Department of Veterans Affairs
Office of Inspector General

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities

October 2003 through September 2004

Report No. 04-03310-94

March 7, 2005

VA Office of Inspector General
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 VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Appendixes

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

Memorandum to:

Secretary (00)
Acting Under Secretary for Health (10)

Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2003 through September 2004

1. This report summarizes recommendations and suggestions made in reports of Office of Inspector General (OIG) Combined Assessment Program (CAP) reviews conducted at Department of Veterans Affairs (VA) Veterans Health Administration (VHA) medical facilities during the period October 2003 through September 2004. CAP reviews evaluate selected medical facility operations, focusing on patient care, quality management (QM), and financial and administrative management controls.

2. During the period covered by this summary report, the OIG published 40 reports of CAP reviews conducted at VHA medical facilities. Each of the issues highlighted in this report was identified at two or more medical facilities. We also provided fraud and integrity awareness training for 8,424 VHA employees, and in specific instances, examined issues or allegations referred to the OIG by employees, patients, Members of Congress, or others.

3. The Acting Under Secretary for Health should ensure that all VHA directors and managers are advised of the issues identified in this summary report. We may follow-up on the issues reported here in future CAP reviews and include new areas of inquiry. This report was prepared under the direction of Ms. Linda Halliday, Director, OIG Audit Planning Division.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Background

During the period October 2003 through September 2004, the OIG published 40 reports of CAP reviews conducted at VHA medical facilities.

Scope of CAP Reviews

The scope of our CAP reviews is tailored to address both national and facility specific issues. This report summarizes issues, reported in two or more CAP reports, for which recommendations or suggestions were made. Because the scope of review has been modified through time, the areas of inquiry described in this report were not reviewed at each medical facility in all cases.

Fraud and integrity awareness briefings were also conducted during each of the 40 CAP reviews, and 8,424 VHA employees attended the briefings. The briefings included a film that describes the types of fraud that can occur in VA programs and the OIG's role in the investigation of criminal activity, followed by question and answer sessions.

CAP Reports Issued

The following are the 40 VHA CAP reports issued by facility and Veterans Integrated Service Network (VISN) during the period October 2003 through September 2004.

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Togus, ME	1	03-03207-120	04/02/04
Combined Assessment Program Review, VA Medical Center Northampton, MA	1	04-00627-172	07/30/04
Combined Assessment Program Review, VA Medical Center Bath, NY	2	04-01096-162	07/02/04
Combined Assessment Program Review, VA Medical Center Northport, NY	3	04-00403-128	04/14/04
Combined Assessment Program Review, VA Medical Center Coatesville, PA	4	03-02278-008	10/29/03
Combined Assessment Program Review, VA Medical Center Lebanon, PA	4	03-02577-062	01/12/04
Combined Assessment Program Review, VA Medical Center Wilkes-Barre, PA	4	03-01357-061	01/12/04
Combined Assessment Program Review, Louis A. Johnson VA Medical Center Clarksburg, WV	4	03-03136-069	01/28/04
Combined Assessment Program Review, James E. Van Zandt VA Medical Center Altoona, PA	4	03-03208-076	02/02/04
Combined Assessment Program Review, VA Medical Center Erie, PA	4	04-01619-211	09/24/04
Combined Assessment Program Review, VA Maryland Health Care System Baltimore, MD	5	04-00356-130	04/16/04
Combined Assessment Program Review, W.G. (Bill) Hefner VA Medical Center Salisbury, NC	6	03-02420-006	10/14/03
Combined Assessment Program Review, VA Medical Center Salem, VA	6	03-03210-109	03/18/04
Combined Assessment Program Review, VA Medical Center Beckley, WV	6	04-00540-208	09/24/04

