not been thoroughly cleaned, public restrooms at the Cooper Drive Division were dirty and needed more thorough cleaning, and carpets needed vacuuming and deep cleaning. Public areas of the canteen had accumulations of dirt underneath all the counters and behind all the equipment, such as the coffee station and the pie stand. Some of the medication containers on Pharmacy Service storage shelves had heavy accumulations of dust.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the VAMC Director implemented actions to: (a) secure sharp objects and chemicals in patient care areas, (b) protect patient confidentiality, and (c) maintain a pest-free and clean environment. The VISN Director and the VAMC Director agreed, and stated that medication security was being monitored on a daily basis, and that nurse managers had been notified in writing of the importance of medication security. Locking cabinets had been installed in patient care areas to store dangerous items, and supervisors and nurse managers were instructed to monitor patient care areas to ensure that these items were secured when not being used. The Information Security Officer (ISO) had been instructed to install software to lock out unattended computers, and information security was added to the VAMC's Environment of Care inspections. The VAMC management team formulated a nine-point plan to improve facility cleanliness that included increased monitoring, hiring additional permanent and temporary housekeeping staff,

revisions of VAMC policy, and long-term planning for environment of care issues. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Government Purchase Card Program – Administrative Oversight Should Be Strengthened

Conditions Needing Improvement. VAMC management and the Purchase Card Coordinator (PCC) needed to ensure that the Government purchase card program was administered effectively. As of March 31, 2002, the VAMC had 81 cardholders and 35 approving officials. We reviewed purchase card use that occurred from December 2001 through March 2002. During that period VAMC staff authorized 5,819 transactions costing $2.9 million. Cardholders reconciled purchases on time, and staff deactivated purchase cards when cardholders were separated from employment or otherwise had their cardholder duties terminated. However, staff had not implemented some required administrative controls, approving officials did not always monitor purchases, and cardholders did not always comply with policy. Management needed to address the following control deficiencies.

Purchase Card Administrative Requirements Not Met. VAMC staff did not fully comply with VHA policy on PCC oversight, data security, and training:

- VAMC management had allowed the PCC to delegate several PCC duties to other staff. VHA policy prohibits delegation of coordinator duties to other individuals.

- VA policy requires that access to automated data be limited to personnel with a demonstrated need. VAMC records showed 45 individuals with access to the Purchasing Agent Menu in the Integrated Funds Distribution, Control Point Activity, and Accounting Procurement system. Of these 45 individuals, 17 had a need for access based on their duties, but the remaining 28 (VAMC and VHA data processing staff) had no responsibility for any aspect of the VAMC's purchase card program.

- Training for cardholders and approving officials should be documented. VAMC staff did not document all aspects of the training of cardholders on 8 of 10 occasions. In addition, staff did not document training for approving officials at all on 7 of 10 occasions, and did not document all aspects of the training on the other 3 occasions.

Purchases Not Monitored. Approving officials did not ensure that purchases were appropriate and that purchased goods and services were actually received:

- To circumvent the $2,500 per purchase limitation, 2 cardholders split 3 purchases totaling $24,656 into 23 transactions.

- Approving officials had not approved 140 purchases totaling $56,077.

- We reviewed approving official actions for 10 purchases totaling $3,647. For five of these purchases, five different approving officials did not ensure that all items purchased had been received. They told us they never verified deliveries unless they were informed of a problem.

Purchases Not In Compliance With Policy. Because the PCC and approving officials did not provide effective oversight, cardholders purchased telecommunications services and made unnecessary open market purchases:

- On 20 occasions, 2 cardholders purchased telecommunication services totaling $1,739. VHA policy prohibits the use of purchase cards for such services.

- A cardholder purchased publications costing $5,770 from an open market source instead of making the purchase through an available Government contract.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the VAMC Director implemented controls to: (a) preclude the delegation of PCC duties; (b) limit access to the Purchasing Agent Menu to staff with a demonstrated need; (c) document purchase card training; (d) require approving officials to approve all purchases and verify receipt of purchased items; and (e) prevent cardholders from purchasing unauthorized items, splitting purchases, and making unnecessary open market purchases.

The VISN Director and VAMC Director agreed with the recommendation. The VAMC Director took steps to ensure that the PCC did not delegate his duties to other VAMC staff. The number of staff with access to the Purchasing Agent Menu was reduced, and controls over access to the menu were strengthened. By September 30, 2002, the PCC will have conducted and documented training for all purchase cardholders. The PCC was directed to monitor purchases for approvals, receipt of items, purchase splitting, and inappropriate and open market purchases. The PCC was also directed to refer any violation of policy to the VAMC Director. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Endoscopy Procedures – Only Qualified Staff Should Administer Conscious Sedation and Attending Physicians Should Be Available

Conditions Needing Improvement. Management needed to end the practice of allowing licensed practical nurses (LPNs) to administer conscious sedation[3] for endoscopy procedures and ensure that attending physicians were available for emergencies in the Endoscopy Suite.

Conscious Sedation Administered by LPNs. LPNs were allowed to administer conscious sedation for diagnostic endoscopy procedures. Only properly trained physicians or registered nurses should have performed this duty. Clinical managers told us that the LPNs had been trained, but they could provide no evidence of this training. In addition, they could not document how the LPNs demonstrated their competency to administer conscious sedation.

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[3] Under conscious sedation, the patient is awake and aware but sufficiently sedated to be free of pain and anxiety.

Clinical managers agreed the LPNs should not administer conscious sedation, and agreed to stop this practice.

<u>Attending Physicians Not Always Available</u>. Attending physicians responsible for supervising procedures in the Endoscopy Suite were not always available for emergencies. Senior residents, who were qualified to work without immediate supervision by an attending physician, performed most diagnostic endoscopy procedures. However, the attending physicians are required to be physically available for emergencies. On some occasions, attending physicians were not at the VAMC or the UKMC and did not arrange for substitute coverage.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the VAMC Director made certain that (a) only properly trained physicians or registered nurses administered conscious sedation and (b) attending physicians were available for emergencies in the Endoscopy Suite. The VISN Director and VAMC Director agreed, and reported that as of September 2002 only specifically trained registered nurses were being permitted to administer conscious sedation. VAMC management also took actions to ensure that attending physicians were always available for emergencies. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Patient Waiting Lists – Reported Data Should Be More Accurate

Conditions Needing Improvement. The VAMC needed to improve the accuracy of patient waiting list data. VHA has required each VISN and VAMC to submit data showing the number of patients waiting for VA care and how long they have been waiting. It is important that this data be accurate because VHA uses it in planning budget priorities, measuring performance, and determining whether strategic goals are met.

VHA required that waiting list data be reported in the following format: Category A–veterans whose enrollment applications had been received but not processed; Category B–newly enrolled veterans awaiting first appointments; Category C–currently enrolled veterans awaiting first primary care appointments; and Category D–currently enrolled veterans awaiting appointments for designated specialty care clinics. We found that Category A waiting times were inaccurate and the number of veterans on the Category B list was overstated:

- <u>Category A</u>. VAMC staff did not date stamp veteran enrollment applications when received. As a result, the VAMC reported estimated waiting times based on the dates veterans signed their applications.

