Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Spark M. Matsunaga VA Medical & Regional Office Center Honolulu, Hawaii

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Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and 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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Contents

Executive Summary

Introduction

During the week of May 21–25, 2001, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Spark M. Matsunaga VA Medical and Regional Office Center (VAMROC) Honolulu, Hawaii. The purpose of the review was to evaluate selected health care system and benefits delivery operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. We also provided fraud and integrity awareness training to about 140 employees.

Results of Review

VAMROC patient care and QM activities reviewed were generally operating satisfactorily. Managers actively supported quality patient care and performance improvement. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the VAMROC managers needed to:

- Monitor and evaluate veterans' care at Tripler Army Medical Center (TAMC).
- Perform thorough needs assessments for veterans in the Independent Living Services program.
- Strengthen controls over the purchase card program.
- Require proper inspections, inventories, and security of all controlled substances.
- Improve documentation to show critical test results were communicated to providers and patients.
- Secure the electronic compensation and pension (C&P) files of all employees receiving benefits.
- Locate off-site storage for critical automated files, use updated anti-virus software, and terminate access for inactive users.
- Implement a security incident-reporting plan and strengthen training in medical record privacy.
- Obtain background investigations for all newly hired practitioners.
- Monitor a laundry service contractor's performance and billings more closely.
- Ensure that clinicians perform and record required clinical practice guideline interventions.

VAMROC Director Comments

The Spark M. Matsunaga VAMROC Director concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix A, pages 16-24, for the full text of the Director's comments.) We consider all review issues to be resolved but may follow up on implementation of planned actions.

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

Introduction

Medical and Regional Office Center Profile

Organization. Based in Honolulu, Hawaii, the VAMROC is comprised of an Ambulatory Care Center (ACC), a Center for Aging (CFA), a psychiatric inpatient care unit, administrative offices, and Veterans Benefits Administration (VBA) offices, all located on the campus of the TAMC. Additionally, the facility operates a Post-Traumatic Stress Disorder Residential Rehabilitation Program (PRRP) in Hilo on the island of Hawaii. Outpatient care is provided at the ACC and also at five community-based outpatient clinics (CBOCs) located on the islands of Hawaii (two), Maui, Kauai, and Guam. The VAMROC is part of Veterans Integrated Service Network (VISN) 21 and serves a veteran population of about 115,000 in a primary service area that includes the state of Hawaii, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa, covering an area of 4.6 million square miles. VBA activities are part of Service Delivery Network 9.

Programs. The VAMROC provides medical, dental, behavioral health, geriatric, and rehabilitation services. The VAMROC has 60 nursing home and rehabilitation beds in the CFA, 20 psychiatric inpatient beds through a sharing agreement with TAMC, and 16 PRRP beds in Hilo. Additionally, VBA provides C&P and vocational rehabilitation services to Hawaii beneficiaries.

Affiliations and Research. The VAMROC is affiliated with the University of Hawaii John A. Burns School of Medicine and supports 30 medical resident positions in medicine, psychiatry, and geriatrics. The VAMROC also supports training programs in nursing, social work, laboratory technology, pharmacy, and occupational therapy. In Fiscal Year (FY) 2000, the VAMROC research program had 29 projects and a budget of $1.6 million.

Resources. In FY 2000, VAMROC medical care expenditures totaled $70.9 million. The FY 2001 medical care budget was $75.6 million, 6.6 percent more than FY 2000 expenditures. FY 2000 staffing was 412.8 full-time employee equivalents (FTEE), including 26.8 physician and 51.6 nursing FTEE. The FY 2000 regional office general operating expenses totaled about $4.1 million, and the regional office staffing was 57.6 FTEE.

Workload. In FY 2000, VAMROC clinicians treated 14,431 unique patients, a 9.4 percent increase over FY 1999. The inpatient care workload totaled 702 discharges, and the average daily census was 70.1, including PRRP and CFA patients. The outpatient care workload was 120,588 visits. In FY 2000, about $110 million in C&P and $7.1 million in Vocational Rehabilitation and Employment (VR&E) benefits were paid to veterans, servicepersons, dependents, and survivors.

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 and benefits services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected medical center and regional office operations, focusing on patient care, QM, benefits delivery, 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, benefits delivery, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

Quality Management	Information Technology (IT) Security
Primary Care Clinics	Government Purchase Card Program
Behavioral Health Care	Benefits Processing and System Messages
Laboratory and Radiology	Vocational Rehabilitation and Employment
Background Investigations	Benefits Delivery Network (BDN) Security
Medical Record Privacy	Claims Record Security
Controlled Substances Accountability	Fiduciary and Field Examinations
Means Test Certifications	Large One-Time Benefit Payments
Insurance Billing and Collections	Returned Mail Processing
Service Contracts	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. We provided the full survey results to VAMROC managers.

We presented four fraud and integrity awareness briefings for about 140 VAMROC employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered VAMROC operations for FY 2000 and FY 2001 through April 2001 and was done in accordance with OIG standard operating procedures for CAP reviews.

In CAP review reports, we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VAMROC managers until corrective actions are completed.

Results of Review

Organizational Strengths

Controls to Detect and Prevent Compensation and Payment Errors Were Effective. The Veterans Service Center (VSC) processed C&P system messages within reasonable time frames. These messages were generated by the BDN to identify possible changes in a beneficiary's status that can affect his or her benefit payments. System message notifications include those that are generated when VA matches records with another Federal agency and results indicate the beneficiary or spouse may be deceased. We analyzed 12 messages issued to the VAMROC in January 2001 and found that for each message, the VSC had either adjusted the beneficiary's record or were in the process of determining the beneficiary's current status.