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Tuscaloosa, AL	7	04-00931-166	07/15/04
Combined Assessment Program Review, William Jennings Bryan Dorn VA Medical Center Columbia, SC	7	04-01863-219	09/28/04
Combined Assessment Program Review, VA North Florida/South Georgia Health System	8	04-01718-222	09/29/04
Combined Assessment Program Review, VA Medical Center Memphis, TN	9	04-00631-190	08/27/04
Combined Assessment Program Review, VA Medical Center Chillicothe, OH	10	04-00928-164	07/15/04
Combined Assessment Program Review, VA Ann Arbor Healthcare System, MI	11	03-02729-140	05/06/04
Combined Assessment Program Review, Aleda E. Lutz VA Medical Center Saginaw, MI	11	03-03038-168	07/15/04
Combined Assessment Program Review, VA Medical Center Battle Creek, MI	11	04-00602-171	07/30/04
Combined Assessment Program Review, VA Medical Center Tomah, WI	12	03-02067-029	11/21/03
Combined Assessment Program Review, VA Chicago Health Care System, IL	12	04-00937-196	08/30/04
Combined Assessment Program Review, VA Medical and Regional Office Center Wichita, KS	15	03-02735-103	03/16/04
Combined Assessment Program Review, VA Medical Center Muskogee, OK	16	03-02374-017	11/07/03
Combined Assessment Program Review, G.V. (Sonny) Montgomery VA Medical Center Jackson, MS	16	03-02446-023	11/13/03
Combined Assessment Program Review, VA Gulf Coast Health Care System Biloxi, MS	16	04-01946-188	08/27/04
Combined Assessment Program Review, VA Amarillo Health Care System, TX	18	04-00566-173	08/09/04
Combined Assessment Program Review, Carl T. Hayden VA Medical Center Phoenix, AZ	18	04-01456-181	08/13/04
Combined Assessment Program Review, VA El Paso Health Care System, TX	18	04-00230-191	08/27/04

Report	VISN	Report Number	Issue Date
Combined Assessment Program Review, VA Medical Center Grand Junction, CO	19	03-02290-012	11/04/03
Combined Assessment Program Review, VA Medical Center Sheridan, WY	19	03-02612-027	11/21/03
Combined Assessment Program Review, VA Medical/Regional Office Center Cheyenne, WY	19	03-02029-045	12/19/03
Combined Assessment Program Review, VA Southern Oregon Rehabilitation Center and Clinics White City, OR	20	03-02850-066	01/28/04
Combined Assessment Program Review, VA Medical Center Portland, OR	20	04-01128-201	09/07/04
Combined Assessment Program Review, VA Greater Los Angeles Healthcare System, CA	22	03-01948-018	11/10/03
Combined Assessment Program Review, VA Southern Nevada Healthcare System Las Vegas, NV	22	04-00489-167	07/15/04
Combined Assessment Program Review, VA Black Hills Health Care System, SD	23	03-02996-094	03/01/04
Combined Assessment Program Review, VA Medical Center St. Cloud, MN	23	04-00059-110	03/18/04

CAP Findings by VISN and by Medical Facility

Veterans Integrated Service Networks (VISNs)

Findings	1		2	3	4						5	6			7		8	9	10	11			12		15	16			18			19			20		22		23	
	VA Medical Center (VAMC) Togus, ME	VAMC Northampton, MA	VAMC Bath, NY	VAMC Northport, NY	VAMC Coatesville, PA	VAMC Lebanon, PA	VAMC Wilkes-Barre, PA	VAMC Clarksburg, WA	VAMC Altoona, PA	VAMC Erie, PA	VA Maryland Health Care System (HCS) Baltimore, MD	VAMC Salisbury, NC	VAMC Salem, VA	VAMC Beckley, WV	VAMC Tuscaloosa, AL	VAMC Columbia, SC	VA North Florida/South Georgia Health System	VAMC Memphis, TN	VAMC Chillicothe, OH	VA Ann Arbor HCS, MI	VAMC Saginaw, MI	VAMC Battle Creek, MI	VAMC Tomah, WI	VA Chicago HCS, IL	VA Medical and Regional Office Center (VAMROC) Wichita, KS	VAMC Muskogee, OK	VAMC Jackson, MS	VA Gulf Coast HCS Biloxi, MS	VA Amarillo HCS, TX	VAMC Phoenix, AZ	VA El Paso HCS, TX	VAMC Grand Junction, CO	VAMC Sheridan, WY	VAMROC Cheyenne, WY	VA Southern Oregon Rehabilitation Center and Clinics White City, OR	VAMC Portland, OR	VA Greater Los Angeles HCS, CA	VA Southern Nevada HCS Las Vegas, NV	VA Black Hills HCS, SD	VAMC St. Cloud, MN
Community Residential Care					●	●	●	●															●										●				●			
Environment of Care				●	●		●	●		●	●			●		●		●	●	●	●	●	●	●	●			●								●			●
Management of Moderate Sedation														●		●		●	●					●					●								●			
Patient Transportation Services	●	●		●				●	●				●	●							●		●		●						●				●			●	●
Quality Management	●				●		●	●	●			●	●	●				●				●	●	●	●	●					●	●	●	●		●	●		
Accounts Receivable														●		●					●			●															
Agent Cashier												●				●					●			●												●			
Contract Award and Administration	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●			●	●	●	●
Government Purchase Cards	●	●			●		●	●		●	●	●				●				●				●					●		●			●					
Information Management Security					●	●	●	●	●	●	●	●		●	●		●	●	●	●	●	●	●			●	●	●	●	●	●	●	●	●	●	●		●	●
Management of Equipment Inventories		●																	●	●						●				●	●		●			●	●	●		
Management of Supply Inventories	●	●	●	●	●	●	●		●				●	●		●	●	●	●		●	●		●	●	●			●	●	●		●		●	●	●	●	●
Medical Care Collections Fund	●									●			●	●		●			●	●			●		●	●			●	●	●		●		●	●	●		
Part-Time Physician Time and Attendance	●					●					●						●	●		●									●								●		
Patient Funds		●																				●		●															
Pharmacy - Controlled Substances Accountability	●	●		●	●	●	●			●			●	●	●	●	●		●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●
Pharmacy - Physical Security				●																	●									●						●	●		
Physician Conflict of Interest	●				●							●						●																					