- <u>Category B</u>. We reviewed information on a judgment sample of 20 veterans on the Category B list and found that 4 (20 percent) had previously received VA care and therefore should not have been on this list. In addition, when veterans were initially enrolled VAMC staff did not attempt to identify those who did not intend to seek care. These veterans were not identified until staff attempted to schedule appointments for them. VAMC staff estimated that 10 percent of newly enrolled veterans did not intend to seek care.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director implemented controls for: (a) date stamping enrollment applications when received, (b) including on the Category B waiting list only veterans who have never received care, and (c) determining whether new enrollees intend to seek care. The VISN Director and the VAMC Director agreed, and reported that all enrollment applications were being date stamped and that the VAMC will comply with new VA guidance for including only new Category B veterans on waiting lists and determining whether enrollees will seek care when that guidance is issued. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Deficiencies Should Be Corrected and Equipment and Software Accounted For

Conditions Needing Improvement. We reviewed IT security controls to determine if they were adequate to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that Information Management Service (IMS) staff had conducted risk assessments, implemented virus detection procedures, and established effective procedures for assigning passwords. However, we identified eight IT security and accountability deficiencies that needed corrective action:

IT Security

- The VAMC did not have a consolidated IT contingency plan. Instead, the ISO made service chiefs responsible for developing contingency plans for their services.

- The off-site storage area for information system back-up disks was not equipped with a required fireproof safe.

- Access to the computer room was not monitored or controlled. VAMC staff had developed a log to monitor access to the room, but the log had not been used for 2 months at the time of our review.

- Unauthorized internal and external modems were installed on personal computers connected to the Local Area Network (LAN), creating a vulnerability to external intrusion.

- The VAMC had not developed the VHA-required local policy outlining the separation of IT duties.

Equipment and Software Accountability

- Accountability for IT equipment and software needed improvement. We inventoried 48 IT equipment items costing less than $5,000 each and could not find 13 items (valued at $48,915). VAMC staff later told us that they had found some of the equipment in locations not noted on the inventory list.

- We identified eight items of computer equipment that had been loaned to employees to take home for periods not to exceed 1 year. The equipment had been loaned between June 1990 and October 1998. As of June 2002, the VAMC did not have documentation that the items had been returned or otherwise accounted for.

- VHA policy requires that IMS maintain an accurate inventory of all the VAMC's software and approve the purchase of all software to be installed on VAMC computers. IMS staff could only account for software purchased by IMS or VACO. Other VAMC services had purchased software without the knowledge of IMS. For example, one service purchased at least $800 in software without IMS approval.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director took action to: (a) develop a consolidated IT contingency plan, (b) install a fireproof safe in the off-site storage area, (c) monitor access to the computer room, (d) determine the need for all modems connected to the LAN, (e) develop a VAMC policy on the separation of IT duties, (f) perform an inventory and account for all IT equipment, (g) account for loaned computer equipment, and (h) have IMS control software purchasing and accountability.

The VISN Director and VAMC Director agreed and reported that by October 1, 2002, the ISO would develop a consolidated IT contingency plan. As of September 2002, a fireproof safe had been installed in the off-site storage area, and access to the computer room was being controlled and monitored. As of August 23, 2002, the ISO had begun conducting required quarterly reviews of modem connections, and by September 30, 2002, VAMC staff will issue a VAMC policy on separation of IT duties. In July 2002, VAMC staff completed an inventory of IT equipment at the Cooper Drive Division, and the inventory at the Leestown Division was to be completed by October 1, 2002. As of September 2002, VAMC staff had accounted for all loaned equipment, and VAMC management had directed Fiscal Service and Acquisitions and Materiel Management Service (A&MMS) staff not to process requests for computer software unless IMS staff had approved the requisitions. The improvement actions are acceptable, and we consider the issues resolved.

Management of Violent Patient Behavior – Policy, Training, Coordination, and Response Procedures Should Be Improved

Conditions Needing Improvement. The VAMC needed to strengthen the following elements of its policy and procedures for preventing and managing violent patient behavior.

Policy Not Complete. The VAMC policy on preventing and managing patient violence did not address critical aspects of the program. The policy needed revision to: (1) describe the role and qualifications of the program coordinator, (2) require annual employee training on preventing and managing violent patient behavior, (3) define procedures for reviewing, analyzing, and reporting incidents to the VISN, and (4) provide for specifically trained code response teams.

Training Not Documented. We reviewed training records for 11 employees, including new employees, front line clerks, and clinicians who work in the Emergency Room, Long Term Care,

and Mental Health areas. Five (45 percent) of the 11 records did not contain documentation that the employees had received violent patient management training in the past 12 months.

<u>Incident Review Procedures Not Developed</u>. There were no procedures for reviewing violent or potentially violent incidents or for deciding on protocols for managing violent patients. Ideally, an interdisciplinary group should be tasked with these responsibilities (for example, employees from Mental Health, Social Work, Nursing, Medicine, Police and Security, and Risk Management Services).

<u>Response Procedures Not Clear</u>. Nursing Service had a "show of force" procedure that summoned additional nursing employees and notified the VAMC police when a show of force was needed to control a violent patient. However, it was not clear who should take charge of the show of force or who had other specific responsibilities, making this process potentially unsafe for the patient and the responding employees. Ideally, when management of a disturbed patient is needed, interdisciplinary response teams should be available, similar to the Code Blue teams that respond to cardiopulmonary arrests. The teams should cover all shifts, have team leaders, and have specialized training in de-escalation and "take down" techniques (that is, techniques for subduing a disturbed patient without injuring the patient or employees). The team leader is usually a physician, typically a psychiatrist. However, any licensed independent practitioner, such as a nurse practitioner or clinical nurse specialist, can fulfill this role.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director took action to: (a) develop a comprehensive policy on managing violent patient behavior, (b) make sure that employee training is documented, (c) establish an interdisciplinary team to review violent and potentially violent incidents, and (d) establish trained response teams to manage incidents of violent patient behavior. The VISN Director and the VAMC Director agreed and stated that a Violent Behavior Program Coordinator had been appointed. The Coordinator was instructed to revise VAMC policy and reestablish the VAMC Disturbed Behavior Committee by October 31, 2002. By December 2002, response team participants will be trained. The improvement actions are acceptable, and we consider the issues resolved.

Homemaker/Home Health Aide Program – Clinical and Administrative Oversight Should Be Strengthened

Conditions Needing Improvement. VAMC management needed to improve clinical and administrative oversight of the H/HHA Program. VHA has made long-term care an important element of its effort to provide comprehensive care for VA patients. Congress reinforced the importance of long-term care in the Veterans Millennium Health Care Act (Public Law 106-117, Section 101). VHA's policy is to develop an innovative, flexible approach to provide home and community-based care that is fully integrated into the VA healthcare system and uses resources efficiently and effectively to meet the needs of an aging and chronically ill patient population. As part of this policy, VHA medical facilities are required to implement the H/HHA and several other non-institutionally based programs to provide long-term care.

The H/HHA Program allows VA medical facilities to contract with private providers for home health care and other in-home assistance for eligible beneficiaries. VHA facilities are required to coordinate and review the appropriateness of home care referrals, determine the most appropriate in-home services for individual patients, and monitor costs (VHA Directive 98-022). In FY 2001, the VAMC authorized $140,978 for H/HHA services. As of June 2002, the VAMC used 12 Community Health Agencies (CHAs) to provide H/HHA services for 28 patients. The following areas needed improvement:

- Patient Assessments. Four of 10 medical records reviewed did not include assessments by 1 or more members of the interdisciplinary treatment team.

- Reassessments of Need for Services. Every 3 months clinicians should document the need for continuing H/HHA services. This was not present in any of the 10 records reviewed.

- Review of CHA Plans of Care. Two of 10 medical records reviewed did not have current care plans.

- Agreements with CHAs. VAMC contracting staff had not negotiated contracts or other formal agreements to ensure that H/HHA rates were appropriate. Instead, each time a patient was referred to the program, the fee basis program support assistant contacted the prospective CHA and informally agreed on a rate. This left the VAMC vulnerable to changes in rates or services by the CHAs. One CHA had raised its rate without notice or justification. Another CHA had changed the type of services it provided without the approval of H/HHA staff.

