



Office of Inspector General

Combined Assessment Program

Review of the Southern Nevada Veterans Healthcare System

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**Office of Inspector General
Washington DC 20420**

Executive Summary

Combined Assessment Program Review of the Southern Nevada Veterans Healthcare System

1. The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Southern Nevada Veterans Healthcare System (System). The CAP team consisted of representatives from the OIG's Offices of Healthcare Inspections, Audit, and Investigations. The purposes of the CAP review were to: (a) evaluate issues/allegations referred to the OIG by a member of Congress based on complaints made to the General Accounting Office (GAO) during a review of a prior matter; (b) conduct a multidisciplinary team assessment of selected clinical and administrative operations, focusing on the quality of patient care and the effectiveness of management controls; and, (c) provide fraud and integrity awareness training to System employees.
2. The System utilizes several locations to provide a wide range of primary and secondary healthcare services. The System's headquarters and the main outpatient clinic is the Addeliar D. Guy III Ambulatory Care Center (ACC), a 164,000 square foot facility that opened in July 1997. Outpatient care is also provided at a Community Based Outpatient Clinic (CBOC) in Henderson, Nevada. In September 1999, a second CBOC will be opened in Pahrump, Nevada. Inpatient medical, surgical, and psychiatric care are provided at the Mike O'Callaghan Federal Hospital (MOFH), which was built as a joint venture between the U. S. Air Force and VA. Under the joint venture agreement, the Air Force administers the hospital and provides VA various support services that are reimbursed at cost. Of the MOFH's 114 beds, 52 are allocated to VA. VA paid personnel staff these beds. The System also operates a psychiatric day treatment center and an outreach center for homeless veterans.
3. An affiliation was established with the University of Nevada Medical School. A medical residency-training program is being developed, and beginning in July 1999 several medical residents will be assigned to work at the MOFH. The System operates under the jurisdiction of Veterans Integrated Service Network (VISN) 22, which covers Southern California and Southern Nevada. The Fiscal Year (FY) 1999 budget is \$60.1 million, a 8.4 percent increase over the FY 1998 expenditures of \$55.4 million. At the time of our March 1999 review, the System had an authorized staffing level of 546.5 full-time equivalent employees (FTEE) and had actual on-duty staffing of 474.9 FTEE. The Director had been in place for 4 years, the Chief of Staff for 11 months, and the Associate Director for 18 months.
4. The patient care workload has grown significantly in recent years, with the increase in outpatient care being particularly dramatic. In FY 1998, the System reported 198,608 outpatient visits, an 82.6 percent increase over the 108,761 visits reported 4 years earlier in FY 1994. The FY 1999 outpatient workload is projected to be 235,000 visits, which will be an 18.3 percent increase over the FY 1998 workload. The inpatient workload has also increased significantly. In FY 1994, when the MOFH opened, 177 patients were admitted. By FY 1998, the patient workload had increased to 2,037 admissions, and the FY 1999 workload is projected to be 2,239 admissions.

5. Our review of the referenced issues/allegations concluded that the four discussed below were substantiated and required management attention:

- **Long Waits for Clinic Appointments.** GAO reported allegations that patients had to wait too long for clinic appointments, particularly appointments in the specialty clinics. We confirmed that this problem existed. During FY 1998, 21 of the System's specialty clinics had waiting times for new patient appointments in excess of 30 days, and 7 had waiting times greater than 90 days. Management is working to address this issue by recruiting more clinical staff and by strengthening the medical school affiliation as a means of gaining physicians and residents to staff specialty clinics.
- **Uncorrected Construction Deficiencies in the Ambulatory Surgery Suite.** GAO reported an allegation that the VA's new Ambulatory Surgery Suite had not been put into service because of uncorrected deficiencies in the suite's air conditioning system. When we began our review in March 1999, management did not have an action plan for correcting the deficiencies and opening the Suite. This occurred because System staff and VISN engineering staff were not able to reach agreement about the nature of the deficiencies and the best way to correct them. To resolve the disagreement, we suggested that VA award a contract to identify, analyze, and correct the deficiencies. System and VISN management agreed to this approach. In April 1999, management prepared the statement of work for the suggested contract. If this contract is properly managed, the Surgery Suite should be open by November 1999.
- **Excessive Costs for Radiology Services.** GAO reported that certain employees had expressed concerns that VA might have paid too much for radiology and magnetic resonance imaging (MRI) services. This allegation was partially substantiated. The VA had negotiated reasonable contract prices for radiology/MRI procedures. However, improvement was needed in contract administration to ensure that payments were consistent with negotiated prices.
- **Unused EEG System.** GAO reported that VA had purchased a \$55,000 electroencephalograph (EEG) system for the Neurology Clinic but had not utilized it. The system had been requested in the belief that opening the ACC would lead to enough increase in EEG workload to justify an in-house capability, consisting of the EEG system and a technician to operate it. However, the anticipated workload increase did not occur, no technician was hired, and as a result, the EEG system was not utilized. At the time of our review, VA was exploring the feasibility of negotiating a sharing agreement with a community hospital to operate the EEG system at reduced rates, which could allow for the recovery of the cost.

These four issues are discussed in more detail in Appendices I and II of this report. In addition to these issues, we also reviewed allegations pertaining to sexual harassment, misuse of VA property, and management reprisals. These allegations will be discussed in a separate report.

6. The medical care Quality Program Assessment (QPA) identified several issues that required management attention, including recruiting more staff to meet the expanding workload,

reviewing the operation of the post-traumatic stress treatment program, improving the system for transporting patients to other VA medical centers for care, and providing employee training on violence prevention and management. (The QPA results are discussed in more detail in Appendix I.)

7. The management control review identified opportunities to improve operations by strengthening pharmacy security, properly scheduling controlled substances inspections and agent cashier audits, obtaining means test information from veterans, reducing excess inventories of supplies, revising information technology contingency plans, and pursuing employee debts. (Appendix II contains a detailed discussion of these issues.)