SHADED = AREA REVIEWED AT THIS SITE
● = IMPROVEMENT NEEDED AT THIS SITE

Summary of CAP Findings

1. Community Residential Care (findings at 7 of 9 medical facilities)

- Develop and implement Community Residential Care (CRC) performance improvement monitors.
- Complete and document psychosocial, medical, and mental health assessments prior to patients' placements in CRC homes, and assess patients' adjustments to placements within 30 days of CRC placements.
- Ensure CRC program managers and Veterans Benefits Administration Fiduciary and Field Examiners supervisors meet annually to address issues involving incompetent veterans with assigned fiduciaries.
- Verify that CRC facility employees are not also employed by the medical facility and that CRC facilities are not owned and operated by VA employees.
- Require Memorandums of Understanding addressing CRC services and fees to be developed and documented in the CRC sponsors' records.
- Ensure local CRC policies comply with VHA policies.
- Provide and document annual training to Residential Care Facility (RCF) employees, and train case managers and social workers to annotate changes in medical conditions in patient medical records and inform CRC sponsors of these changes.
- Require CRC teams to conduct inspections of RCFs at least every 2 years.
- Ensure clinicians perform and document monthly visits to RCFs and conduct annual physical examinations of RCF patients.
- Require fire safety inspectors to conduct annual evaluations of RCFs.

2. Environment of Care (findings at 19 of 40 medical facilities)

- Train employees in emergency response procedures.

- Conduct risk assessments of locked psychiatry units to determine if there are safety hazards which pose suicide risks for patients.
- Reprocess Supply Processing and Distribution sterile supplies when they are outdated.
- Ensure biohazardous storage rooms are secured.
- Ensure that Veterans Canteen Service (VCS) employees adhere to infection control policies.
- Ensure that VCS employees maintain current Material Safety Data Sheets for potentially hazardous chemicals as required by the Occupational Safety Health Administration.
- Remove medication room entry codes from public access areas.
- Document Pyxis MedStation discrepancy reports at the end of each shift.
- Properly secure all medications, surgical carts, housekeeping closets, prescription pads, potentially hazardous chemicals, products, and sharp instruments.
- Regularly inspect pest control devices, and replace as necessary.
- Regularly inspect furniture and mattresses in patient care areas, and remove from service if damaged.
- Store medical equipment and oxygen tanks appropriately.
- Monitor the temperature of medication and patient food refrigerators daily.
- Correct maintenance and safety issues requiring immediate attention, such as patient care areas when insects or pests are reported, obstructed fire exits, peeling paint, and broken tiles in the sterile processing room.
- Ensure patient privacy is maintained in outpatient intake and treatment areas.
- Protect confidential patient information from inadvertent disclosure.

3. Management of Moderate Sedation (findings at 7 of 11 medical facilities)

- Ensure that patients receive pre-sedation American Society of Anesthesiologists classifications before receiving moderate sedation.