- Billing Information From CHAs. CHA bills were sent to Fiscal Service for payment and were then forwarded to H/HHA managers for review and approval. H/HHA managers should review and approve all CHA bills before payment.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director implemented controls to: (a) have all members of the treatment team complete interdisciplinary assessments, (b) reevaluate the need for continued H/HHA services at least every 3 months, (c) include plans of care in patient medical records, (d) negotiate formal agreements for CHA services, and (e) have H/HHA staff approve bills before payment. The VISN Director and VAMC Director agreed and reported that by September 30, 2002, interdisciplinary medical record note templates will be introduced, an interdisciplinary team evaluation process will be implemented, and contracts for CHA services will be in place. Medical record reviews will be conducted for a minimum of 6 months to ensure that interdisciplinary team notes and plans of care are completed. VAMC management also instructed Fiscal Service staff not to pay bills for CHA services without evidence of prior review by H/HHA staff. The improvement actions are acceptable, and we consider the issues resolved.

Equipment Accountability – Research Equipment Should Be Properly Accounted For

Conditions Needing Improvement. Research Service needed to improve accountability for VAMC equipment located at the UKMC. VA policy requires that equipment be physically inventoried every 2 years or more frequently if problems are identified. We reviewed Equipment Inventory Listings (EILs) for Radiology, Pathology, and Research Services. The EILs for these 3 services listed 215 items costing $11.5 million. Radiology and Pathology Services could account for all their equipment. However, Research Service needed to address two equipment accountability issues:

- <u>Temporary Transfer of Microscope Not Approved</u>. Research Service had approved the temporary transfer of a microscope (cost = $14,218) to UKMC. When we checked this item, it had a UKMC property tag on it.

- <u>Equipment Taken to UKMC Without Proper Authorization</u>. VAMC policy stated that equipment could not be taken to the UKMC without authorization from A&MMS staff. We found two equipment items, a centrifuge (cost = $5,812) and a microscope (cost = $19,782), that had been relocated to the UKMC without the required authorizations.

Accountability for research equipment at the VAMC was complicated by the fact that the VAMC is collocated with the UKMC. In addition, the VAMC had a large number of portable equipment items used by researchers who held joint appointments at the UKMC and the VAMC. Research Service had 38 EILs with 95 equipment items costing about $1.4 million (average cost = $14,620). Research Service staff responsible for the EILs agreed that quarterly inventories, instead of annual inventories, should be done because of the number of EILs and the high value and portability of the equipment.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director implemented controls to: (a) properly account for VAMC equipment located at the UKMC, (b) remove UKMC property tags from VAMC equipment, (c) obtain proper authorization from A&MMS staff before relocating equipment to the UKMC, and (d) conduct quarterly inventories of Research Service EILs. The VISN Director and VAMC Director agreed and reported that VAMC staff had accounted for all VAMC equipment located at UKMC, the UKMC property tag had been removed from the microscope, and proper authorizations had been received for VAMC equipment at UKMC. VAMC management concluded that performing quarterly inventories of all Research Service equipment would require too much staff time, but agreed that all loaned research equipment would be inventoried each quarter. The improvement actions are acceptable, and we consider the issues resolved.

Controlled Substances Security – The Drug Courier Should Be Protected, Ward Stock Secured, and Alarms Repaired

Conditions Needing Improvement. The VAMC's controlled substances accountability program was generally operating effectively. Controlled substances inspections were conducted in accordance with VA policy, and staff resolved or reported discrepancies as required. However, management needed to address three security issues:

- Employee Transporting Controlled Substances. A Pharmacy Service employee was assigned as a controlled substances courier, transporting controlled substances from the Cooper Drive Division to the Leestown Division in a locked canvas bag. He made these trips on a regular schedule 3 days a week, riding unescorted on the shuttle bus that ran between the two divisions. Because the employee made the trips unescorted and on a schedule known to many people, he was vulnerable to robbery. The VAMC should find a safer way to transport controlled substances and/or make sure the courier is adequately protected.

- Ward Security. At the Cooper Drive Division, our inspection found five unlocked and unattended medication carts (four on inpatient wards and one in the Primary Care area).

- Pharmacy Security. Intrusion alarms and panic buttons in the Cooper Drive Division Inpatient and Outpatient Pharmacies did not function when tested.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director took action to: (a) provide for the safe transport of controlled substances between the VAMC divisions, (b) improve the security of medication carts, and (c) repair the intrusion alarms and panic buttons in the Cooper Drive Division Inpatient and Outpatient Pharmacies. The VISN Director and VAMC Director agreed and reported that as of September 2002 VAMC Police and Security Section staff were escorting couriers when they transported controlled substances between the Cooper Drive and Leestown Divisions. Medication security on wards was being closely monitored, new intrusion alarms had been installed in the Cooper Drive Division Pharmacy, and panic buttons were operable and were being tested weekly. The improvement actions are acceptable, and we consider the issues resolved.

Human Resources Management – VHA Evaluation and Assistance Should Be Requested

Conditions Needing Improvement. During the CAP review, 10 employees made hotline complaints about HRM activities, and 4 other employees contacted us to express concerns about personnel practices, although they did not lodge formal hotline complaints. Because of these complaints, we concluded that the HRM Service should have an in-depth evaluation by VHA's HRM Group, which has responsibility for reviewing VHA human resources programs, identifying problems, and assisting local managers in implementing solutions. The HRM Group has the expertise to help the VAMC resolve individual employee issues and generally strengthen its HRM program.

Our review identified another HRM issue that required management attention. HRM staff did not request required background investigations on all IMS employees. VA policy requires that HRM Service initiate these investigations through the Office of Personnel Management (OPM) for IMS employees who have system or programmer access to VA data. The level of security clearance assigned to an employee's position dictates the type of investigation that should be done.

We reviewed the personnel files of five IMS employees who had security clearances to determine if HRM Service had requested the appropriate investigations. One of the five employees had not completed the paperwork needed to initiate an investigation, and HRM Service had not acted to ensure compliance. According to the National Crime Information Center, this employee had a prior felony conviction. Another IMS employee not included in the five discussed above had properly reported a prior felony conviction, but HRM Service had not notified VAMC or IMS management. In addition, in this instance IMS had incorrectly designated the position as moderate risk, and as a result OPM performed a less rigorous investigation that did not identify the prior conviction.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director (a) requested an in-depth HRM Group evaluation of HRM Service and (b) implemented controls to complete all required background investigations. The VISN Director and VAMC Director agreed, and stated that they had contacted the HRM Group to initiate a comprehensive review of the VAMC's HRM Service. The review was scheduled for completion by September 30, 2002. The Directors also reported that as of September 2002, the VAMC's HRM practices had been revised to ensure completion of required background investigations. The improvement actions are acceptable, and we consider the issues resolved.

Physician Time for Patient Care–March 2002

Tables 2 and 3 show documented patient care time for the 67 physicians in Medical and Surgical Services. Table 4 shows estimated total productive hours worked. (See explanatory notes at the end of each table and see pages 29-30 for the calculation of physician overstaffing.)