8. As part of the review, the CAP team conducted three Fraud and Integrity Awareness Briefings that discussed the recognition of fraudulent situations, referrals to the Office of Investigations, and the type of information needed in making a complaint or referral. (Appendix III contains more detail on the content of the briefings.)

9. In the Appendices to the report, we made recommendations that, we believe, warrant management attention. The Director concurred fully with 11 of the 12 recommendations and concurred with exception on one recommendation. The Director's comments and plans for corrective action are set forth verbatim in Appendix IV. The Director also clarified data relating to annual budget allocation and workload. We have made those changes in the report. The Office of Inspector General may follow-up at a later date to evaluate corrective actions taken.

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

Combined Assessment Program Description

The Combined Assessment Program (CAP) combines the knowledge and skills of the OIG's major components to provide collaborative assessments of Veterans Health Administration (VHA) medical facilities on a cyclical basis. Consisting of staff from the OIG's Offices of Healthcare Inspections, Audit, and Investigations, the CAP review team provides independent and objective evaluations of key facility programs, activities, and controls. A typical CAP review has three parts:

- Office of Healthcare Inspection (OHI) staff conduct a Quality Program Assessment (QPA), which is a proactive review that uses standardized survey instruments and medical record reviews to evaluate the quality of care provided by the facility. The purpose of the QPA is to determine the extent to which the facility is accomplishing its mission of providing high quality care and improving access to care, with high patient satisfaction.
- Office of Audit staff perform limited reviews of selected administrative activities to ensure that management controls are effective. The activities reviewed are selected by analyzing various types of management information maintained by VHA, the Veterans Integrated Service Network, and the facility.
- A special agent from the Office of Investigations conducts a Fraud and Integrity Awareness Briefing. The purpose of this briefing is to provide key facility employees with insight into the types of fraudulent activities that can occur in VA programs. The briefing includes an overview and case-specific examples of fraud that can affect healthcare procurements, false claims, conflicts of interest, bribery, and illegal gratuities.

In addition to this typical coverage, a CAP review may include investigation or evaluation of issues or allegations that have been referred to the OIG by VA employees, members of Congress, veterans' service organizations, or others.

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Quality Program Assessment

Objectives and Scope

The objectives of the review were to (a) determine if two issues/allegations pertaining to poor health care service and quality of care were substantiated; and (b) conduct a quality assessment of the System's overall delivery of healthcare services.

The Quality Program Assessment (QPA) process provides a balanced perspective of a VA healthcare System's ability to provide safe, effective patient care to the greatest possible number of eligible veterans. The QPA uses structured survey instruments to assess the adequacy and efficiency of key operating elements and their ability to provide or support healthcare delivery.

OHI inspectors reviewed numerous quality assurance documents and 40 medical records and inspected all the System outpatient and inpatient treatment facilities. Inspectors also interviewed executive managers, 19 clinical managers, 75 clinicians, veterans service officers (VSOs) from 5 veterans service organizations, and 131 patients. We distributed questionnaires to 160 full-time employees whom we randomly selected from the System's staffing roster. The questionnaires return rate was 57 percent. We also interviewed several patients and employees who asked to be interviewed, in order to elicit their concerns regarding patient care.

Results

Executive Management Planning and Oversight

The System's top management team consists of the Director, the Chief of Staff (COS), the Associate Director (AD), and the Chief Medical Officer (CMO) of the MOFH. The Southern Nevada Healthcare System consists of a free-standing ACC, a CBOC, a Psychiatric Day Treatment Center, a Homeless Veterans Center, and a joint venture agreement for the provision of inpatient primary and secondary care with the Air Force at the MOFH. All non-emergent tertiary inpatient care is provided by Southern California VA medical centers in VISN 22 (Long Beach, Loma Linda, San Diego, and West Los Angeles). Emergency care is provided at the MOFH. The complexity of the System, in combination with the distance from the other VISN 22 facilities and a rapidly expanding patient population, pose a number of challenges in planning and oversight activities.

Executive managers report that resources are not adequate for the significant increase in workload that the System is experiencing. Therefore, managers at all levels are encouraged to examine their administrative processes to ensure clinical efficiency before requesting increased resources. Specifically, executive managers ask mid-level managers to clarify and prioritize needs, avoid duplication of efforts, and expedite recruitment of physicians and nursing employees.

Executive managers told us they have had a difficult time recruiting qualified physicians for vacancies. The COS is working with officials at the University of Nevada Medical School at Las Vegas to establish medical and surgical residency programs. This will increase the number of specialists who are available to treat VA patients. At the time of our visit, medical residents were scheduled to start working on July 1, 1999, and surgical residents were to start on July 1, 2000.

Executive managers initiated a mentoring program in which managers and supervisors work with their employees to develop leadership skills. This has improved communications, and managers hope it will provide current employees with the training needed to assume future leadership positions. Executive managers also established performance improvement measures that are designed to assess current operating procedures with the goal of reducing duplication and redundancy. For example, managers found duplicate and unnecessary patient care and administrative efforts in the specialty consultation process. Corrective actions significantly reduced the backlog of consultation requests.

The Director stated, and interviews confirmed, that he is involved in activities designed to facilitate effective communication among executive managers, employees, and patients. He conducts quarterly employee and patient Town Hall forums; and periodically stages “rallies” that are open to all System employees. The format of these latter meetings is casual and designed to encourage employee ownership of VA performance measures. The Director is also involved in the community and attends regularly scheduled meetings with veterans service officers to share information and concerns. The Director has an open door policy and he encourages patients and employees to discuss their concerns and ideas regarding patient care with him or in writing.

We interviewed the Commanding Officer (CO) at the MOFH. On the whole, he feels that the joint venture between the U. S. Air Force and VA has benefited both organizations. He told us that VA and Air Force managers meet weekly to discuss and plan oversight and review activities. The CMO at the MOFH is the liaison between VA and System managers and clinicians. Her job is to “troubleshoot” and effect or recommend correction of issues identified by VA clinicians and managers.