Filmless Radiology Services Improved Access to X-Rays. In April 2000, the VAMROC implemented filmless radiology where digital imaging is used to transfer x-rays to the computer system. After the transfer, the x-rays are available for immediate viewing by radiologists and providers and can easily be transmitted to clinicians for consultations. Because x-rays no longer must be stored and transported, filmless radiology also eliminated the problem of lost x-rays.

Means Tests Certifications and Third Party Insurance Collection Procedures Were Effective. Fiscal Service and the Health Administrative Service had established effective controls to ensure that signed means tests forms were obtained and appropriate actions were taken to collect outstanding bills. For the 12-month period ending May 7, 2001, we reviewed 10 medical administrative folders and determined that all of the means tests forms had been properly signed. To evaluate collection activities, we reviewed 14 outstanding bills for the 6-month period ending March 31, 2001. For the 14 bills, Fiscal Service employees had issued timely collection letters, made follow-up telephone calls, and referred outstanding bills over 90 days to the contracted collection agency.

Patient Tracking System Was Innovative. The CFA had implemented Care Trak, a high technology security system for monitoring patients who are at risk for wandering and for locating patients who are missing. More than 50 percent of the CFA patients were cognitively impaired, and this system allowed them maximum freedom without the use of chemical or physical restraints. High-risk patients were provided with a frequency-coded bracelet to wear. Nursing personnel checked and documented the presence of high-risk patients every two hours. When employees were unable to locate a missing patient by performing a local search, the safety officer activated the Care Trak receiver and set the frequency according to the patient's bracelet. The receiver pinpoints the direction and proximity of the patient's location within a 1-mile radius.

Opportunities for Improvement

Quality Management – Veterans' Care at Tripler Army Medical Center Should Be Monitored

Condition Needing Improvement. The QM program was comprehensive and provided appropriate oversight of patient care provided at the VAMROC. However, the facility did not have a systematic process to fully evaluate the quality of inpatient care provided to veterans through the TAMC sharing agreement. To evaluate the QM program, we interviewed key employees and reviewed policies, plans, committee minutes, investigation reports, and tort claim files.

We found that VAMROC nurses reviewed all TAMC veteran patients' admissions and continued stays for appropriateness. However, TAMC clinicians had not consistently notified VAMROC managers of all adverse events or medical errors involving veteran inpatients. When notified of an adverse event, the VAMROC Risk Manager would request the TAMC Risk Management Committee to conduct a clinical peer review. From January 1999 through April 2001, TAMC clinicians had reviewed 37 incidents or complications involving VAMROC inpatients.

We concluded that the VAMROC managers did not effectively monitor the quality of veteran inpatient care at TAMC. The QM Coordinator agreed that the VAMROC needed a more effective process and informed us that they were considering changes to the TAMC sharing agreement to strengthen accountability to the VAMROC. They also planned to establish a peer review group, led by a VAMROC physician, to review veteran inpatient care issues at TAMC.

Suggested Improvement Action. We suggested that the Director implement a procedure for the VAMROC to monitor and evaluate veterans' care at TAMC, including peer review with VAMROC clinicians.

The Director concurred and reported that as of August 2001, the VAMROC will better monitor veterans' care at TAMC through membership on the TAMC Risk Management Committee, attendance at the TAMC clinical morning report, and attendance at TAMC Morbidity and Mortality conferences. The VA and TAMC have developed a plan for a VA-staffed and managed inpatient medical team to admit and manage veteran patients at TAMC. Managers will revise the sharing agreement with TAMC to provide regular reports of adverse outcomes in veteran patients. The target date for completion is in January 2002. The improvement actions are acceptable, and we consider the issue resolved.

Independent Living Services Program – Case Management Practices Should Be Improved

Condition Needing Improvement. VR&E Division managers needed to ensure that more thorough needs assessments were completed for veterans enrolled in the Independent Living Services (ILS) program. For VR&E purposes, independent living means the ability of a veteran to live and function within the veteran's family and community, either with or without the services of others. Vocational Rehabilitation Specialists (VRS) purchase the services, incidental goods, and supplies that veterans need to achieve documented rehabilitation goals and objectives in the ILS program. Enrollment in the ILS program generally should not exceed 24 months but can be extended up to 30 months.

To evaluate program performance, we reviewed files for 8 of the 244 veterans enrolled in the ILS program as of May 18, 2001. The eight veterans met eligibility requirements and had documented achievable goals and objectives in their files. However, in 88 percent (7/8) of the cases, the VRS invested VA resources and purchased goods and services allowed under the ILS program without thoroughly assessing the veterans' conditions, resources, and needs. In 57 percent (4/7) of the cases, the VRS purchased goods and services that could be counterproductive to the veterans' long-term rehabilitation goals. The following example illustrates the problem:

> A VRS purchased a used $20,000, 28-foot motorized catamaran fishing boat for a veteran who was angry and depressed because he could not provide food for his wife and three children. The VRS purchased the boat believing the veteran's self-esteem and emotional well-being would improve if he could feed his family. VR&E also paid for the boat's maintenance and a spare engine because the veteran could not afford it on a monthly income of $184. In our opinion, the VRS did not adequately consider what would happen to the veteran if he could not afford to maintain the boat after his enrollment in the ILS program ended.

In the remaining three cases, a VRS purchased computer equipment and related supplies and services based on the recommendations of computer consultants and the requests of veterans. The VRS did not ensure that the proposed purchases were reasonable given the veterans' rehabilitation goals and available resources. Subsequently, these practices created the appearance of a conflict of interest and may have allowed some veterans to receive computer equipment and related supplies and services that were desirable but not essential to meeting their long term rehabilitation goals and objectives. For example:

> A VRS purchased $45,000 in computer equipment, supplies, and services for three veterans that included $22,000 in purchases from the company of the consultant who performed the veterans' computer needs assessment. In contrast, three veterans with similar ILS rehabilitation plans who were evaluated by different computer consultants only received $11,000 in computer equipment, supplies, and services.