Table 2. Medical Service Documented Patient Care Hours

Physician Assignment/ FTEE		a Available Hours	b Patient Encounters	c Encounter Hours	d % Documented Patient Care Hours/ Available Time
Cardiology	0.875	126	10	5.0	4.0%
Cardiology	0.625	90	0	0.0	0.0%
Cardiology	0.625	90	18	9.0	10.0%
Cardiology	0.500	72	27	13.5	18.8%
Cardiology	0.500	72	27	13.5	18.8%
Cardiology	0.500	72	223	111.5	154.9%
Cardiology	0.375	54	0	0.0	0.0%
Cardiology	0.125	18	28	14.0	77.8%
Internal Medicine	1.000	144	0	0.0	0.0%
Internal Medicine	0.625	90	78	39.0	43.3%
Internal Medicine	0.500	72	0	0.0	0.0%
Internal Medicine	0.500	72	9	4.5	6.3%
Internal Medicine	0.500	72	14	7.0	9.7%
Internal Medicine	0.250	36	12	6.0	16.7%
Endocrinology	0.875	126	19	9.5	7.5%
Endocrinology	0.750	108	0	0.0	0.0%
Endocrinology	0.625	90	0	0.0	0.0%
Endocrinology	0.625	90	53	26.5	29.4%
Endocrinology	0.625	90	0	0.0	0.0%
Pulmonary	0.625	90	0	0.0	0.0%
Pulmonary	0.625	90	0	0.0	0.0%
Pulmonary	0.625	90	0	0.0	0.0%
Pulmonary	0.375	54	19	9.5	17.6%
Pulmonary	0.125	18	16	8.0	44.4%
Ambulatory Care	0.375	54	92	46.0	85.2%
Ambulatory Care	1.000	144	155	77.5	53.8%
Ambulatory Care	1.000	144	187	93.5	64.9%
Ambulatory Care	1.000	144	316	158.0	109.7%
Ambulatory Care	0.500	72	52	26.0	36.1%
Gastroenterology	0.875	126	75	37.5	29.8%
Gastroenterology	0.750	108	44	22.0	20.4%
Gastroenterology	0.750	108	2	1.0	0.9%
Hem/Oncology	1.000	144	27	13.5	9.4%
Hem/Oncology	0.875	126	22	11.0	8.7%
Hem/Oncology	0.375	54	0	0.0	0.0%
Renal	0.625	90	7	3.5	3.9%
Renal	0.625	90	37	18.5	20.6%
Infectious Disease	0.625	90	0	0.0	0.0%
Infectious Disease	0.625	90	0	0.0	0.0%
Dermatology	0.125	18	1	.5	2.8%
Combined	24.5	3528	1570	785	22.3%

Notes to Table 2

a. Available Hours = 168 work hours for March 2002 minus earned leave.

b. Number of Patient Encounters = data from VAMC's March 2002 Patient Encounter Activity Report.

c. Encounter Hours = number of encounters times 30 minutes per encounter (average encounter time based on discussions with VAMC staff).

d. Documented Patient Care Hours/Available Hours = encounter hours divided by available hours to show percentage of available time spent on documented patient care.

Table 3. Surgical Service Documented Patient Care Hours

| | | a | b | c | d | e | f | g |
| | | | | | | | Documented | % Documented |
Physician Assignment/ FTEE		Available Hours	OR Cases	OR Hours	Patient Encounters	Encounter Hours	Patient Care Hours	Patient Care Time/ Available Time
Cardiothor.	0.375	54	1	3.8	32	8.0	11.8	21.9%
Cardiothor.	0.250	36	1	1.8	18	4.5	6.3	17.5%
Cardiothor.	0.250	36	2	4.5	0	0.0	4.5	12.5%
Cardiothor.	0.250	36	0	0.0	9	2.3	2.3	6.4%
Ophthalm.	0.625	90	3	5.3	52	13.0	18.3	20.3%
Ophthalm.	0.250	36	7	12.1	31	7.8	19.9	55.3%
Ophthalm.	0.250	36	0	0.0	0	0.0	0.0	0.0%
Ophthalm.	0.125	18	0	0.0	9	2.3	2.3	12.8%
ENT	0.625	90	2	23.2	15	3.8	27.0	30.0%
ENT	0.375	54	1	2.6	4	1.0	3.6	6.7%
ENT	0.250	36	2	17.8	19	4.8	22.6	62.8%
Vascular	0.625	90	3	12.2	43	10.8	23.0	25.6%
Vascular	0.625	90	3	9.6	21	5.3	14.9	16.6%
Vascular	0.625	90	1	6.6	30	7.5	14.1	15.7%
Vascular	0.625	90	1	3.5	13	3.3	6.8	7.6%
General	0.875	126	8	28.5	102	25.5	54.0	42.9%
General	0.625	90	17	42.0	56	14.0	56.0	62.2%
General	0.625	90	0	0.0	0	0.0	0.0	0.0%
Orthopedic	0.625	90	6	17.9	59	14.8	32.7	36.3%
Orthopedic	0.375	54	0	0.0	0	0.0	0.0	0.0%
Orthopedic	0.250	36	1	1.3	3	.8	2.1	5.8%
Plastic	0.500	72	1	2.7	13	3.3	6.0	8.3%
Plastic	0.375	54	2	4.1	14	3.5	7.6	14.1%
Neurosurg.	0.625	90	3	10.3	6	1.5	11.8	13.1%
Neurosurg.	0.375	54	6	14.1	4	1.0	15.1	28.0%
Urology	1.000	144	75	107.6	679	169.8	277.4	192.6%
Urology	0.625	90	7	23.9	5	1.25	25.2	28.0%
Combined	13.0	1,872	153	355.4.4	1237	309.859	665.3	35.5%

Notes to Table 3

a. Available Hours = 168 work hours for March 2002 minus earned leave.

b. Number of OR cases = number of surgical procedures shown on the OR log.

c. OR hours = procedure time shown on the OR log plus 1 hour per procedure for pre and post-operative activities.

d. Number of Patient Encounters = data from the VAMC's March 2002 Patient Encounter Activity Report.

e. Encounter hours = number of encounters times 15 minutes per encounter (average encounter time based on discussions with VAMC staff).

f. Documented Patient Care Hours = OR hours plus encounter hours.

g. Documented Patient Care Time/Available Time = documented patient care hours divided by available hours to show percentage of available time spent on documented patient care.

Table 4. Estimated Physician Total Productive Hours

Service	Physician FTEE	Available Hours	Documented Patient Care Hours	Estimated Other Productive Hours	Estimated Total Productive Hours
Medical	24.5	3,528	785.0	1,771.8	2,556.8
Surgical	13.0	1,872	665.3	940.2	1,605.5
Combined	37.5	5,400	1,450.3	2,712.0	4,162.3
Percent Available Hours	100%		26.9%	50.2%	77.1%

Notes to Table 4

a. Based on discussions with clinical management and staff, we distributed estimated other productive physician hours as follows: 1,080 hours for research and administrative time for staff physicians, 147 hours for administrative time for the two service chiefs, 958 hours for inpatient care, 322 hours for resident supervision, and 205 hours that were provided by substitute physicians from the UKMC (1,080 + 147 + 958 + 322 + 205 = 2,712). (As discussed on page 4, the VAMC did not have controls to ensure that substitute physicians provided services. However, in some instances these physicians did record patient encounters in the Patient Encounter Activity Report. We credited time for this patient care since it would otherwise have had to be provided by VAMC physicians.)

b. Estimated other productive hours for Medical and Surgical Services were based on FTEE allocations. Medical Service had 24.5 FTEE of the 37.53 total for the 2 services, or 65.33 percent of the total. Surgical Service FTEE represented 34.67 percent of the total. Medical Service had 1,771.8 other productive hours (.6533 x 2,712 total other productive hours =

1,771.74 rounded to 1,771.8). Surgical Service had 940.2 other productive hours (.3467 x 2,712 = 940.20).