- Ensure that electronic monitoring device alarms outside of the operating room are always set in the "alert" position during moderate sedation procedures to notify providers of critical changes in the patients' status, and to ensure timely response to prevent further deterioration in patients' clinical conditions.

- Monitor patients' vital signs during transports to post-procedure recovery areas.

- Require physicians to document the reevaluations of patients immediately before moderate sedation procedures outside of the operating room or co-sign the nurses' notes addressing the reevaluations. Also, require clinicians consistently perform and document medical evaluations within 30 days prior to procedures and reevaluations immediately before the administration of moderate sedation.

- Ensure clinicians comply with VHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) procedures for obtaining privileges to administer moderate sedation.

- Capture all moderate sedation data during performance improvement monitoring, including Intensive Care Unit and cardiology procedures.

- Designate a committee to aggregate and analyze moderate sedation outcome data, and require clinicians to report outcome data to this committee.

- Establish training guidelines and specific competency standards for registered nurses who administer moderate sedation.

- Comply with system policy for Advanced Cardiac Life Support certification, annual written tests, and demonstrations of skills.

- Ensure that all clinically active employees involved in the care of patients who receive moderate sedation are cardiopulmonary resuscitation certified.

- Clinical managers should ensure that the medical records of patients who receive moderate sedation include all pertinent documentation.

4. Patient Transportation Services (findings at 14 of 15 medical facilities)

- Provide and document initial medical evaluations for drivers, and provide health screenings for all drivers every 4 years.
- Ensure motor vehicle operators are screened for valid drivers' licenses, safe driving records, and personal auto insurance.
- Ensure employee and volunteer drivers receive the required annual motor vehicle safety, cardiopulmonary resuscitation, and first aid training, and that the training is documented.
- Ensure medical facility patient transportation policies conform with VHA policy.
- Document in the patients' medical records significant events that occur during transport for consideration when scheduling the patients for future transportation needs.
- Ensure drivers adequately secure all patient care equipment during transport operations.
- Ensure that all patient transport vehicles are placed on a routine cleaning schedule and that interiors are checked daily.
- Include infection control supplies in all first aid kits.
- Ensure contracting staff request and periodically review records of training, character, and physical capabilities of drivers from contract transport companies.
- Document employees' collateral transportation duties in their position descriptions and performance evaluations.
- Critically analyze, trend, document, and act upon patient complaint data.

5. Quality Management (findings at 20 of 40 medical facilities)

- Require healthcare providers to notify patients or surrogate decision makers of unanticipated outcomes or adverse events and appropriately review and document events. Also, assign a safety assessment code score and enter it into the patient safety database.

- Ensure root cause analysis teams identify appropriate root causes for reportable occurrences such as adverse patient events or close calls, define recommended improvement actions, establish measurable outcomes, document implementation, monitor effectiveness of improvement actions until deficiencies are resolved, and communicate outcomes to responsible managers or committees.

- Ensure Quality Management (QM) data is consistently collected, trended, analyzed, and reported to medical facility management in order to identify opportunities to improve the quality of patient care.

- Ensure available benchmarks or goals are consistently used for analyzing data.

- Establish evaluation criteria and procedures to monitor the implementation and effectiveness of recommended corrective actions from QM reviews until deficiencies are resolved.

- Revise the Performance Improvement/QM Program to improve its scope and operations regarding the outpatient spinal chord injury and community nursing home programs.

- Require peer reviewers to complete the practitioner quality of care scale to ensure consistent documentation of peer review outcomes.

- Ensure the Peer Review Committee meets and performs mandated functions.

- Document communication of peer review results to providers and their responses.

- Report administrative and clinical issues discussed during peer reviews to the Medical Executive Board for follow-up, and include the issues in the Quality Improvement Program.

- Document action plans, including their effectiveness in meeting goals as required by JCAHO and VHA, and communicate outcomes to responsible managers or committees.

- Ensure annual performance plans are developed encompassing performance improvement plans from all services, as well as VHA and VISN performance measures.

- Require the Clinical Executive Board to review and evaluate the Special Care Unit Committee (SCUC) minutes quarterly.

- Ensure that the SCUC collects, trends, and analyzes resuscitation data to evaluate outcomes and identify opportunities to improve care, and documents appropriate corrective actions taken.

- Ensure Nursing Service managers analyze patient restraint data.