VISN 22 managers provide administrative oversight and management of the System and its current programs. VISN managers are working closely with System managers to address the rapidly increasing outpatient workload and associated waiting times for primary care and specialty clinics.

Impediments to Ensuring Access to High Quality and Timely Care

Outpatient Clinic Waiting Times Need Continued Attention. The System's patient care caseload is growing rapidly. In Fiscal Year (FY) 1994, the ACC's first year of operation, the facility reported 107,671 outpatient visits. In FY 1998, the System reported 198,608 outpatient visits, and managers project 235,000 outpatient visits for FY 1999. The MOFH treated 177

inpatients in FY 1994, 2,037 inpatients in FY 1998, and project that they will treat 2,239 inpatients in FY 1999.

The outpatient care growth rate, in particular, is posing a significant challenge to health care employees. Managers, clinicians, and patients told inspectors that waiting times for scheduled appointments in primary care clinics, specialty clinics, and for radiology procedures are excessive and need improvement. Our patient interviews confirmed that 58 percent of the patients are rarely/never able to schedule a non-emergent appointment with their primary care provider within 7 days, and 50 percent of the patients were rarely/never seen by a specialist within 30 days of referral.

During FY 1998, 21 outpatient specialty clinics had waiting times, for the next available new patient appointments, in excess of 30 days. Seven of these 21 clinics had waiting times greater than 90 days (Cardiology - 101 days; Dermatology - 128 days; Gastroenterology - 151 days; Neurology - 173 days; Orthopedics - 202 days; Pain - 185 days; and Sexual Trauma Counseling - 132 days).

Executive managers are aware of these concerns, and are working to address the issues. Management actions to date include: recruitment of five primary care physicians, two of whom specialize in cardiology and neurology; recruitment of two radiologists; and establishment of medical and surgical affiliations with the medical school which will also increase the number of clinical staff available in both primary care and specialty clinics. Executive managers are also considering extending the ACC's operating hours to include evening and weekend appointments.

In view of the outpatient workload, the timeliness of outpatient care is an issue that needs additional VISN and System management attention.

Significantly, 73 percent of the clinicians that we interviewed told us that patients were rarely/never seen by their providers within 30 minutes of their scheduled appointments. Clinicians attribute the delays in seeing patients to the fact that, in addition to a full schedule of patients, each Primary Care Unit (PCU) is expected to see up to 15 walk-in patients. Managers told us that this expectation stemmed from the need to reduce workload in the Walk-in Clinic.

OHI does not believe adding walk-ins to the already heavy PCU workload is an adequate solution for correcting the patient dissatisfaction problem. Managers need to assess this issue and develop a plan that will decrease the number of walk-ins, instead of shifting the workload to the PCUs.

Waiting Times for Prescriptions and Special Procedures Need Improvement. Forty-eight percent of the patients whom we interviewed told us that outpatient prescriptions are not available from the pharmacy within 60 minutes. Patients told us that they frequently had to wait up to 2 hours to pick up their medications. We asked patients why they did not use the prescription mail-out system, and the most common response was that the mail-out program took too long and engendered too many errors. Patients also complained that it is difficult to submit an outpatient prescription. Patients must submit their prescriptions on the second floor of the pharmacy area, but are required to pick the medications up on the first floor. This is often

difficult for handicapped and elderly patients. Managers are aware of these and other problems within Pharmacy Service and have requested a team of experts to assess the efficiency and effectiveness of Pharmacy Service operations.

While on site, patients who asked to be interviewed told us that waiting times for scheduled radiology procedures are excessive and that Radiology Service employees are often rude. Managers were also aware of these issues and, as discussed above, have hired two new radiologists, one of whom will serve as service chief. The COS told us that the two physicians are aware of these and other operational issues that will require their immediate attention.

Delays in Scheduling Biopsies and Follow-up on Laboratory Test Results. Several patients who asked to be interviewed told us that they had experienced long delays in scheduling biopsies, especially prostate biopsies. Managers told us that urology services are available only on a contract basis. The contract urologists see patients at the ACC 1 day each week. Managers are aware that this is not adequate for their patient mix and workload, and are exploring other avenues for obtaining urology services. Managers have established a goal of 30 days as an acceptable waiting period for prostate biopsies.

Patients alleged that there are delays in obtaining laboratory test results from their providers. We discussed this issue with managers and they were aware that delays had occurred. They told us that they were evaluating the use of alert mechanisms that would notify providers of abnormal test results so that the providers could contact their patients.

Staffing Issues Related by Employees. During our review, a number of managers, supervisors, and employees asserted that they need staff, or they need to achieve more with available employees. Fifty-two (46 percent) of the patients whom we interviewed told us that there did not seem to be enough employees to meet their medical needs and to answer their questions. Forty-three (59 percent) of the clinical employees whom we interviewed told us they did not have enough time to spend with patients who are anxious or in need of emotional support.

According to a March 1999 Strength Report, the authorized full-time employee equivalent (FTEE) staffing level was 546.575, with an actual FTEE on duty of 474.875. Managers reiterated that they have difficulty recruiting physicians and nurses because of competing opportunities available to these professionals in the Las Vegas area. We made several observations regarding the lack of staffing that could affect the quality of patient care. We offer these observations for consideration in developing staffing priorities.

VA clinical employees on the Medicine/Surgery and Psychiatry Units at the MOFH told us that nurse staffing is not adequate to provide appropriate and timely treatment. Nurses are often required to remain on duty past their normal tours of duty, to complete clinical assignments. They complained that use of vacation time is limited. Many nursing employees feel pressured about their workloads or, more significantly, that their ability to attend to patient needs is at times inadequate. Nursing employees told us that neither the Chief nor the Associate Chief of Nursing Service makes regular rounds at the MOFH and may not be aware of the potential negative impact that staffing deficiencies can have on patient care. The CO at the MOFH declined comment on the appropriateness of the number of VA nursing employees, but he was aware of the number of vacant nursing positions. He attributes the vacancies to difficulties in

recruiting civilian health care professionals in Las Vegas. The CO told us that the MOFH received high scores on their most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey and did not receive any deficiency citations.