Calculation of Estimated Physician Overstaffing

We used a 7-step process to reach our estimate that Medical and Surgical Services were overstaffed by 7.3 FTEE physicians:

1. **Available Work Hours.** The two services had 37.5 FTEE physicians. There were 21 working days in March 2002, so for each FTEE there would be 168 available working hours (21 days x 8 hours per day = 168 hours). During the month, each FTEE earned 24 hours of annual and sick leave, leaving 144 available work hours per FTEE. For the month, the 37.5 FTEE had a total of 5,400 available work hours (37.5 FTEE x 144 available hours = 5,400).

2. **Inpatient Care Hours.** Because inpatient care time is not reported by physician, we allocated this time based on the total inpatient care workload. To calculate this time, we obtained patient days of care data for all Medical and Surgical Service inpatient units, including intensive care. Based on discussions with clinical management and staff, we allowed 20 minutes of physician time per patient care day for the inpatient wards and 30 minutes per patient care day for the intensive care unit. This approach yielded 723 hours of ward inpatient care time and 235 hours of intensive care time. The total inpatient care time was 958 hours (723 + 235 = 958).

3. **Outpatient Care Hours.** To account for outpatient workload, we used the March 2002 Patient Encounter Activity Report, reviewed outpatient clinic schedules, and interviewed VAMC staff. We allowed 30 minutes per outpatient visit for Medical Service physicians and 15 minutes per visit for Surgical Service physicians. During March, Medical Service physicians had 785 hours of outpatient care time (1,570 medical outpatient visits x 30 minutes per visit = 785 hours). Surgical Service physicians had 309.3 hours of outpatient care time (1,237 surgical outpatient visits x 15 minutes per visit = 309.3 hours). The Medical and Surgical Service physicians spent another 233 hours on resident supervision in the outpatient clinics. In addition, substitute physicians from the UKMC provided 205 hours of outpatient care. The total outpatient care time for the month was 1,532.3 hours (785 medical + 309.3 surgical + 233 resident supervision + 205 substitute = 1,532.3 hours).

4. **Operating Room Hours.** We used the March 2002 OR log to determine the time surgeons spent performing procedures. Actual OR time, including 1 hour per procedure for preoperative and postoperative activities, was 355.4 hours. An additional 89 hours was spent supervising residents in surgery. Total OR time was 444.4 hours (355.4 + 89).

5. **Administrative and Research Hours.** Based on discussions with the part-time Chiefs of Medical and Surgical Services, we allowed 147 hours for their administrative duties. For all the other physicians, we allowed 20 percent of available hours for administrative and research duties, which equated to 1,080 hours (5,400 available hours x 20 percent = 1,080 hours). The total administrative and research time was 1,227 hours (147 + 1,080 = 1,227).

6. **Total Hours Accounted For.** The total work time accounted for was 4,162 hours (985 inpatient care hours + 1,532.3 outpatient care hours + 444.4 OR hours + 1,227 administrative and research hours = 4,161.7 rounded up to 4,162).

7. **Hours Not Accounted For.** The physician work time not accounted for was 1,238 hours (5,400 available hours – 4,162 hours accounted for = 1,238). The 1,238 hours equates to about 7.3 FTEE (1,238 hours ÷ 168 hours per FTEE = 7.36 FTEE rounded down to 7.3 FTEE).   The 7.3 FTEE estimate is conservative because we allowed estimated administrative, research, inpatient care, and resident supervision time for physicians who had no documented patient care time. It could be argued that these physicians should be credited with little or no administrative time, since most administrative work is patient care-related. Similarly, they should have little research time because VA physicians typically do not have VA-approved research projects unless they also provide patient care. They should also have little inpatient time because VA physicians typically would not have inpatient care duties unless they also worked in the medical and surgical clinics. If these physicians were not credited with "other productive time," then Medical and Surgical Services would be overstaffed by about 10.9 FTEE physicians.

Monetary Benefits in Accordance with
IG Act Amendments

Report Title: Combined Assessment Program Review of VA Medical Center Lexington, Kentucky

Report Number:

Recommendation	Explanation of Benefit	Better Use of Funds
2(a)–(b)	Better use of funds by reallocating resources spent on unneeded physician staff in Medical and Surgical Services.	$1,150,000
6(a)–(c)	Better use of funds by reducing excess medical and prosthetics supply inventories.	500,000
	Total	$1,650,000

VISN 9 Director Comments

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**DEPARTMENT OF   MEMORANDUM
VETERANS AFFAIRS**

Date: September 6, 2002

From: Network Director (10N9) MidSouth Healthcare Network, Nashville, TN

Subj: Status Request – Combined Assessment Program Review Lexington VAMC

To: Director, Operational Support Division (53B)

         THRU: Director, Management Review and Administration Service (105E)

1. Attached is the current Status of Implementation and supporting documentation based on our request for information relating to the Lexington VAMC CAP review.

2. If you have any questions or require additional information, please contact Vivieca Wright, Health Systems Specialist/Compliance Officer, (615) 340-2393.

      /s/
John Dandridge, Jr.
Network Director

Attachment – Lexington VAMC CAP Response

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Department of Veterans Affairs   MEMORANDUM

Date: September 4, 2002

From: Medical Center Director, VAMC Lexington, KY (596/00)

Subj: Response to Draft Report of the Combined Assessment Program Review

To: Assistant Inspector General for Auditing (52), Office of Inspector General, Chicago, IL 60666

1. Attached are responses and the action plan based on the draft report for the Combined Assessment Program Review of the VA Medical Center in Lexington, Kentucky. This is being submitted within the 10 day timeline agreed upon by OIG, the facility and the network. The attached document contains corrective action plans for both the *Recommended Improvements* (which will be monitored by the Office of the Inspector General) and the *Suggested Improvements* (which are to be monitored at the medical center and network levels).

2. We do appreciate the professional manner in which the OIG performed this review including preparation, on site survey activity and follow up communication.

/s/
Forest Farley
Director

CAP Action Plan
VAMC Lexington

Action Plan
CAP Survey – VA Medical Center – Lexington, KY.

Recommended Opportunities for Improvement

Recommended Improvement Action 1.

Physician Time and Attendance – Physician Duty Assignments and Timekeeping Should Comply with VA Policy
We recommend that the VISN Director ensure that the VAMC Director implements controls to fully comply with VA policy on physician time and attendance and the completion of physician timecards.

VAMC Comments: We agree that Lexington's practice has been problematic in several clinical services, primarily Medicine, Surgery and Pathology. This was the case because of the difficulty inherent in matching the variable service demands to a rigid time-based accounting method. We also note that physicians are treated differently than other VA employees in that they are expected to work uncompensated overtime if needed for patient care, and are required by professional responsibility to cover services "on-call" around the clock although, unlike other VA employees, they are not entitled to on-call pay. Nevertheless, we recognize the need to comply with VA time and attendance regulations. All three services (Medicine, Surgery, Pathology) will be in compliance by the end of November 2002 using either core/flexi-time or contract arrangements. Fiscal will conduct quarterly audits of core/flexi-time using the OIG methodology.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Mike Holland   Date
Chief, Fiscal Officer

_____/s/_____   _____9/6/02_____
Steve S. Kraman, M.D.   Date
Chief of Staff

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VAMC Lexington

Recommended Improvement Action 2.

Physician Productivity – Physician Staff Resources Should Be Reallocated To Better Meet the Primary Care Workload
We recommend that the VISN Director ensure that the VAMC Director: (a) eliminates unneeded physician positions in Medical and Surgical Services and (b) reallocates the resources associated with these positions to Primary Care Service or other VAMC activities that need resources.