- Ensure the Medical Record Review Committee reviews documentation supporting physician supervision of residents.

- Obtain and compare to appropriate measurement standards provider-specific data including core and supplemental clinical privileges from affiliated hospitals, QM data such as patient complaints, Utilization Management, and medication management before granting privileges or re-privileging to facility physician specialists.

6. Accounts Receivable (findings at 4 of 12 medical facilities)

- Establish bills of collection, and record and reconcile accounts receivable timely.

- Determine whether debts owed by vendors and former employees can be offset against future obligations and Government retirement, respectively, and perform the offset of funds, if appropriate.

- Refer delinquent accounts receivable to the Treasury Offset Program (TOP)[1] for collection.

- Follow up on delinquent accounts receivable by conducting follow-up telephone calls after the bills remain unpaid for 30 days and documenting all follow-up actions.

- Follow up on decisions regarding requests of waiver for suspended employee accounts receivable.

7. Agent Cashier (findings at 5 of 10 medical facilities)

- Provide a security escort for the Agent Cashier during cash replenishment trips.

[1] VA policy requires that most debts over 180 days delinquent be referred to the TOP for collection. The TOP is a centralized offset program, administered by the Financial Management Service's (FMS) Debt Management Services (DMS), to collect delinquent debts owed to Federal agencies and states. "Creditor agencies," submit delinquent debts to FMS for collection and inclusion in TOP and certify that such debts qualify for collection by offset.

- Evaluate the adequacy of the cash advance.

- Conduct unannounced audits of the Agent Cashier at least every 90 days. Open the Agent Cashier and alternate Agent Cashier cash boxes, include their contents in unannounced audits when assigned cashiers are unavailable, and reconcile any cash discrepancies found during the unannounced audits.

- Transfer accountability and responsibility of the Agent Cashier's advance to an alternate cashier for a period of at least 2 weeks every calendar year.

- Ensure that VA separation of duty policies are followed when selecting employees for Agent Cashier and Agent Cashier Auditor positions.

- Provide refresher training to Agent Cashier Auditors, and rotate them.

- Change the combination to the Agent Cashier vault after changes in the Agent Cashier position.

8. Contract Award and Administration (findings at 35 of 40 medical facilities)

- Ensure appropriate training requirements are met for Contracting Officers (COs) before granting warrants.

- Conduct database searches of the Federal Government's Excluded Parties Listing System to ensure contractors' eligibility to compete for contracts.

- Require COs to fully document the rationale for awarding contracts, contract modifications, option year justifications, and the basis for price reasonableness determinations in Price Negotiation Memorandums, and file all applicable Federal Acquisition Regulations (FAR) and VA required documents in the contract files.

- Develop and utilize a checklist to ensure all required documentation is included in the contract files.

- Ensure COs conduct price analyses for negotiated acquisitions.

- Ensure the CO obtains legal and technical reviews prior to awarding competitive contracts over $1.5 million and non-competitive contracts over $500,000. Also, obtain business reviews and pre-award audits (for non-competitive commercial items contracts valued at $500,000 or more), and forward contracts to the Director, Medical Sharing Office when required by VA policy.

- Ensure that all contractors are registered in the Central Contractor Registration database.
- Write contract specifications clearly to prevent misinterpretations.
- Ensure facility Directors plan and establish contracts for recurring procurements, and conduct quarterly reviews of purchasing activities.
- Designate CO's Technical Representatives (COTRs) in writing for all contracts, file designation letters in contract files, and monitor COTR appointments to verify that they are current and appropriate.
- Ensure COTRs thoroughly review work performed by contractors for compliance with contract terms and conditions, adequately review invoices, and certify acceptance of contractors' invoices before payments are authorized.
- Ensure that a contract exists before issuing a purchase order against it.
- Provide COTRs initial and annual refresher training on their roles and responsibilities.
- Ensure COs initiate background investigations for contractor personnel with access to VA computer systems and sensitive information prior to contract performance.
- Verify contractors are maintaining contractor liability insurance for all clinical services contracts.

9. Government Purchase Cards (findings at 14 of 28 medical facilities)

- Ensure acquisition personnel and purchase cardholders use mandatory Federal Supply Schedule or national contracts. When mandatory sources are unavailable for procurements exceeding $2,500, solicit at least three vendor quotations to promote competition, and document justifications for sole source procurements using purchase cards.
- Improve accountability for Engineering Service purchases.
- Ensure the Purchase Card Coordinator, Billing Official, and Dispute Officer are not designated cardholders, and ensure adequate separation of purchase card duties. For those instances where it is not feasible to achieve adequate separation of duties, the facility Director should document reasons for the lack of separation of duties, and ensure that compensating controls are established.