In response to our review, the Chief, VR&E agreed that employees needed to perform more thorough assessments of veterans' needs and to develop clear, specific guidelines for ILS

program purchases. VRS will be required to complete procurement training for purchases of $25,000 or less to ensure they are aware of acquisition policies and issues such as conflicts of interest. In addition, VR&E employees will work to ensure that ILS purchases assist veterans in attaining long-term life goals and do not just address current needs or wants.

Suggested Improvement Actions. We suggested that the VAMROC Director monitor ILS case management practices to ensure that: (a) Thorough needs assessments are completed, and (b) Proposed purchases are consistent with applicable acquisition policies and ILS program goals. The Director concurred and reported that the local VR&E Officer had developed clearer ILS program guidelines stipulating the need for a more thorough evaluation. The guidelines will be disseminated, and training will be conducted for all employees and stakeholders. The target date for completing these actions is September 30, 2001. The improvement actions are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Purchase Card Controls Should Be Strengthened

Condition Needing Improvement. VAMROC managers needed to improve controls over the use of government purchase cards to ensure that purchases were made in accordance with VA policy and Federal Acquisition Regulations (FAR). The VAMROC is required to use commercially issued purchase cards for purchases of goods and services of $2,500 or less. The Program Coordinator should work with Fiscal Service and Acquisition and Materiel Management Service employees to monitor and oversee the purchase card program. Before issuing purchase cards, the Program Coordinator should certify that each cardholder and approving official has received required training. VA policy specifically prohibits the Program Coordinator and the Alternate Program Coordinator from being cardholders and approving officials. All cardholders and approving officials are responsible for ensuring that purchases are completed in accordance with applicable regulations.

To evaluate purchase card program controls, we interviewed the Program Coordinator and reviewed purchase card records and transactions for the 6-month period ending March 2001. We identified four weaknesses in purchase card program controls:

Inadequate Documentation. VAMROC managers had no documentation showing that 87 cardholders and 25 approving officials had received appropriate training and had accepted responsibility for the use of the purchase cards.

Contracting Warrants. VR&E employees who did not have appropriate contracting warrants exceeded their $2,500 transaction limits and made 72 purchases totaling about $428,000. Cardholders who make purchases above $2,500 are required to complete a 40-hour training course on acquisition policies and procedures and to obtain a warrant that allows them to spend up to, but not exceed, a specific higher dollar limitation.

Sole Source Procurements. VR&E employees did not justify four computer system purchases totaling $16,855 using sole source contracts. FAR requires a justification to be prepared when mandatory supply sources and competition are not used for purchases. The use of mandatory sources and competition is required to ensure the government receives the most advantageous price possible.

Cardholder and Approving Official Assignments. The Program Coordinator made 1,066 purchases, totaling about $157,000 as a cardholder. The Program Coordinator and Alternate Program Coordinator approved 3,287 transactions, totaling about $840,000. VAMROC managers were aware that the Program Coordinator and the Alternate Program Coordinator were prohibited from being cardholders or approving officials. However, the VAMROC managers felt this practice was necessary because of a shortage of staff and acknowledged that it was an internal control weakness on the facility's most recent Annual Certification of Accounting Records dated October 16, 2000.

Suggested Improvement Actions. We suggested that the VAMROC Director ensure that: (a) The Program Coordinator develops, implements, and documents an adequate purchase card and acquisitions training program; (b) cardholders do not exceed the $2,500 transaction limit unless they have an appropriate contracting warrant; (c) purchase card transactions are reviewed to ensure that VA purchase card policies and FAR requirements are followed; and (d) cardholder and approving official responsibilities are removed from the Program Coordinator and the Alternate Program Coordinator.

The Director concurred and reported that approving officials and cardholders will receive training and will sign a purchase card certification form that denotes completion of training and acceptance of responsibility. Purchasing authority will be restricted to $2,500 until each cardholder has completed basic contracting warrant training. VR&E cardholders and the approving official will receive training to ensure a thorough understanding of policies and regulations. The Program Coordinator will continue to be a cardholder, but the Associate Director will review and approve his transactions. The Alternate Program Coordinator is not a cardholder and will continue as the approving official for purchasing agents and cardholders under his responsibility. The target date for completing all these actions is September 30, 2001. The improvement actions are acceptable, and we consider the issues resolved.

Controlled Substances Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. VAMROC managers needed to address weaknesses in controlled substances inspection and inventory processes, security, and inventory management. VHA policy requires all controlled substances to be (a) reviewed by trained inspectors during a monthly unannounced inspection, (b) inventoried every 72 hours, and (c) stored securely. VHA policy also requires pharmacies to maintain only a 10-day inventory of pharmaceuticals, including controlled substances. To evaluate controlled substance accountability, we reviewed inspection reports and inventory records, observed an unannounced controlled substance

inspection, toured Pharmacy areas, interviewed Pharmacy and Engineering Services employees, and reviewed controlled substance stock levels. We identified three areas where controlled substance accountability needed improvement.

Inspections and Inventories. Controlled substance inspections and inventories were not properly conducted. The VAMROC's Controlled Substance Inspection Coordinator did not require controlled substance inspectors to attend formal, documented training; inspect all controlled substance areas; review inventory records; or review medication entries in patient records. The Pharmacy Service employees also did not inventory all controlled substances every 72 hours.

Security. Pharmacy Service employees stored controlled substances on open shelving or in wood cabinets. VHA policy requires controlled substances kept in a "Type I" vault to also be secured in locked steel cabinets. In addition, the VAMROC had installed motion detectors, but Pharmacy and Engineering Service employees had not required the contractor to connect the remote monitoring and local alarm features of the detection system.