Currently, the ACC has four PCUs. Three of the PCUs have one team leader and the fourth has two team leaders. The team leaders told us that they do not have enough employees assigned to the PCUs to treat all the patients who need treatment. Team leaders told us that primary care providers frequently take patients' vital signs and escort patients into the examination rooms because nursing employees are not available. Team leaders believe that insufficient staffing is the major cause for the long waiting times for obtaining appointments and being seen for scheduled appointments.

Executive managers told us that physician primary care patient panel sizes should be 1,000 unique patients and that the nurse practitioner (NP) and physician assistant (PA) panel sizes should be 500 unique patients. Physicians told us, however, that their panel sizes are increasing and patients told us they have waited up to 7 months after enrollment for their first PC clinic appointment. Managers are aware of these workloads and appointment delays and, as stated above, have recruited five physicians to work in primary care. Managers also plan to add a fifth PCU.

We reviewed the Nursing Service FTEE Calendar Year Data report for the 26-month period from January 1997 to April 1999. Nursing Service managers hired 50 new employees and lost 26 employees during this 26-month period. The service is still well below ceiling, but managers are actively recruiting and hiring additional nursing personnel.

Fifty percent of the randomly selected employees whom we surveyed disagree or strongly disagree that there is sufficient staff in their work areas to provide care to all patients who need care.

In view of the System's workload growth, active recruitment of qualified physicians and nursing employees is an issue that needs additional VISN and System management attention.

Post-Traumatic Stress Disorder (PTSD) Treatment Needs Improvement. Several ACC patients who receive treatment for PTSD asked to be interviewed. The patients alleged that they do not receive appropriate treatment for their PTSD conditions. They alleged that they receive too much medication and not enough group therapy. They told us that if they report that they are experiencing symptoms, clinicians always just give them more medications. The patients also complained that the PTSD group therapy rooms are too small to accommodate comfortably the entire group. Since patients perceive that they are not receiving proper treatment for their PTSD conditions, we recommend that the System Director request a VA team with expertise in PTSD treatment to review the System's PTSD program and make recommendations, as appropriate.

Alleged Excessive Narcotic Prescriptions for Pain Management Patients. Employees who asked to be interviewed alleged that patients enrolled in the Pain Clinic receive excessive doses of narcotics. This issue was addressed by the Pain Clinic treatment team before our review, and the treatment team found that several patients were receiving controlled substances from multiple providers outside the System. Treatment team members met with these patients and concluded

that some of these patients should be discharged from the Pain Clinic and others needed to enroll in the Alcohol and Drug Treatment Program. Team members also initiated tighter controls on patients who receive pain medications. For example, if patients have drug screens that are negative for the controlled substance they are receiving, medications are discontinued and the patients are discharged from the Pain Clinic.

ACC Bathrooms Are Not Handicapped Accessible. Several patients who asked to be interviewed told us that while the ACC bathrooms have automated handicap access, this access is usually not activated. We discussed this issue with executive managers and they assured us that all bathrooms are handicapped accessible. However, because of the time it takes for the doors to close, non-handicapped patients and employees continually deactivate the mechanisms. The Director has and will continue to stress the importance of keeping the mechanisms activated.

The VISN Transportation System Needs Improvement. VISN 22 in-patient facilities include four tertiary care Southern California facilities and MOFH, a secondary care facility. Therefore, when Las Vegas patients need non-urgent tertiary care or special procedures, they need to travel to one of the Southern California facilities. Patients complained about the time (approximately 5 hours each way) and the cost associated with this travel. They allege that travel funds for eligible veterans are not sufficient to pay the round trip bus ticket from Las Vegas to California and the transportation to and from the bus station to the facility.

We think that this is a serious VISN issue that needs immediate attention because Las Vegas veterans' access to care may not be comparable with veterans who are enrolled at other VISN 22 facilities. We recommend that managers develop a VISN-wide transportation policy that will ensure equity for all patients.

Employees Need Training on Violence Prevention and Management. Employees perceive that the number of patients who threaten violence in the outpatient clinics has increased. Several clinicians told us that there are certain patients who frequently exhibit threatening behavior and that employees are very uncomfortable being alone in examination rooms with these patients. These employees alleged that because managers have not taken appropriate actions to manage these patients' abusive behaviors, the patients continue to threaten employees. Employees feel that managers do not properly support them when they allow this type of "employee abuse" to continue.

Fifty-two percent of the employees whom we surveyed that were involved in direct patient care had not received violence prevention and management training. Several employees who asked to be interviewed also told us that they had not received violence prevention and management training.

Because several ACC employees perceive that patient violence is increasing, OHI recommends that clinical managers provide violence prevention and management training for all employees who are involved in direct patient care.

Mammography Services Appear to Be Adequate. An employee expressed concern that the ACC does not offer mammography services. The employee alleged that female patients will not go to contract facilities for mammography. Mammography services are provided on a contract

basis at three community facilities and will soon be offered at the MOFH. Female patients whom we interviewed told us they were pleased with the services they received at the contract facilities and did not feel that lack of mammography services at the ACC was a deterrent to women for receiving the examinations.

OHI believes that, with adequate mammography services available on a contract basis, managers may not need to purchase a mammography device or hire mammography staff for the ACC. In order to determine the most cost effective manner of providing these services, a cost comparison should be undertaken.

CBOCs Provide Primary Care in the Community, Thereby Improving Access to Care and Patient Satisfaction

The System's community based outpatient clinic programs include the Mobile Assistance Services to Veterans which is primarily a VA Homeless Outreach Program, operating as the Mash Village Homeless Center (MVHC) and the Henderson Clinic, a primary care provider. An OHI inspector visited these two clinics and the Psychiatric Day Treatment Center (Arville House), which provides supportive day treatment to chronic psychiatric patients who live in the community.