- Require documentation of receipt for goods and services to enable reconciliation and certification of transactions, and ensure approving officials approve purchase card transactions within 14 days of reconciliation.

- Ensure that purchase card holders enter purchase orders into the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system no later than 1 workday following purchases.

- Ensure that monthly joint reviews of cardholders' accounts are performed.

- Require quarterly audits of all cardholder accounts not included in the monthly statistical sampling audits conducted by the VA Financial Service Center.

- Implement controls to monitor cardholder purchase levels to ensure that cards are needed, and deactivate those that are unnecessary.

- Ensure purchase cardholders do not split purchases and/or exceed the assigned spending limits of their warrants. Also, monitor the expiration dates of temporary warrants.

- Provide cardholders and approving officials acquisition training to ensure purchase card transactions comply with FAR and VA procurement policies.

- Establish contracts for recurring procurements.

10. Information Management Security (findings at 31 of 40 medical facilities)

- Monitor computer room access and employee Internet usage, and limit computer room access based on the level of employee need.

- Ensure availability of plastic covers to protect information technology equipment in the computer room from water damage.

- Perform risk assessments for the Veterans Health Information Systems and Technology Architecture (VistA) and Local Area Network systems.

- Develop contingency and recovery plans including identification of critical computer equipment, and priorities for restoring equipment; designate an alternate processing facility consistent with VA policy, and update plans when changes occur.

- Update the VistA contingency plan to include configurations for the Automated Information System hardware and software, detailed recovery procedures, identification of files requiring backup, labeling schemes for back-up tapes, and procedures regarding the VistA Imaging System.

- Ensure disaster recovery teams' and the members' responsibilities are included in the contingency plans for major systems. Include the pager and cell phone numbers of key medical facility personnel in contingency plans.

- Test contingency plans under conditions that simulate a disaster, and include community-based outpatient clinics.

- Ensure the alternate off-site storage for back-up tapes and data processing sites are located sufficient distances from the main computer processing location so that they are not subject to the effects of a potential disaster at the main computer processing location.

- Ensure VistA user access is promptly terminated for inactive users and individuals without a continuing need for system access.

- Indicate in VistA user profiles whether the users are employees, contractor personnel, volunteers, or affiliated educational institution personnel.

- Establish unique user access accounts instead of generic accounts for all VistA users.

- Monitor failed and unauthorized attempts to access VistA.

- Ensure all system users receive annual computer security awareness training.

- Establish policies and procedures to reinstate or reactivate VistA access for prior authorized users.

- Require background investigations for all key staff and contract employees having access to automated information systems, document their need for access, and specific access requirements.

- Include the appropriate information security clause in position descriptions for high-risk positions.

- Require the Information Security Officer (ISO) position to be assigned as a primary duty, and ensure that all ISO responsibilities are met.

- Establish local policy to ensure continued segregation of automated information security duties.

- Remove signage identifying the locations of sensitive information and automated systems.

- Ensure alternate ISOs do not have programmer level access to the medical facility's automated information systems.

11. Management of Equipment Inventories (findings at 10 of 14 medical facilities)

- Ensure Equipment Inventory Lists (EILs) are completed by medical facility management and verified by Acquisition and Materiel Management Service (A&MMS) staff timely, inform Facility Management Staff (FMS) when equipment is moved or excessed, and update EILs.

- Require the FMS Chief to ensure proper classification of sensitive items, and include them on EILs.

- Require service chiefs to ensure equipment purchased is put into service when received.

- Require medical facility staff to promptly submit Reports of Survey when equipment is lost, damaged, or destroyed.

- Ensure that A&MMS staff attach a VA property tag, prepare appropriate documentation, and update the EIL for new equipment placed into service.

- Ensure FMS staff conduct quarterly inventory spot checks, A&MMS supervisors perform inventories of nonexpendable equipment annually, and update EILs.

- Send timely delinquent inventory notices to responsible officials when scheduled inventories are not performed.