Inventory Management. Pharmacy Service controlled substance inventories exceeded the 10-day inventory level mandated by VHA policy. Pharmacy Service procedures directed employees to maintain 2-4 week inventories (or 14-28 days of stock) for all pharmaceuticals and did not require the use of available automated inventory management software. As a result, the stock levels for 69 percent (56/81) of controlled substances averaged 89 days.

Suggested Improvement Actions. We suggested that the VAMROC Director ensure that: (a) The controlled substance inspection program meets all requirements, (b) all controlled substances are properly inventoried, (c) narcotics are stored in locked steel cabinets in the pharmacy vaults, (d) motion detectors are properly installed and monitored, and (e) controlled substance and general pharmaceutical inventory levels are maintained in accordance with VHA policy.

The Director concurred and reported that all controlled substance inspectors will receive documented training and all controlled substance areas will be included in the inspections. All controlled substances in the pharmacy will be inventoried every 72 hours as required. The Echo Inventory Management System will be implemented to comply with the 10-day inventory level for all pharmaceuticals. A locked steel cabinet will be installed in the CFA, and motion detectors will be properly installed at the ACC and CFA pharmacies. The target date for completing all these actions is August 31, 2001. The improvement actions are acceptable, and we consider the issues resolved.

Communication of Critical Test and Procedure Results – Documentation Procedures Should Be Improved

Condition Needing Improvement. VAMROC managers needed to improve procedures for documenting test and procedure results in patients' medical records. VHA facilities perform many clinical and diagnostic tests and procedures. Therefore, facilities must establish effective

processes for communicating and documenting critical results (those requiring immediate attention). To evaluate the effectiveness of test and procedure result notifications, we reviewed medical records and local procedures and interviewed 10 primary care practitioners and clinical managers.

We reviewed medical records for a sample of 20 patients who had undergone diagnostic tests or procedures with critical results during February 2001. For the 10 laboratory tests, all medical records reviewed showed that the critical results had been communicated to the requesting providers. However, we did not find any documented evidence that radiologists had contacted the providers to report the 10 radiology interpretations. Interviews with providers indicated that radiologists were informing providers despite the lack of documentation. We discussed our findings with the Chief, Radiology Service, who agreed that documentation of provider notification needed improvement.

Utilizing the same 20 patient medical records, we reviewed provider progress notes to determine if clinicians had notified patients of critical results. Of the medical records reviewed, 60 percent (12/20) did not contain documentation that providers had notified patients of critical results. However, all 20 records did contain documentation that the requesting providers had taken appropriate follow-up treatment actions. The Associate Chief of Staff for Primary Care agreed that improved documentation was necessary.

Suggested Improvement Action. We suggested that the Director ensure that critical test results are communicated to providers and patients and are documented in the medical record. The Director concurred and submitted a target date for completion by December 31, 2001. The improvement action is acceptable, and we consider the issue resolved.

Benefits Delivery Network Security – Improved System Access Controls Could Prevent Fraudulent Misuse

Conditions Needing Improvement. VAMROC managers needed to better control access to BDN and to comply with Veterans Benefits Administration (VBA) security requirements. BDN is the VBA automated processing system used to process veterans' benefits payments and to maintain entitlement information. BDN security controls are intended to protect the privacy of personal data and to prevent fraudulent misuse of the system.

To evaluate security, we interviewed the BDN Security Officer and reviewed BDN security policies, procedures, and records. VBA policy requires the claims records of all veterans employed by VA and their relatives to be placed in electronically "locked" files. We identified weaknesses in the security of BDN records. VAMROC managers did not require all new employees to identify whether they or family members received C&P benefits, and some employee C&P files that should have been electronically locked were not secured.

Of the VAMROC's employees hired during FY 2001, 36 percent (4/11) had not completed the "Notice of Employment, Transfer, or Separation of Veteran" form certifying whether or not they or family members received C&P benefits. As a result, the VAMROC managers could not be sure that they had identified all employees and family members who required electronically locked C&P files.

In addition, C&P files for 12 percent (4/34) of the VAMROC's employees currently receiving C&P benefits were not electronically locked. VAMROC officials had locked all of the C&P files belonging to employees at the regional office. However, they had not secured the C&P files for four medical center employees currently receiving benefits. VBA program officials confirmed during our review that all employee claim files at the VAMROC should be electronically locked.

In response to our review, the Chief, Human Resources Service and BDN Security Officer obtained completed forms from the four new employees, and the BDN Security Officer electronically locked the C&P files of the four medical center employees currently receiving benefits.

Suggested Improvement Actions. We suggested that the VAMROC Director ensure that: (a) All current and new employees have completed the necessary C&P benefit disclosure form, and (b) the claims files of all employees receiving C&P benefits are electronically locked. The Director concurred and reported that as of August 2001, Human Resources Service had implemented a system to ensure that new employees complete required documents and that all files belonging to employees receiving C&P benefits had been locked. The improvement actions are acceptable, and we consider the issues resolved.

Information Technology Security – Deficiencies Should be Corrected

Condition Needing Improvement. VAMROC managers needed to improve IT security to protect automated resources from unauthorized access, disclosure, modification, destruction, or misuse. The Medical Information Security Service (MISS) manages and implements VHA's automated information security program for all VHA medical facilities, including VAMROCs. VHA policy requires facilities to establish, maintain, and enforce a comprehensive security program to ensure an adequate level of protection for all automated information systems.

VAMROC managers had implemented effective policies and procedures to protect the integrity and confidentiality of data and to control and monitor access to automated systems and local area network applications. However, we identified three areas where security needed to be improved.