VAMC Comments: We agree with the need to evaluate the physician workforce and match it appropriately to the needs of the medical center. We also appreciate the efforts of the OIG to do this. We believe that the timekeeping issues cited in recommendation #1 and the use of WOC physicians adversely impacted the ability to accurately assess physician workload and productivity. The following actions are being taken:

- 2.0 physician FTE will be shifted to Primary Care by 12/31/02.
- As the timekeeping solution for #1 above, physician 8ths in Medical Service are being realigned to ensure proper accounting of both VA physician time and workload. This new system will make it possible to more accurately measure productivity and to determine if further adjustments in physician FTEE are warranted.
- Because of the nature of surgical coverage and rotations, we are anticipating the use of contract vs. FTEE-based physician coverage in Surgery. The contract approach should effectively right size the physician staffing commitment in this service.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Steve S. Kraman, M.D.   Date
Chief of Staff

Recommended Improvement Action 3

Resident Coverage – Psychiatry Residents Should Provide Irregular Hours Coverage
We recommend that the VISN Director ensure that the VAMC Director makes arrangements with the UK medical school to obtain adequate psychiatric resident coverage during irregular hours.

VAMC Comments: We agreed that the College of Medicine should honor the terms of the resident disbursement agreement and provide coverage at the VAMC by residents

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VAMC Lexington

on a 24 hours per day, 7 days per week basis and initiated discussions with UK about this. Effective July 1, 2002, UK psychiatric residents are covering the VA inpatient service day and night.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Steve S. Kraman, M.D.   Date
Chief of Staff

Recommended Improvement Action 4

Procurement of Cardiac Surgery – A Written Agreement with the Medical School Should Be Developed
We recommend that the VISN Director ensure that the VAMC Director develops a written agreement with the UK medical school to obtain cost-effective cardiac surgery.

VAMC Comments: An agreement between UK and VA is currently being developed that will be clear, concise and in accordance with regulations governing contracting and affiliations.   We anticipate this contract being finalized with Network approval by the end of this year (December 2002).

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Richard Coger   Date
Chief, Acquisition/Material Management

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

Recommended Improvement Action 5

General Post Funds – Donations into and Disbursements from GPF Accounts Should Be Properly Approved

Recommended Improvement Action 5.   We recommend that the VISN Director ensure that the VAMC Director: (a) implements controls to bring GPF accounts into full compliance with VA policies on accepting donations and monitoring expenditures; (b) provides training on GPF policies and procedures for fund control point officials and all

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VAMC Lexington

other staff involved in administering GPF accounts; (c) issues guidance reminding employees about Government ethics rules on soliciting and accepting honoraria; and (d) determines, in conjunction with Office of General Counsel ethics officials whether any of the honoraria received should be returned to the payers and whether administrative action should be taken against recipients of the donations.

a) VAMC Comments: We agree that adequate controls were not in place to control the acceptance of donations and monitor expenditures. A new hospital policy incorporating controls, processes and procedures for all donations and expenditures will be developed and published by 10/31/02. Processes will focus on proper methods for donations and acknowledgment letters, disbursement of funds, and the establishment of procedures for expenditures. Fiscal will also complete a review of all existing GPF accounts in order to determine the purpose of the accounts and the need for elimination or consolidation of accounts, or a change in control point personnel. This will also be completed by 10/31/02.

b) VAMC Comments: Fiscal Service will provide training for all appropriate staff. Training will be completed by 10/31/02.

c) VAMC Comments: The Chief of Fiscal to develop guidance and training for all appropriate staff by 10/31/02.

d) VAMC Comments: The VAMC Director contacted the Office of General Counsel immediately after receipt of the revised recommendation (9/5/02) and was advised to forward this section of the OIG report to James Adams in the Office of General Counsel. Mr. Adams has indicated that the facility should receive a General Counsel opinion/response to this inquiry within 30 days.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Mike Holland   Date
Chief, Fiscal Service

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

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CAP Action Plan
VAMC Lexington

Recommended Improvement Action 6

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved
We recommend that the VISN Director ensure that the VAMC Director implements controls to: (a) reduce excess medical and prosthetics supply inventories; (b) effectively use GIP to manage SPD inventories; and (c) preclude ordering more stents than needed.

a) VAMC Comments: GIP and PIP (Prosthetic Inventory Package) are being fully implemented in order to reduce excess medical and prosthetics supply inventories. GIP has been fully implemented in SPD (Anesthesia, OR, Medicine, and other supported services) and will be fully implemented in Radiology, PLMS, EMS, Nuclear Medicine, and Dental services by 9/30/02. SPD inventory exceeding 30 days has been reduced from $230,000 at the time of the CAP survey to $200,000. The excess cardiology stent inventory has been reduced from $270,000 at the time of the survey to $92,392. The ultimate goal is to use consignment agreements for stent procurements. If successful, such agreements could result in up to an 85% decrease in inventory.

b) VAMC Comments: Reorganization of AMMS will result in the availability of additional line item managers for managing and performing inventories.

c) VAMC Comments: With the implementation of the Prosthetic Inventory Package (PIP), Acquisition has reduced the Cardiology stent inventory to the current balance of $92,392. Future stent purchases will be via consignment agreements. AMMS is now actively involved in communications with current and potential sales representatives to assure that the inventory represents not more than two companies at a given period of time. Once VA owned inventory has been completely reduced and full consignments are established, the pricing structure will be re-visited in an attempt to obtain better pricing.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
 Richard Coger   Date
 Chief, Acquisition/Material Management

_____/s/_____   _____9/6/02_____
 Wayne Pfeffer   Date
 Associate Director

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VAMC Lexington

Recommended Improvement Action 7

Environment of Care – Patient Safety and Confidentiality, Pest Control, and Cleanliness Should Be Improved
We recommend that the VISN Director ensure that the VAMC Director implements actions to: (a) secure sharp objects and chemicals in patient care areas, (b) protect patient confidentiality, and (c) maintain a pest-free and clean environment.

a) VAMC Comments: Locking cabinets were installed in the physical therapy and occupational therapy area in the Nursing Home Care Unit immediately following the CAP survey. The items cited are used in teaching and re-training patients on their activities of daily living. These teaching tools are now being kept under lock and key when not used. Rehabilitation Medicine has instructed the therapists to monitor the area to ensure that the items are locked as required. The therapists' supervisor will do and document periodic random spot checks. In addition, the nurse manager of the unit has been asked to monitor the area on a weekly basis and e-mail the Nurse Executive re: problems noted.

b) VAMC Comments: The Information Security Officer is in the process of locating new software that will automatically lock out unattended computer screens in a manner which will not be disruptive to patient care. In the interim, efforts have been made to increase staff awareness of computer security via staff meetings, the Performance Improvement Council (all service chiefs) and reminders issued by the facility ISO. In addition, the Information Security Officer is conducting unannounced/unscheduled spot checks. The medical center Environment of Care Inspection process has also been modified to:
- Include the ISO as an inspection team member
- Incorporate the use of an Inspection Checklist which includes specific items related to information security, safety and cleanliness. Specifically, there is a checklist item related to ensuring that computers in all areas reviewed are attended or appropriately logged off.

c) VAMC Comments: This issue has received high level management attention and several strategies to improve overall cleanliness have been implemented including:
- The Associate Director is revising the hospital environmental rounds process to more specifically delegate responsibilities of team members and to incorporate use of a checklist with specific safety, cleanliness, and information security criteria to be reviewed by team members during rounds. This will be finalized by 9/30/02.
- Established a Cleanliness Task Force (4/15/02) to serve as an advisory team in recommending ideas and strategies to ensure the medical center is clean, safe and pest free
- Sponsored a medical center wide "Cleaning Week" August 5-9 and encouraged staff to clean their offices, eliminate clutter and excess equipment. We plan to continue this quarterly.