The MVHC focuses on providing outreach assistance and services where homeless veterans are located. Clinical services include preventive health care assessment and education; mental health and substance abuse assessments and counseling; individual, group, and family therapy; residential rehabilitation referral; and case management of referrals from the ACC and MOFH. Clinicians told us that they see 25 to 30 homeless veterans each month.

The Henderson CBOC provides primary care and treatment services to approximately 1,500 Southern Nevada and Northern Arizona veterans. The CBOC offers limited on-site laboratory and radiology services and is operated by a contracted healthcare provider organization, under the direction of the System. The waiting time for a first appointment is between 24 and 48 hours. OHI has two concerns regarding the Henderson CBOC. First, at the time of our visit, the NP position was being terminated because clinician panel sizes do not support the need for the NP position. However, a Veterans Health Fair was scheduled, in part to increase the primary care enrollment at the CBOC. Second, CBOC space is inadequate for the current workload. With any increase in workload, patient flow and patient privacy may be compromised. Healthcare System managers need to assess these two issues to continue to provide accessible quality health care services at the Henderson CBOC.

Arville House has a daily attendance of 20 patients with the length-of-stay averaging from 9 to 18 months. During FY 1997, Arville House treated 110 patients. Most patients treated had significant clinical acuity, a psychiatric diagnosis that was considered to be severe and/or chronic, and a history of multiple admissions for psychiatric hospitalization. Seventy-two percent of the active patients have a psychiatric co-morbidity and are rated as high risk for psychiatric readmission. The rate of readmission for Arville House patients was three percent in 1998. This compares favorably to an anticipated readmission rate of 10.7 percent in VISN 22 and a 12.8 percent national readmission rate.

Clinical Manager, Clinician, and Patient Survey Results

Clinical employees and patients generally told us that:

- Employees are courteous.
- Patients are involved in decisions regarding their health and treatment needs.
- Patient and family education is provided and is understandable.
- Patients can identify their primary care provider.
- Patients privacy needs are met.
- The facility is usually clean.
- System signage is easy to read and understand.

We asked patients and clinicians if they would recommend this facility to a VA eligible family member or friend. Seventy of 116 patients (60 percent) said that they would recommend medical care at this facility all or most of the time. However, less than half of the clinicians, 27 of 56, (48 percent) said that they would recommend medical care at this facility all or most of the time.

VSO Patient Care Concerns

Inspectors interviewed representatives of American Veterans, Blind Veterans Association, Disabled American Veterans, Jewish War Veterans, Veterans of Foreign Wars, and the State of Nevada Commission for Veterans Affairs. All of the VSO representatives whom we interviewed told us that they are grateful to have the System, and they praised the mission of the facility and the dedication of most ACC and MOFH employees. The VSO representatives all told us that their clientele are very concerned with the long waits for clinic appointments. They also told us that they are concerned that staffing at the ACC and the MOFH is not adequate to provide treatment to all the patients who need care. The VSO representatives told us that the ACC is too small to accommodate the rapidly expanding patient population. They also expressed concerns regarding what appears to be an increased sense of frustration among their clientele and System employees resulting in poor communication and a sense of adversarial contentiousness among patients and employees, and among clinicians and managers. Following are some specific concerns raised by the VSO representatives:

- The ACC does not have scheduled evening or weekend clinic appointments.
- Handicapped door access at the ACC does not always operate properly.
- Patients are not always notified of clinic appointment cancellations.
- Employees are not properly trained to work with blind patients.

- Nursing employees at MOFH are required to perform non-nursing duties such as passing out food trays and are, therefore, not available to answer call lights.

Employee Questionnaire

The vast majority of employees who responded to the confidential OHI questionnaire indicated that they believe they are qualified to do their jobs and agree or strongly agree that, directly or indirectly, their jobs contribute to improving patient satisfaction. More than 60 percent agree or strongly agree that most of the time they have manageable workloads. However, 64 percent agree or strongly agree that they cannot be totally efficient because of inadequate resources. Only 42 percent agree or strongly agree that recognition and awards adequately reflect performance.

Sixty-six percent feel safe coming to and leaving work, and 61 percent agree or strongly agree that they feel safe from physical harm in their work areas. Sixty-one percent of the surveyed employees who are involved in direct patient care reported that they receive annual TB testing. Fifty-six percent of these employees had been offered Hepatitis B immunizations, and 64 percent told us that they are offered annual flu shots.

Sixty-one percent of the surveyed employees agree or strongly agree that sometimes incompetence is encouraged and rewarded, and 59 percent agree or strongly agree that who you know is what counts, not what you know. Fifty-eight percent disagree or strongly disagree that the System offers equal opportunity when hiring and promoting. Managers should assess these practices to ensure equitability.

Quality Management Issues

Medical Record Review. OHI inspectors reviewed a random sample of 40 medical records. We assessed 20 patients' last ambulatory care visits; 11 patients' last full year of outpatient visits; and 9 patients who died within 24 hours of admission. We assessed the terminal care that clinicians provided to these latter nine patients. We found that clinicians properly recorded patient care and the patients' conditions. However, consultations were not always promptly completed. We concluded that medical care generally appeared to be good.

Patient Incident Reports. We reviewed Reports of Special Inquiry Involving a Beneficiary (VA Form 10-2633) for the last three quarters of FY 1998. Employees properly reviewed all of the reported patient incidents as required by VHA policy.

Peer Reviews and Mortality and Morbidity (M&M) Reviews. We reviewed 18 cases that resulted in peer reviews and 7 M&M reviews. Clinical employees conducted the reviews according to VHA policy. Review conclusions, corrective actions, and follow-up assessments were consistent with the investigative findings.

Administrative Boards of Investigations (BOIs) and Focused Reviews. We reviewed the summaries and recommendations of 4 BOIs and reviewed 20 Focused Reviews. The BOIs were appropriately conducted when there was a high probability that investigators might recommend

disciplinary actions. For example, managers conducted BOIs into such issues as misuse of government property, missing patient funds, employee misconduct, and patient abuse. The conclusions, recommendations, corrective actions, and follow-up assessments on each review were consistent with the investigative findings.