Contingency Plans. VHA facilities are required to develop and implement automated information system contingency and recovery plans to reduce the impact of disruptions in service, provide critical interim processing support, and ensure the resumption of normal operations as soon as possible after disasters or emergencies. The VAMROC's contingency plan adequately addressed most of these issues. However, backup files were stored at TAMC and the

ACC, both of which are in the same building complex. The MISS requires back-up files to be stored at an off-site location away from the main facility to safeguard them during disasters or emergencies. The Chief, Information Resources Management (IRM) Service agreed to review the issue of off-site storage and to revise the contingency plan accordingly once an off-site location has been found.

Anti-Virus Control Procedures. We randomly selected 10 personal computers to determine if anti-virus control procedures were adequate. Fifty percent (5/10) of the personal computers had outdated anti-virus software. The Chief, IRM Service stated that this is a problem throughout VHA and that it is being aggressively addressed through the VHA-wide implementation of new anti-virus software. The target date for completion is the end of this calendar year.

Inactive User Accounts. Procedures for terminating VHA Information Systems and Technology Architecture (VISTA) access for inactive users were not adequate. We provided the Chief, IRM Service a list of VISTA user accounts that had not been accessed for 90 days or more. The Chief, IRM Service reviewed the list of user accounts and terminated 53 percent (187/356) of these accounts.

Suggested Improvement Actions. We suggested that the VAMROC Director ensure that: (a) An off-site location is found for the storage of critical back-up files, (b) new anti-virus software is installed on all personal computers when available, and (c) inactive VISTA user accounts are reviewed and terminated within a reasonable time frame. The Director concurred and reported that an off-site storage location will be established and utilized by September 30, 2001. New anti-virus software will be installed by December 31, 2001. The VISTA system now reviews and disables any user accounts that have not been accessed in 90 days. Human Resources managers will be enforcing clearance through IRM for termination or change in employment. The improvement actions are acceptable, and we consider the issues resolved.

Medical Record Privacy – Security Procedures Should Be Developed and Employee Training Reinforced

Conditions Needing Improvement. VAMROC managers needed to enhance medical record privacy by developing and implementing a security incident-reporting plan, ensuring employees appropriately use the sensitive record tracking system, and providing adequate education and training to employees. To evaluate the effectiveness of medical record privacy controls, we reviewed policies and procedures, interviewed employees, examined education and training files, and performed physical inspections of clinical areas.

VAMROC managers had not developed a security incident-reporting plan as required by VHA policy. The facility did not have a written plan to guide employees on how to respond to actual or suspected threats to the integrity, availability, or confidentiality of information systems and data. We were told that the Acting Information Security Officer (ISO) was in the process of developing this plan.

The facility used a system to identify sensitive medical records and had procedures in place to deter unauthorized access through the use of electronic alerts and mail message tracking. However, we found that employees were not using the system as originally intended. Instead, employees used the system to monitor patient categories such as active duty personnel, humanitarian treatment, and allied veterans. The Chief, IRM Service agreed that employees should use the system appropriately.

We examined 10 employee education and training records and found that facility managers had not consistently provided adequate training to employees regarding medical records protection and privacy. Eighty percent (8/10) of the training records reviewed indicated that employees had completed information security awareness training, which included the concept of accessing records on a need-to-know basis. However, only 20 percent (2/10) of these training files included evidence that the topic of auditory privacy was addressed. Managers agreed with our suggestion that both concepts be included in the educational curriculum for new employee orientation and the mandatory annual review program.

Suggested Improvement Actions. We suggested that the Director ensure that: (a) A formal security incident-reporting plan be developed and implemented, and (b) employees are provided annual information security awareness training that includes security incident-reporting, use of the sensitive record tracking system, and auditory privacy. The Director concurred and reported that a new ISO has been appointed and will be working on a security incident-reporting plan. When completed, the plan will be incorporated into new employee orientation and annual training for all employees. The target date for completing these actions is September 14, 2001. The improvement actions are acceptable, and we consider the issues resolved.

Background Investigations – Investigations Should Be Completed for All New Practitioners

Condition Needing Improvement. VAMROC managers needed to ensure that required Office of Personnel Management (OPM) background investigations were done for all licensed independent practitioners such as physicians, dentists, and nurse practitioners. To evaluate controls for obtaining background investigations, we reviewed the official personnel files for a random sample of 19 practitioners hired in the previous 3 years.

In 10 percent (2/19) of the cases, the personnel files did not contain the required documentation showing that background investigations were conducted. The Chief, Human Resources Management Service agreed that background investigations should be initiated for these two employee cases.

Suggested Improvement Actions. We suggested that the Director ensure that: (a) Background investigations are requested and completed for all practitioners hired in the future, and (b) personnel files of previously hired practitioners are reviewed and background investigations are initiated as needed. The Director concurred and reported that background investigations were

initiated for the two identified practitioners. Employees have been reminded of the importance of conducting background investigations on all new practitioners. In addition, personnel will be reviewing all practitioners currently employed to determine if background investigations were conducted. The target date for completing these actions was July 15, 2001. The improvement actions are acceptable, and we consider the issues resolved.

Service Contracts – Contract Administration Controls Should Be Strengthened

Condition Needing Improvement. The VISN 21 Consolidated Contracting Authority (CCA) and VAMROC employees needed to improve contract administration controls to ensure that contractor performance and billings were properly monitored. To determine if contract negotiations and administration procedures were effective, we reviewed five service contracts with a combined value of $412,018 and interviewed contracting officers and their technical representatives. The five contract files were generally well-organized and contained required documentation such as solicitations, price negotiation memorandums, and cost and pricing data. However, we identified two issues on a competitively bid contract that required corrective actions.