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VAMC Lexington

- Committed to the hiring of 4 additional permanent and 7 temporary EMS FTEE. As of 9/4/02, 3.6 are on board with the remainder of the hirings in progress. The medical center is developing a proposal for network approval to establish a recruitment ceiling for Housekeeping Aids in EMS in order reduce lag time in obtaining approval for and filling future vacancies.
- Use of overtime as necessary
- Established pest control contracts at both divisions including a provision for prompt contractor response to problems
- Instructed nursing staff to use the nursing 24 hour report to document any concerns or issues related to pests and to immediately contact the EMS supervisors by phone. The Chief of EMS follows up on any reported concerns. The Nurse executive reports to the Quad daily at morning report on any issues or concerns raised.
- Purchased a new riding floor scrubber and are in the process of purchasing additional supplies and minor equipment
- Drafted a new Medical Center Wide Cleanliness policy which includes a provision for a new subcommittee of Environment of Care Committee to deal with longer term issues such as infrastructure, carpet and equipment replacement, etc. Policy will be published by 9/30/02.

The Network Director and staff have begun to conduct environment of care rounds during their visits to the facility. A Network-wide contract to address pest control issues is currently being developed.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Lincoln Bonds   Date
Chief, Environmental Management Service

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

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CAP Action Plan
VAMC Lexington

Recommended Improvement Action 8

Government Purchase Card Program – Administrative Oversight Should Be Strengthened
We recommend that the VISN Director ensure that the VAMC Director implements controls to: (a) preclude the delegation of PCC duties, (b) limit access to the Purchasing Agent Menu to staff with a demonstrated need, (c) document purchase card training, (d) require approving officials to approve all purchases and verify receipt of purchased items, and (e) prevent cardholders from purchasing unauthorized items, splitting purchases, and making unnecessary open market purchases.

a) VAMC Comments: A new delegation of authority has been issued to the Purchase Card Coordinator. This delegation, issued by the Director, specifically addresses the fact that this authority and responsibility may not be delegated further. It also outlines specific education, monitoring and documentation expectations of the Purchase Card Coordinator. Receipt of this will be acknowledged by the designee.

b) VAMC Comments: A review of access to the Purchase Agent menu has been completed. Each individual with access was identified and justification for access reviewed in detail. As a result of this, the number of individuals with access to the menu has been reduced from 40 to 20. Future requests for access to this menu will be handled in writing with written justification accompanying the request. Approvals will also be in writing by the Chief, AMMS. Because the Network is transitioning to an Acquisitions product line, the approving official may change over the course of the next year but the process of requiring written requests for access to this menu should not.

c) VAMC Comments: Training sessions for all purchase card holders and approving officials have been taking place. The Director has advised the Purchase Card Coordinator in writing that this training is to be completed for all appropriate individuals by September 30. As of that date, credit card holders and approving officials who have not received the training will have their privileges revoked until their training has been completed. All training is being documented in TEMPO.

d, e) VAMC Comments: The Purchase Card Coordinator has been requested by the Director in writing to establish a system of monthly monitoring of purchases and approvals sufficient to ensure that (1) approving officials approve all purchases and verify receipt of purchased items as required and (2) cardholders do not purchase unauthorized items, split purchases and/or make unnecessary open market purchases. Any violations identified are to be reported immediately, in writing, to the service chief and appropriate higher level supervisor (Chief of Staff, Associate Director, Associate Director for Patient Care Services). The PCC has been instructed that any concerns about repeat offenders or unaddressed violations should be brought to the attention of the Director in writing and that sufficient documentation of all monitoring and violation follow-up activities must be maintained.

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The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Richard Coger   Date
Chief, Acquisition/Material Management

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

Recommended Improvement Action 9.

Endoscopy Procedures – Only Qualified Staff Should Administer Conscious Sedation and Physicians Should Be Available
We recommend that the VISN Director ensure that the VAMC Director makes certain that: (a) only properly trained physicians or registered nurses administer conscious sedation and (b) physicians are available for emergencies in the Endoscopy Suite.

(a) **VAMC Comments:** GI Technicians (LPN's) are no longer involved in sedation administration or patient monitoring in endoscopy. There is only one part time GI Tech currently and this individual's responsibility is limited to maintaining and assisting with equipment during procedures. We have hired two RN's with endoscopy experience since the CAP visit to ensure that sedation and monitoring are performed only by RN's with appropriate training and demonstrated competency in conscious sedation care. The hospital policy on conscious sedation has been revised to specify that only privileged licensed independent practitioners and registered nurses may administer sedation.

(b) **VAMC Comments:** On review, it was discovered that the VA GI attending physician of record had a scheduling conflict which made him unavailable one afternoon per week. This has been resolved.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Steve S. Kraman, M.D.   Date
Chief of Staff

_____/s/_____   _____9/6/02_____
Anthony Burgett, RN, MSN   Date
Associate Director for Pt. Care Services

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Suggested Improvement Opportunities

Suggested Improvement Action 1

Patient Waiting Lists – Reported Data Should Be More Accurate
We suggest that the VISN Director ensure that the VAMC Director implements controls for: (a) date stamping enrollment applications when received, (b) including on the Category B waiting list only veterans who have never received care, and (c) determining whether new enrollees intend to seek care.

a) VAMC Comments: The VAMC began date stamping enrollment applications within one week of the CAP survey. Health Administration Service will be monitoring a sample of applications monthly to ensure compliance with date stamping.

b) VAMC Comments: We are currently complying with all existing network and national instructions and timelines for wait list data submission. It is our understanding that new national wait list software is being developed and will be rolled out this fall. That software should improve and standardize record keeping and it will be implemented and used at the facility level as soon as it is available.

c) VAMC Comments: It is important to note that the enrollment process was never standardized nationally and this has adversely impacted the accuracy and availability of information needed for waiting time reports that are now being requested. There is a draft of a new national directive entitled "Enrollment Process for Clinical Care". The draft includes processes for obtaining information about the main reason the veteran is enrolling in the system; whether or not he/she intends to seek care; what types of appointments are required/desired, etc. These national policies and procedures will be implemented once the directive is finalized and published.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Judy Rittenhouse   Date
Chief, Health Administration Service

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

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Suggested Improvement Action 2

Information Technology Security – Deficiencies Should Be Corrected and Equipment and Software Accounted For
We suggest that the VISN Director ensure that the VAMC Director takes action to: (a) develop a consolidated IT contingency plan, (b) install a fireproof safe in the off-site storage area, (c) monitor access to the computer room, (d) determine the need for all modems connected to the LAN, (e) develop a VAMC policy on the separation of IT duties, (f) perform an inventory and account for all IT equipment, (g) account for loaned computer equipment, and (h) have IMS control software purchasing and accountability.

a) VAMC Comments: A consolidated IT contingency plan will be developed by the ISO by October 1, 2002.

b) VAMC Comments: A fireproof safe has been installed in the off-site storage area.

c) VAMC Comments: Access to the computer room at Cooper Drive Division is controlled by a coded key pad which monitors each entry. Codes are assigned to authorized IM staff. Any other individuals requiring access to the room must be accompanied by an authorized IM representative. IM staff are being issued written reminders of their responsibility for ensuring that non-IM staff who access the computer room sign in as required by policy.

d) VAMC Comments: The Information Security Officer is conducting quarterly reviews of modem connections per VA regulations. He has furnished the most recent inventory and report (dated August 23, 2002) and has certified that all connections identified are deemed essential for facility operations and the assessment of risk/vulnerability has been certified by management as acceptable in balance with financial considerations and clinical functional requirements. Additionally, the modems used for medical care equipment/systems that are connected to the VA Network have been certified by management as essential for contract vendor maintenance and/or troubleshooting services.

e) VAMC Comments: A VAMC policy on separation of IT duties will be finalized by September 30.

f) VAMC Comments: Physical inventory of Cooper Drive equipment was completed in July 2002. The Leestown inventory will be completed by 10/1/02.

g) VAMC Comments: All items on the list originally furnished by OIG have been located. In addition, a complete inventory of all laptops has been completed and those have also been accounted for. Information Management has developed new policies and procedures for laptops including a checkout system and more clear delineation of responsibility for laptop accountability.