Clinical managers appropriately conducted Focused Reviews on all incidents and/or unplanned clinical occurrences that resulted in or had the potential to cause major patient injury. The Focused Reviews followed the root-cause analysis protocol, and the conclusions and recommendations were consistent with the findings.

Controlled Correspondence

We reviewed controlled and congressional correspondence for FY 1998. The System maintains a status file of all correspondence that is received from patients or their significant others, and congressional correspondence related to a complaint or concern expressed by or for a patient. During FY 1998, and to date in FY 1999, the System received 120 items of controlled correspondence and 121 congressional inquiries. Most of the congressional correspondence followed up on controlled correspondence that patients or their significant others had initiated. Issues raised in the correspondence include inquires regarding eligibility for veterans benefits, information requests for employment, payment of bills for ambulances and emergency medical treatment, and difficulties receiving medical care. Managers categorize, track, and answer each piece of correspondence. The most frequent issue raised by the correspondents related to long waits for appointments.

Physical Plant Tour

Inspectors toured the ACC, the MOFH's VA wards, both CBOCs, and the Psychiatric Day Treatment Center. The ACC was generally clean and odor-free. However, waiting areas did not appear to have adequate seating to accommodate all of the patients waiting to be seen in clinic. Patients were sitting on the floor, standing, and leaning against the walls. Exits were clearly marked, signage was visible and legible, and fire alarms were visible and accessible. However, there did not appear to be adequate auditory privacy in the pharmacy area for patients to discuss medication concerns. During normal business hours, trained greeters are stationed at the ACC entrance to welcome and direct patients.

The MOFH's VA wards (hallways, patient rooms, nursing stations, and bathrooms) were clean and odor-free. The patient and public bathrooms were clean, wheelchair accessible, and adequately stocked with paper towels, toilet paper, and soap.

The Henderson CBOC is a clean, well-maintained, but small clinic located in an office building. Any significant increase in this CBOC's caseload may well overwhelm the existing space and compromise patient privacy. The MVHC is located in an area of Las Vegas that is frequented by homeless veterans. The five offices that are designated for MVHC operations are in an older building that houses local, state, and Federal government agencies. The space, donated to the VA, appears clean and adequate for the patient workload. Arville House is located in a rented house in a residential area. Day treatment patients are responsible for maintaining the home, and each patient is assigned a job that is a part of his/her ongoing therapy.

Summary of Recommendations

We recommend that:

1. The System Director establish process action teams to:

a. Assess the causes of excessive waiting times for prescriptions and special procedures, and reduce waiting times to acceptable limits.

b. Study the reasons why increasing numbers of patients visit the Walk-in Clinic for treatment, and recommend actions to decrease the number of walk-in patients who have been diverted to the already heavy PCU workload. One option may be to develop such procedures as telephone nursing triage.

a. VASNHS Response: Concur.

Process Action Teams and independent clinical reviews of these functions have resulted in recommendations to provide greater efficiencies and enhance customer service. We continue to assess the causes that are considered contributing factors for excessive patient waits in Pharmacy Service, Radiology Service and a number of Subspecialty Clinics.

Pharmacy Service

Action: Redesign existing Pharmacy space on the second floor to accommodate patient waiting room area and to provide a single point of access for medical drop off and pick up.

Status: Space redesign and Statement of Work is complete. Renovation should be completed during FY99.

Action: Obtain an independent review of Pharmacy operations.

Status: Accomplished. An implementation plan with timelines are being developed.

Action: Utilize available Consolidated Mail Out Pharmacy capability to the maximum extent.

Status: Ongoing.

Action: Continue to provide sufficient FTE to staff each primary care team with a “team pharmacist” position to maximize prescription entry and minimize patient waiting times.

Status: In place.

Radiology Service

Action: Provide additional clinical staffing at the ACC and MOFH.

Status: Accomplished. Two additional Radiologists were hired (Dr. Correa, Acting Chief of Radiology 4/99, (replaces Dr. Marta Chaplynsky, former Chief, Radiology Service). Dr. Darrah, Staff Radiologist 6/99.

Action: Provide additional Radiology staffing support.

Status: Accomplished. New additions include a program assistant, file room clerk, service secretary and administrative officer.

Action: Provide for the timeliness of special procedure examinations.

Status: Accomplished. The Radiology Service has developed contingency planning to provide additional staffing for special procedures when emergent/urgent studies precede scheduled examinations.

Action: Provide customer service training.

Status: Accomplished. Two 16-hour mandatory customer service training programs have recently been conducted at this Healthcare System for all employees. To date, 408 have graduated from this program.

Action: Joint acquisition of shared MRI equipment.

Status: Accomplished. In addition, requests for all MRI studies are reviewed for clinical appropriateness prior to acceptance to ensure greater availability and timeliness of scheduled studies.

Subspecialty Clinics

It was reported that during FY 1998, 21 subspecialty clinics had waits in excess of 30 days and that seven others had waits of 90 days. Within the past 90 days, data reflects significant improvement. Presently, waiting times in numerous subspecialty clinics have been minimized to reflect as few as nine clinics with waits in excess of 30 days and four with waits beyond 90 days. The reason for this significant reduction in patient waiting times is attributed to the expansion of existing subspecialty clinic operations, establishing consult referral criteria, utilization of available contracted physicians, creative recruitment and/or hiring practices in partnership with the University of Nevada School of Medicine (UNSOM).

b. VASNHS Response: Concur.

A limited Telephone Link Care (TLC) Program was established in FY98 and recently expanded and linked to the VISN 22 TeleCare Program to provide VISN-wide 1-800 service twenty-four hours a day, seven days a week. Similarly, in March a Nursing Triage Program was implemented in an effort to more appropriately manage our walk-in patient workload. This new process has worked well to redirect and re-educate walk-in patients. Patients who require emergent or urgent care are referred directly to our Evaluation Unit; those who are not emergent or urgent but require a same day appointment are given an appointment with their PCT provider; and those with routine conditions are given appointments with their PCT provider within one to three days. Patients do not receive primary care services in the Evaluation Unit.