In December 2000, the CCA awarded a 5-year, $104,000 per year, laundry service contract that required the contractor to launder VAMROC hospital linens and the personal clothing of CFA patients. The contract did not require VAMROC employees to weigh the laundry before the contractor picked it up for laundering. Therefore, VAMROC employees were not able to ensure that the contractor had not overcharged the facility for laundry services.

At the time of our review, the contractor was billing the VAMROC for laundering an average of 336 pounds of linens and 14 pounds of personal clothing per day. Because these averages were consistent with the laundry weight estimates the CCA used to establish the contract price, we did not believe there was significant overcharging on this contract. However, controls are still needed to ensure that the VAMROC is not paying for more laundry services than it is receiving. Additionally, the Administrative Officer (AO) for the CFA did not realize until we reviewed the contract that the contractor had billed the facility $1 per pound instead of the 67 cents per pound contract rate to launder the personal clothing of CFA patients. Consequently, the AO for the CFA initiated steps to obtain reimbursements for about $762 (2,309 pounds x 33 cents) in overcharges that had accrued since the award of the contract.

Suggested Improvement Actions. We suggested that the VAMROC Director and CCA officials ensure that: (a) The laundry service contract is modified to require performance monitoring, (b) the VAMROC obtains reimbursement for overcharges, and (c) CFA employees properly monitor the contract to ensure the VAMROC is not overcharged. The Director concurred and reported that as of August 2001, CCA had modified the laundry service contract to include performance monitoring, the VAMROC had been credited for overcharges, and the CCA Contracting Officer reviewed contract administration duties and responsibilities with the

Contracting Officer's Technical Representative. The improvement actions are acceptable, and we consider the issues resolved.

Primary Care of Mental Health Patients – Management of Chronic Medical Problems Needs Improvement

Condition Needing Improvement. VAMROC managers needed to ensure that clinicians use established guidelines for managing chronic medical problems of mental health patients. VHA implemented clinical practice guidelines for high volume diagnoses as part of its National Performance Measures. To determine if VAMROC clinicians applied the same guidelines for mental health patients, we reviewed nine medical records of patients with one or more of the following diagnoses: coronary artery disease, diabetes, and hypertension. Of the records we reviewed, 67 percent (6/9) did not have documented evidence that clinicians adequately managed the patients' chronic medical problems using established medical interventions. For example, clinicians had not performed a required annual test for a diabetic patient for the previous five years. While our review primarily involved mental health patients, we found that the facility's overall clinical practice guidelines results for FY 2000 exceeded the established baseline.

Suggested Improvement Action: We suggested that the Director ensure that clinicians perform required clinical practice guideline interventions. The Director concurred and reported that on-going efforts included utilization of the monthly External Peer Review Program data to ensure that patients' primary care needs are met, monthly Medical Records Committee chart reviews that focus on implementation and documentation of quality measures, and use of the Decision Support System data to conduct population-based reviews. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

Spark M. Matsunaga VAMROC Director Comments

Department of Veterans Affairs **Memorandum**

Date: AUG 3 2001

From: Director, Spark M. Matsunaga VA Medical & Regional Office Center (459/00)

Subj: Response to Draft Report: Combined Assessment Program (CAP) Review Of the Spark M. Matsunaga VA Medical & Regional Office Center dated 6/25/01

To: Assistant Inspector General for Healthcare Inspection (54)

1. This is in response to your memorandum dated June 25, 2001, transmitting the Draft CAP Review of the VAMROC. We concur, for the most part, with the recommendations and improvement actions indicated in the report.

2. Attached is our written response describing specific corrective action plans for each recommendation and improvement action. These responses have also been incorporated into the actual Draft Report for easy reference.

3. The following demographic data is provided as requested on the **Introduction** page of the CAP Report.

   Resources. FY 2000 general operating expenses totaled about $4.1 million and the Regional Office had 57.6 full-time equivalent employees. **Workload.** In FY 2000, approximately $110 million in C&P benefits were Paid to approximately 16,072 beneficiaries. VRE services were provided To about 1,700 veterans, serviceperson, dependents, and survivors with Estimated benefits totaling $7.1 million in FY 2000.

4. We appreciate the time and effort put into your collaborative assessment and we are grateful for the excellent fraud and integrity awareness training your office provided. If you desire additional information regarding our response to the CAP review, please contact Mr. Ron Yonemoto, Acting Associate Director, at 808-433-0103.

(Original signed by:)
H. David Burge

Attachment

Quality Management

Suggested Improvement Action. The Director should implement a mechanism for the VAMROC to monitor and evaluate veterans' care at TAMC, including peer review with VAMROC clinicians.

Acknowledgement: Concur.

Corrective Action: VAMROC has several initiatives that will allow the VA to better monitor and evaluate veterans' care at Tripler Army Medical Center (TAMC), including participation by the VA in peer review activities. These initiatives include, but are not limited to, the following:

(1) VAMROC membership on TAMC Risk Management Committee which provides peer review of adverse and "near miss" clinical outcomes
(Target Completion Date: COMPLETE)

(2) VAMROC is seeking attendance and participation at clinical, department-specific Morbidity and Mortality conferences
(Target Completion Date: 1/2002)

(3) VA is seeking concurrence on a revised sharing agreement with TAMC (revision due 1/2002) that would require TAMC to provide regular reports of adverse outcomes in veteran patient care. Specific reports will include but not be limited to:

a. Occurrence of skin ulcers
b. Falls
c. Nosocomial infections
d. Readmissions
e. Increased length of stay

(4) A VA clinician/case manager will be attending the TAMC clinical morning report where issues pertaining to the care of specific veterans are discussed
(Target Completion Date: On-going)

(5) VA and TAMC are currently developing a plan for a VA-staffed and managed inpatient medical team which will directly admit and manage hospitalized patients with medical problems as well as provide consultation and case management to veterans for non-medical services, e.g., surgery
(Target Completion Date: COMPLETE)

Independent Living Services Program

Suggested Improvement Action. The VAMROC Director should monitor ILS case management practices to ensure that thorough needs assessments are completed and that

proposed purchases are consistent with applicable acquisition policies and ILS program goals.