- Conduct follow-up physical inventories within the required 6-month timeframe for items costing more than $5,000, with an expected life of more than 2 years, if the inventory accuracy rate is below 95 percent.

12. Management of Supply Inventories (findings at 29 of 33 medical facilities)

- Ensure that A&MMs at facilities work together to consolidate purchases within the VISN to avoid a build-up of medical supply inventories.
- Implement the Generic Inventory Package (GIP). Conduct annual physical inventories of medical, engineering, and janitorial supplies to obtain an accurate count of all items to be included in GIP, and inventory spot checks to ensure GIP data is accurate and reliable. Reconcile any differences, and correct inventory records as appropriate.
- Remove "seldom use" or "no use" items from inventory if they are no longer required to meet facility needs.
- Provide additional training to enable staff to better manage medical, engineering, and janitorial supply inventories in the GIP database.
- Monitor medical, engineering, and janitorial supply usage through GIP, reduce excess inventories to meet the 30-day goal, develop a comprehensive plan for controlling these supplies to improve the accuracy of GIP data, and require the use of GIP automated tools.
- Improve the accuracy of the Prosthetics Inventory Package (PIP) data by recording all appropriate transactions into the system, and require the use of PIP automated tools.
- Require Prosthetic and Sensory Aids Service to reduce excess prosthetic inventory, and improve the accuracy of PIP data.
- Strengthen prosthetic inventory distribution controls by limiting access through centralization of the storage locations.

13. Medical Care Collections Fund (findings at 17 of 29 medical facilities)

- Obtain and update veterans' insurance information while they are awaiting treatment.
- Review outstanding bills for coding accuracy to determine if there is further collection potential, and submit amended bills as appropriate.

- Develop a timely process to identify and bill for Medical Care Collections Fund (MCCF) receivables. Also, ensure that reasons for not billing are accurate.
- Ensure that bills are processed before insurance carrier filing deadlines expire.
- Bill for optometry services provided by licensed optometry residents.
- Require the facility Directors to reduce the number of invalid insurance bills and the backlog of unprocessed insurance bills.
- Ensure that physicians document patient medical records timely, and that they include all elements required by VHA policy. This should improve billing for all professional fees.
- Promptly contact medical care providers when medical record documentation is missing.
- Pursue MCCF accounts receivable more aggressively by following up with insurance companies on a more regular basis, and requiring follow-up telephone calls with insurers after the bills remain unpaid for 30 days.
- Provide training and follow-up on the Detailed Listing of Patients with Unidentified Insurance Report to ensure the Unbilled Care Report is accurate, and issue bills for collection of the billable care identified.
- Document attending physicians' supervision of residents in the medical records. Review bills that were canceled due to inadequate resident supervision documentation for encounters that may now be billable under VHA's March 2004 guidelines, and bill where appropriate.

14. Part-Time Physician Time and Attendance (findings at 8 of 23 medical facilities)

- Require part-time physicians to obtain written supervisory approvals in advance of working adjusted schedules, and inform the timekeepers of approved schedule changes as soon as possible.
- Ensure appointments of part-time physicians are periodically evaluated and adjusted, as needed, to be consistent with workload requirements.
- Ensure part-time physicians' timecards are submitted and certified by responsible supervisors before timekeepers prepare official time and attendance records.

- Ensure Fiscal Service employees conduct annual refresher training for timekeepers, and perform annual timekeeper desk audits.

- Ensure part-time physicians provide timekeepers completed Subsidiary Time and Attendance Reports, and that the Employee Accounts Section staff review Subsidiary Time and Attendance Reports during the semi-annual desk audits. Also, ensure that unit timekeepers' supervisors receive feedback on timekeeping discrepancies.

- Document medical care provided or resident supervision in patients' electronic medical records to ensure proper workload credit is provided to part-time physicians.

15. Patient Funds (findings at 3 of 5 medical facilities)

- For patients who expire, require the disposition of Personal Funds of Patients (PFOP) accounts within 90 days after notifications of their next of kin or designees and document the notifications.

- Require PFOP clerks to check account balances before disbursing funds to prevent overdrafts. If overdrafts occur due to fault or negligence on the part of a VA employee, the employee is responsible for the overdrafts, and is required to reimburse the accounts of patients overdrawn.

- Annotate account identification cards to show patients' competency status.

- Maintain and use patient signature cards to verify that the signatures on deposit and withdrawal requests are legitimate.