2. The Director request a VA team with expertise in PTSD treatment to review and make any appropriate recommendations.

VASNHS Response: Concur.

We will initiate a formal request to have clinical professionals with expertise in PTSD review our existing program.

3. The Director ensure that clinical managers provide violence prevention and management training for all employees who are involved in direct patient care.

VASNHS Response: Concur.

Violence in the Workplace mandatory training was conducted in April and was repeated again during the month of June. Additionally, existing policies and procedures pertaining to our Committee on Disturbed Behavior are currently being reviewed.

4. The Director assess the adequacy of Henderson CBOC space, in the context of an expanding workload, and reconsider the advisability of terminating any clinical positions that may be needed to manage the expected increased workload.

VASNHS Response: Concur with exception.

At the present time, space at the Henderson CBOC is adequate to serve its 1500 enrollees. We are currently reviewing a proposal from the contractor (Foundation Health Federal Services) to increase the size as well as the workload from 1500 to possibly as high as 2000 enrollees.

We did not concur that any existing contract CBOC staff should be terminated. Action was taken independently by Spectrum Health Care (a subcontractor of Foundation Health Federal Services) to terminate the Nurse Practitioner position. Negotiations are currently underway to have this position reinstated. Our internal standards of clinical practice dictate that physician panels should be no larger than 1000 patients per physician provider.

5. The Director, VISN 22, should develop a VISN-wide transportation policy that will ensure equity of access for all patients.

VASNHS Response: Concur.

At present, a VISN-wide transportation policy exists. However, because of various patient eligibility constraints, many veterans who are required to utilize network facilities are not eligible for travel. While there is a local facility policy in place, because of system-wide eligibility constraints, we cannot ensure equity of access. We are addressing this problem, utilizing the DAV's Transportation Network, developing VISN-wide policies and procedures to implement the "American Veterans Medical Air Lift Program" (AVMAS), and by reviewing a proposal for furnishing and staffing a "veterans shuttle" to transport veterans to network facilities who are otherwise not covered by the existing VISN-wide transportation policy.

Management Control Issues

Objectives and Scope

The Office of Audit's review consisted of two parts, an evaluation of four management issues/allegations and a review of selected administrative activities and management controls.

The objectives of the review were to determine if: (1) the four issues/allegations referred by GAO were substantiated; and (2) selected administrative activities operated effectively.

We reviewed the following four management issues/allegations:

- The U.S. Air Force had overcharged for services provided under the joint venture agreement.
- The new Ambulatory Surgery Suite was not put in service because of uncorrected deficiencies in the suite's heating, ventilating, and air conditioning (HVAC) system.
- The System had purchased an electroencephalogram (EEG) that was not used.
- The System may have paid too much for contract radiology and magnetic resonance imaging (MRI) services.

We reviewed the following 12 administrative activities and management controls:

Clinical Services Contracts	Medical Care Cost Fund
Medical Insurance Billing and Collection	Supply Inventory Management
Equipment Procurement and Accountability	Purchase Card Program
Pharmacy Security	Information Technology Security
Controlled Substances Inspections	Employee Accounts Receivable
Agent Cashier Operations	Telephone Personal Identification Number (PIN) Security

The review covered operations for FY 1998 and the first two quarters of FY 1999. In performing the review, we inspected work areas, interviewed management and staff, and reviewed pertinent administrative, financial, and clinical records.

Results

Management Issues and Allegations Reviewed

We concluded that the allegation pertaining to VA's joint venture reimbursement was not substantiated and that the allegations pertaining to radiology/MRI contracts, the Ambulatory Surgery Suite, and the EEG system were substantiated. These four issues are discussed below.

VA Reimbursement to the Air Force Under the Joint Venture

An allegation was made that the Air Force was charging too much for the services it provided to VA under the joint venture agreement. This allegation was not substantiated. The Air Force's charges were reasonable, and we found no evidence of overcharges. The System's total cost for providing inpatient care under the joint venture was less than if the same number of bed days of care had been provided in other VA facilities or in community hospitals.

Background. The MOFH was constructed under a joint venture agreement, with the Air Force contributing about 89 percent of the construction costs and VA contributing the remaining 11 percent. The hospital has 114 beds, of which 52 are designated as VA beds (36 medical/surgical, 2 intensive care/cardiac care, and 14 psychiatric). The System provides most of the direct care staff for the designated VA beds. The Air Force operates the hospital and provides various kinds of clinical and administrative support services for the VA beds.

The Air Force and the System have agreed that charges for support services provided for VA beds will be based on a Department of Defense medical care cost accounting program called the Medical Expense Performance Reporting System (MEPRS). MEPRS is a computer-based costing methodology that establishes hospital functional area costs per occupied bed day, outpatient visits, and time spent in intensive care.

In FY 1998, the total cost for care provided at the MOFH was \$11.9 million. Of this amount, \$7.8 million (65.5 percent) was the cost for staffing the 52 beds. The remaining \$4.1 million (34.5 percent) was paid to the Air Force for the services it provided under the joint venture. To put the Air Force reimbursement in perspective, the \$4.1 million represented only 7.4 percent of the VA's \$55.4 million total FY 1998 expenditures.

Results of Review. To determine if the reimbursement was reasonable, we reviewed the Air Force joint venture bill for the month of September 1998. (The September bill was the most recent complete bill that the System had received. The bills are similar for each month.) We did not find any indication of charges that were unreasonable or unfair to VA. The largest proportion of charges (\$2.8 million of \$4.1 million) was for the VA's share of direct ward operation costs such as pharmacy, radiology, and laboratory services. The remaining charges were for direct and indirect costs associated with a wide variety of hospital support activities such as building maintenance, housekeeping, food preparation, and emergency room services.