Acknowledgement: Concur.

Corrective Action: VR&E Service designated a team of VR&E Officers to develop clearer guidelines for the Independent Living Program. The team provided the field with a draft report and the local VR&E Officer developed guidelines based on the draft report which will soon be implemented. Although not required by regulation or manual reference, the guidelines stipulate a more thorough evaluation for Independent Living Programs.

The VR&E Officer will train new staff on the new guidelines modeled after Central Office's draft report and will disseminate those guidelines with training to all stakeholders in the VAMROC's jurisdiction.

Target Completion Date: 9/30/01

Government Purchase Card Program

Suggested Improvement Actions. The VAMROC Director should ensure that: (a) The Purchase Card Program Coordinator develops, implements, and documents an adequate purchase card and acquisitions training program, (b) cardholders do not exceed the $2,500 transaction limit unless they have an appropriate contracting warrant, (c) purchase card transactions are reviewed to ensure that VA purchase card policies and regulations requirements are followed, and (d) cardholder and approving official responsibilities are removed from the Program Coordinator and the Alternate Program Coordinator.

Acknowledgement: Concur.

Corrective Action:

(a) Training for approving officials and cardholders will be reviewed and refresher training provided. VA Form 0242, Government-wide Purchase Card Certification, will be initiated for individuals to sign, acknowledge completion of training, acceptance of responsibility, and file copy maintained by Program Coordinator.
(Target Completion Date: 7/31/01)

(b) Purchasing authority for VR&E cardholders will be restricted to the $2,500 micro-purchase limit until each has completed training for their basic contracting warrant (authority exceeding $2,500) in accordance with the FAR and VAAR. In the interim, Form 2237, Purchase Request will be initiated and submitted to Acquisition & Material Management Service, Purchasing Section for purchases exceeding $2,500.
(Target Completion Date: Adjustment to micro-purchase limits effective 7/01/01)
(Estimated date for completion of VR&E employee basic contracting training 8/31/01)

(c) VR&E cardholders and approving official will be provided purchase card refresher and basic contract training to ensure thorough understanding of policies and regulation requirements with emphasis on use of mandatory sources of supply.
Target Completion Date: 9/30/01)

(d) As stated in the OIG Review, VAMROC Honolulu staffing will not support the separation of Program Coordinator and Alternate Program Coordinator duties from their position as Approving Officials. The Program Coordinator is a purchase cardholder, but he does not approve his own transactions. His purchases are reviewed and approved by the Associate Director. He does approve those actions/purchases of purchasing agents and cardholders whom have access to fund control points under his responsibility. The Alternate Program Coordinator is not a cardholder, but he is an Approving Official for purchasing agents and for those control points under his responsibility. To comply with the intent of the OIG recommendation that proper internal controls are in place, their activities will be monitored by the Associate Director to ensure they properly administer their duties.
(Target Completion Date: **7**/31/01)

Controlled Substances

Suggested Improvement Actions. The VAMROC Director should ensure that: (a) The controlled substance inspection program meets all requirements; (b) all controlled substances are properly inventoried; (c) controlled substance inventory levels, as well as those of other pharmaceuticals, are maintained in accordance with VHA policy; (d) narcotics are stored in locked steel cabinets in the pharmacy vaults; and (e) motion detectors are properly installed and monitored.

Acknowledgement: Concur.

Corrective Actions:

(1) All appointed controlled substance inspectors will be trained by the Chief of Pharmacy Service or designee. This training will be documented with the names of participants, content of the training, and date.
(Target Implementation Date: 7/31/01)

(2) All areas storing controlled substances will be inspected, including the nursing modules, the OptiFill, and the Sure Med.
(Target Implementation Date: 7/31/01)

(3) Controlled substances will be inventoried every 72 hours.
(Target Implementation Date: 7/31/01)

(4) ECHO Inventory Management System is being implemented to comply with the 10-day inventory level for all pharmaceuticals.

a. Shelves are being labeled for maximum and minimum levels

b. Drugs in the "A" class, 10% of the drug list which is 70 percent of the total drug cost, will be targeted first.
c. "B" and "C" classes will follow
(Target Implementation Date: 7/31/01)

(5) The motion detectors will be installed at the ACC and CFA pharmacies.
(Target Completion Date: 8/31/01)

(6) A locked steel cabinet will be installed at the CFA to store the controlled substances.
(Target Completion Date: 8/15/01)

Communication of Critical Test and Procedure Results

Suggested Improvement Action: The Director should ensure that critical test results are communicated to providers and patients and are documented in the medical record.

Acknowledgement: Concur.

Corrective Action: Communication of test results to providers and patients will be documented in medical records.

Target Completion Date: 12/01.

Benefits Delivery Network Security

Suggested Improvement Actions. The VAMROC Director should ensure that: (a) All current and new employees have completed all necessary forms, and (b) the claims files of all veteran employees receiving C&P benefits are electronically locked.

Acknowledgement: Concur.

Corrective Actions:

(a) All current employees have completed the necessary forms. In addition, we have implemented a system with Human Resources that ensures all new employees fill out the required documents.
(Target Completion Date: COMPLETE)

(b) All files of veteran employees receiving C&P benefits have been electronically locked.
(Target Completion Date: COMPLETE)

Information Technology Security

Suggested Improvement Actions. The VAMROC Director should ensure that: (a) An off-site location is found for the storage of critical back-up files, (b) new anti-virus

software is installed on all personal computers, and (c) inactive VISTA user accounts are reviewed and terminated within a reasonable time frame.