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h) VAMC Comments: Both network and local policies require that Information Management maintain control of the purchase and accountability of computer software. The Associate Director has instructed Fiscal and Acquisitions Service not to process requests for computer software that have not been approved in advance by IMS.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
James Critchley   Date
Information Security Officer

_____/s/_____   _____9/6/02_____
June Helligrath   Date
Chief, Information Management

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

Suggested Improvement Action 3

Management of Violent Patient Behavior – Policy, Training, Coordination, and Response Procedures Should Be Improved
We suggest that the VISN Director ensure that the VAMC Director takes action to: (a) develop a comprehensive policy on managing violent patient behavior, (b) make sure that employee training is documented, (c) establish an interdisciplinary team to review violent and potentially violent incidents, and (d) establish trained response teams to manage incidents of violent patient behavior.

a) **VAMC Comments:** A new violent behavior program coordinator has been designated. This individual will be expected to revise the medical center policy and procedures and to re-establish and Chair an interdisciplinary medical center Disturbed Behavior Committee to assist in program oversight by October 31, 2002.

b) **VAMC Comments:** Employee training is documented in TEMPO.

c) **VAMC Comments:** A medical center Disturbed Behavior Committee will be re-established and operational by October 31, 2002.

d) **VAMC Comments:** The Program Coordinator (in collaboration with the Committee) will develop a plan for and conduct necessary training of response team participants so that this will be in place by December 2002.

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The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Anthony Burgett, RN, MSN   Date

Suggested Improvement Action 4

Homemaker/Home Health Aide Program – Clinical and Administrative Oversight Should Be Strengthened
We suggest that the VISN Director ensure that the VAMC Director implements controls to: (a) have physicians, nurses, and social workers complete interdisciplinary assessments, (b) reevaluate the need for continued H/HHA services at least every 3 months, (c) include plans of care in patient medical records, (d) negotiate formal agreements for CHA services, and (e) have H/HHA staff approve bills before payment.

a) **VAMC Comments:** Templated notes are being developed for interdisciplinary documentation of assessments. These should be fully implemented by September 30. Following that, medical record reviews will be conducted for a minimum of 6 months to ensure that the templates are in place and properly used.

b) **VAMC Comments:** An interdisciplinary evaluation process will be developed and described as part of the hospital policy on this program. The revised policy will be published by September 30, 2002.

c) **VAMC Comments:** This will be addressed in the new policy and medical records monitoring will be conducted for a minimum of 6 months to ensure that appropriate care plans are documented in the record.

d) **VAMC Comments:** Network contracting staff have been contacted and they are in the process of developing the contracts. Anticipated completion date is 9/30/02.

e) **VAMC Comments:** This will be addressed in the new policy however the process has already begun. Fiscal is being instructed to no longer pay these bills without evidence of review by the HHA team.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Anthony Burgett, RN, MSN   Date
Associate Director for Pt. Care Services

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Suggested Improvement Action 5

Equipment Accountability – Research Equipment Should Be Properly Accounted For
We suggest that the VISN Director ensure that the VAMC Director implements controls to: (a) properly account for VAMC equipment located at the UKMC, (b) remove UKMC property tags from VAMC equipment, (c) obtain proper authorization before relocating equipment to the UKMC, and (d) conduct quarterly inventories of Research Service EILs.

a) VAMC Comments: Administrative staff as well as laboratory staff responsible for CMRs have been instructed to review the Medical Center and Research Service policies for equipment loans/used in locations other than the Medical Center. They have also been asked to certify the location of all equipment. Per item d below, regular quarterly inventories of equipment located at UK will be conducted.

b) VAMC Comments: The tag in question was removed during the visit. No other mismarked equipment was identified. Tagging will be checked and corrected as necessary on all equipment located at UK during the quarterly inventory process (see d below).

c) VAMC Comments: On June 10, 2002, The Associate Chief of Staff for Research issued a memorandum requesting a special re-inventory of all research equipment including noting the location. No additional items were identified as having been moved to UK without proper pre-authorization. In addition, proper authorizations were obtained for the two equipment items identified by OIG. Research is also implementing a new process which will include *written* communication with any investigator who relocates equipment without the proper advance authorization.

d) VAMC Comments: We agree that more frequent audits of items on loan to UK are prudent and will plan to inventory those on a quarterly basis.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
John Thompson, MD   Date
Associate Chief of Staff for Research

_____/s/_____   _____9/6/02_____
Steve S. Kraman, MD   Date
Chief of Staff

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<u>**Suggested Improvement Action 6**</u>

**Controlled   Substances   Security   –   The   Drug   Courier   Should   Be
Protected, Ward Stock Secured, and Alarms Repaired**
We suggest the VISN Director ensure that the VAMC Director takes action to: (a)
provide for the safe transport of controlled substances between the VAMC divisions, (b)
improve the security of medication carts, and (c) repair the intrusion alarms and panic
buttons in the Inpatient and Outpatient Pharmacies at the Cooper Drive Division.

a) VAMC Comments : The process for transporting controlled substances has been
changed so that Police & Security will now escort controlled substances shipped
between divisions.

b) VAMC Comments : Additional measures to improve medication and medication cart
security have been implemented. Nurse Managers have been advised in writing of their
responsibilities for monitoring medication security on their units. Information about daily
monitoring of med cart security and compliance is being provided to nursing
administration via the 24 hour nursing report daily. Information from the 24-hour reports
is being aggregated in an Excel database to analyze for patterns, trends and
performance issues.   Monitoring to date has already revealed one individual
performance problem and this is being dealt with via progressive disciplinary action.   In
addition, management environmental rounds are conducted weekly and include checks
of med carts and medication security in all areas reviewed.

c) VAMC Comments : New intrusion alarms have been installed in the Pharmacy.
The intrusion and the panic alarms in Pharmacy areas will now be tested weekly.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this
recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

_____/s/_____   _____9/6/02_____
Anthony Burgett, RN, MSN   Date
Associate Director for Pt. Care Services

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Suggested Improvement Action 7

Human Resources Management – VHA Evaluation and Assistance Should Be Requested

We suggest that the VISN Director ensure that the VAMC Director (a) requests an in-depth HRM Group evaluation of HRM Service and (b) implements controls to complete all required background investigations.

a) VAMC Comments: The Medical Center Director has contacted Human Resources staff in Headquarters to initiate the recommended in-depth evaluation of the service at Lexington. This on-site review is expected to take place by September 30, 2002.

b) VAMC Comments: New policies and procedures have been implemented by Human Resource Management Service to ensure completion of background checks for transfers, reinstatements, new appointees. Appointments will be contingent upon obtaining appropriate security clearances.

The above VAMC response is true and accurate as of the date affixed below.
I also understand that it is my responsibility to ensure that the requirements of this recommendation continue to be met in the future.

_____/s/_____   _____9/6/02_____
Don Schmonsky   Date
Chief, Human Resource Management Svc.

_____/s/_____   _____9/6/02_____
Wayne Pfeffer   Date
Associate Director

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This report will be available in the near future on the VA Office of Audit Web site at
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