16. Pharmacy - Controlled Substances Accountability (findings at 32 of 39 medical facilities)

- Conduct random monthly unannounced controlled substances inspections in all areas where controlled substances are stored.

- Account for and properly secure returned controlled and non-controlled substances.

- Order controlled substances for use by research laboratories in animal or human research through the Pharmacy Service, and ensure that all storage locations document storage and use of the drugs on VA Forms 10-2638 "green sheets."

- Verify five randomly selected dispensing activities on each unit (inpatient ward or outpatient clinic) during inspections.

- Account for unusable and expired controlled substances in monthly inspections to ensure that they are destroyed quarterly, and document the drugs awaiting destruction using the Drugs Held for Destruction Report.

- Resolve discrepancies in 72-hour pharmacy inventory checks, and maintain documentation for 2 years.

- Appoint controlled substances inspectors in writing for terms not to exceed 3 years.

- Establish controls to ensure that the Controlled Substances Inspection Program is operating effectively, and provide documented refresher training to all inspectors in the program.

- Ensure VHA and local controlled substances inspection policies are followed, including reporting requirements regarding the loss of controlled substances.

- Ensure the Controlled Substances Coordinator monitors the performance of inspectors by periodically observing monthly-unannounced inspections.

- Ensure that access to controlled substances storage sites is limited to less than 10 employees within a 24-hour period.

- Inventory controlled substances stored in ward refrigerators during changes of shifts.

- Use volumetric cylinders to measure all unsealed liquids during inspections.

- Use the prime vendor inventory management program to manage inventory levels of controlled substances.

- Require all controlled substances prescriptions awaiting outpatient pickup to be properly secured, and verify the identity of agents picking up controlled substances and other medications for patients.

- Require mailroom staff to sign for and secure packages containing controlled substances prescriptions

- Ensure separation of duties for ordering and receiving of controlled substances, and that both a Pharmacy Service and an A&MMS employee are the receipt witnesses.

- Ensure blank prescription forms are secured.

- Provide training to pharmacy and ward personnel on accessing the Controlled Substance Balance Report in the automated Pharmacy Production System.

17. Pharmacy - Physical Security (findings at 7 of 23 medical facilities)

- Report any suspected theft, diversion, or suspicious loss of drugs immediately to the VA Police and the OIG's Office of Investigations.

- Install keypad shields to prevent observation of access codes.

- Schedule monthly testing of panic buttons to ensure pharmacy security systems are operational, and that security employees promptly respond to all Pharmacy Service alarms and proceed to the appropriate location.

- Ensure that the electronic entry system for inpatient and outpatient clinic pharmacies meet VA requirements for monitoring and controlling access, and that the pharmacy electronic entry system has a bypass key, to maintain access security, should the electronic entry system become inoperable.

- Verify that controlled substances storage areas are constructed of brick and masonry for exterior walls or reinforce interior walls with a steel security screen mesh or sheet partition if the walls are constructed of wood frame and siding. Also, ensure that vault ceiling and ventilation areas are reinforced as required by VA policy.

- Store Schedule II controlled substances in safes or security containers that have burglary-resistant protections or, if this is impractical, the controlled substances may be stored in a vault that has a steel combination-lock door and a self-closing, self-locking day gate.

- Ensure the controlled substances vault door is locked when the pharmacy is closed.

- Store excess, outdated, unusable, and returned controlled substances in sealed containers.

- Verify that pharmacy dispensing windows are made of bulletproof glass, and that the walls surrounding them are constructed of concrete or similar material that would provide protection from firearms.

- Segregate pharmacy controlled substances prescriptions from other prescriptions while they are awaiting patient pick-up to reduce the risk of medication dispensing errors and drug diversions.

- Ensure annual physical security inspection reports are forwarded to Pharmacy Service managers so that corrective actions can be taken.

18. Physician Conflict of Interest (findings at 4 of 8 medical facilities)

- Ensure the Chief of Staff and each physician, clinician, or allied health supervisor or manager receive a copy of the VHA conflict of interest rules, and sign the conflict of interest acknowledgement form.

- Ensure that signed conflict of interest acknowledgement forms are filed in individuals' official personnel files.

Appendix A

OIG Contact

OIG Contact	Dennis Sullivan, OIG Audit Planning Division Phone Number (202) 565-4685

Appendix B

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on VA, HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

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