Acknowledgement: Concur

Corrective Actions:

(a) An off-site storage location will be established and utilized.
(Target Completion Date: 9/30/01)

(b) The new anti-virus deployment software is a national VA-wide implementation being rolled out for both VHA and VBA networks.
(Target Completion Date: 12/31/01)

(c) The VistA system runs a daily routine that reviews and automatically disables any users accounts which are not accessed over 90 days. In addition, we are working with HRMS to enforce clearance through IRMS during a termination or change in employment.
(Target Completion Date: On-going)

Medical Record Privacy

Suggested Improvement Actions. The Director should ensure that: (a) A formal security incident reporting plan is developed and implemented; and (b) employees are provided annual information security awareness training that includes security incident reporting, use of the sensitive record tracking system, and auditory privacy.

Acknowledgement: Concur.

Corrective Action: The Information Security Officer (newly appointed) is working on a security incident plan for the facility. Once the plan has been written, all employees will be trained regarding the information security elements. Additionally, this plan will be presented during the New Employee Orientation. The system has been purged to now show "sensitive record" for only the following categories: employees, employee veterans, and patients with HIV, Sickle Cell Anemia, and Substance Abuse problems.

Target Completion Date: 9/14/01

Background Investigations

Suggested Improvement Actions. The Director should ensure that: (a) Background investigations are requested and completed for practitioners hired in the future, and (b) a review of personnel files of previously hired practitioners is conducted and background investigations are initiated as needed.

Acknowledgement: Concur.

Corrective Action: Background investigations were initiated for the two (2) staff identified as not having an investigation conducted. Internal controls have been reviewed and staff reminded that investigative supporting data (SF-85) must be completed prior to processing in new employees. A review of all independent practitioners on the rolls will be completed to determine compliance with this finding.

Target Completion Date: 7/15/01

Service Contracts

Suggested Improvement Actions. The VAMROC Director and CCA officials should ensure that: (a) The laundry service contract is modified to require performance monitoring, (b) the VAMROC is reimbursed for any overcharges, and (c) VAMROC employees properly administer the contract.

Acknowledgement: Concur.

Corrective Actions:

a) The laundry contract has been modified to implement a performance-monitoring plan for the laundry services acquired under this contract, as recommended. The laundry contractor will be required to provide a delivery ticket certifying the amount of laundry being delivered and the price per pound with each delivery. The Contracting Officer's Technical Representative (COTR) will periodically weigh the laundry delivered and use the delivery ticket to confirm that VAMROC is correctly being invoiced for the laundry service received. The COTR will be responsible for insuring that all invoices are correct prior to certifying for payment.

(b) On June 13, 2001 the Contracting Officer sent a letter to the contractor requesting reimbursement for the overcharge of $759.20. The contractor has responded to the letter, and a credit of $759.20 has been applied to our current invoice for payment.

(d) The Contracting Officer has re-confirmed the duties and responsibilities in administering the laundry contract with the COTR by reviewing the COTR delegation of authority and the requirements of the contract.

Target Completion Date: COMPLETE

Primary Care of Mental Health Patients

Suggested Improvement Action: The Director should ensure that clinicians perform required chronic disease care indicators.

Acknowledgement: Concur

Appendix A

Corrective Action: We are pleased to note that as per the consultant's report, our facility exceeded the established baseline for Chronic Disease Index results for FY 2000. We are proud to have lead the VISN in this area, however, we do recognize that the deficiencies noted represent an opportunity for us to make significant improvement.. The consultant's report indicated that out of nine charts of mental health patients that were reviewed, six did not have documented evidence that clinicians adequately managed the chronic medical problem using established medical interventions. Because this sample size is so small, we would appreciate the opportunity to review these particular records to determine the cause of this problem. If it is reflective of a larger systems issue, the ACOS for Mental Health and for Primary Care will meet to develop a mechanism that can be widely implemented to ensure correction of this problem. If these six charts are not representative of a systems issue (for example, if they reflect a provider-specific problem), then this will be addressed as indicated.

The facility engages in an External Peer Review Program (EPRP), which is conducted monthly throughout the VHA, provides data for Oahu as well as for the neighbor islands. We will continue to utilize this data as a means of ensuring that all patients have their primary care needs met. In addition, the facility Medical Records Committee conducts monthly chart reviews that look at quality and completeness of charts. Clinicians are part of this review process, and review all charts in the monthly cohort of records pulled for examination. We will continue to monitor this data and seek full compliance from our staff on the implementation and documentation of quality measures. We are in the process of using out Decision Support System program (DSS) staff to develop a Data Warehouse, as has been done in other VHA facilities. The Data Warehouse will ultimately enable us to do population-based reviews on large numbers of patients, which will provide information that we cannot capture in a review based upon a sample of charts pulled for review. The three mechanisms noted above will all assist us in correcting our deficiencies.

Please be assured that both Ambulatory Care and Mental Health are committed to cooperative problem-solving to ensure that our patients receive excellence in all aspects of their care.

Target Completion Date: On-going

Appendix A

Spark M. Matsunaga VAMROC Director Comments

The OIG CAP assessment was carried out in very professional manner by the review team. Our staff was impressed with the team's focus on truly trying to help us improve the quality, efficiency, and effectiveness of our operations. In addition, the fraud and integrity awareness briefings provided to our staff were outstanding. We applaud the OIG in its success in implementing a program that not only improves our performance, but more importantly improves services to our veterans

Appendix B

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This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for two fiscal years after it is issued.