To evaluate further the reasonableness of costs for providing care under the joint venture, we compared these costs to two benchmarks, the cost of care in VA medical centers and the cost of care in community hospitals. These comparisons showed that the joint venture costs were lower than both these benchmarks:

- In FY 1998, the MOFH provided 12,501 bed days of care under the joint venture (medical bed days = 8,011; surgical bed days = 1,011; psychiatric bed days = 3,479). As stated above, the MOFH's total cost for this care, including both VA staff costs and the Air Force reimbursement was \$11.9 million. VA publishes national average billing rates that reflect the costs of providing care in VA facilities. Based on these billing rates, if the same number

of bed days of care had been provided in VA facilities, the cost would have been about \$13.8 million, or \$1.9 million (16.0 percent) more than the joint venture costs.

- The VA's Fiscal Service developed data on the cost of care in local community hospitals. Based on this data, if the System had contracted with the lowest cost community providers, the cost of 12,501 bed days of care would have been about \$14.5 million, or \$2.6 million (21.8 percent) more than the \$11.9 million cost under the joint venture.
- The joint venture costs for a medical and a surgical bed day of care were significantly lower than both VA billing rates and community hospital costs. To illustrate, the joint venture cost for a medical bed day of care was \$867 versus a VA billing rate of \$1,208. For a surgical day of care, the joint venture cost was \$1,906 versus a billing rate of \$2,079.
- For a psychiatry bed day of care, the joint venture cost of \$867 was significantly higher than both the VA billing rate of \$577 and the community hospital cost of \$470. However, this higher cost was not caused by Air Force charges for support services under the joint venture. Instead, it was attributable to the costs VA incurred for staffing the psychiatric ward. Of the \$867 per day cost, Air Force support services accounted for only about \$161 (18.6 percent). VA staff costs accounted for the remaining \$706 (81.4 percent).

System management had recognized the need to reduce psychiatric care costs and had begun exploring the feasibility of contracting with a community psychiatric hospital and then converting the psychiatric beds to additional VA medical and surgical beds.

Conclusion. The Air Force's charges for joint venture support services were reasonable and fair, and the joint venture is a cost-effective way for VA to provide care to veterans. To make the joint venture more cost-effective, System management should follow through with efforts to reduce psychiatric care costs.

Uncorrected HVAC Deficiencies in the Ambulatory Surgery Suite

An allegation was made that the new Ambulatory Surgery Suite had not been put into service because of uncorrected deficiencies in the suite's HVAC system. This allegation was substantiated. When we began our review in March 1999, management did not have a definitive action plan for correcting the deficiencies and opening the Suite. This occurred because System staff and VISN engineering staff had not been able to reach agreement about the nature of the deficiencies and about the best way to correct them. To resolve the disagreement, we suggested that the System award a contract to identify, conclusively and comprehensively analyze, and correct the deficiencies. System and VISN management agreed to this approach. In April 1999, the System prepared the statement of work for the suggested contract. If this contract is properly managed, the Surgery Suite should be open by about November 1999.

Background. In September 1995, the System signed a lease agreement to design and build the ACC. VA approved and accepted the ACC construction work in phases as it was completed. The 17,000 net square foot Ambulatory Surgery Suite was accepted in February 1998. However, after the construction work was accepted, staff identified several deficiencies that prevented the activation of the Surgery Suite. The System was responsible for correcting the deficiencies

because the accepted construction work had been substantially in compliance with contract specifications. GAO reported that management had indicated that the main deficiency was an "air flow" problem with the Suite's HVAC System.

Results of Review. Our review confirmed that management believed there were significant HVAC problems that prevented the opening of the Surgery Suite. There were also several non-HVAC construction deficiencies that needed to be corrected. It was evident that System staff, VISN engineering staff (who had to approve proposed corrective actions), and outside experts hired by the System and the VISN had been unable to reach agreement on the seriousness of the deficiencies or on the best method of correcting them.

In February 1998, the System proposed two nonrecurring maintenance projects to address the Surgery Suite deficiencies. One of the projects was designed to correct the HVAC deficiencies. We found that System and VISN engineering staffs were in general agreement about the deficiencies that the HVAC project would correct. These deficiencies included the lack of individual temperature/humidity controls in each surgery procedure room, the lack of dedicated exhausts in the endoscopy rooms, and humidifiers that did not meet VA standards.

The delay in correcting the Surgery Suite deficiencies was caused by disagreements about another project, which was related to the HVAC project. This project was designed to address the issue of how emergency electrical power would be supplied to the Surgery Suite in the event of a power outage. This issue was linked to the capacity of the ACC's existing emergency generator. System management did not believe that the generator had sufficient capacity to provide emergency power to the entire ACC and, therefore, there was a risk that there would not be enough power in the Surgery Suite (an unacceptable risk given that surgical procedures could be in progress when an outage occurred). To address this problem, in February 1998, a project was proposed to replace the existing generator with a larger generator at a cost of \$250,000. Part of the justification for the larger generator was the need for enough power to operate the 2 existing 50-horsepower electrical pumps that circulated cold water through the entire ACC HVAC System.

The VISN hired an architect/engineering (A/E) firm to assess the need for the proposed generator project. The A/E concluded that the existing generator did not need to be replaced. Instead, it recommended that a 1-horsepower electrical pump be used for emergency circulation of cold water to the HVAC system in the Surgery Suite. The A/E determined that the existing generator had enough capacity to meet the emergency needs of the entire ACC and at the same time operate the 1-horsepower pump so the Surgery Suite would be cooled.

In May 1998, the A/E presented its report. The System management disagreed with the A/E's conclusion, and from May 1998 until February 1999, no action was taken on either the HVAC project or the generator project. In February 1999, the VISN disapproved the generator project and approved the HVAC project.

In March 1999, we reviewed the draft statement of work for the approved HVAC project and discussed the project with Facility Management staff. We concluded that it was still questionable whether the project would correct all the remaining Surgery Suite deficiencies. (In addition to the HVAC problems, the Suite has several other deficiencies that need to be

corrected. For example, the Suite needed to be equipped with an ethylene oxide monitor alarm, an automatic door opener needed to be installed on the main entrance doors, and the Supply Processing and Distribution Section needed an emergency eyewash/shower.)

Conclusion. We suggested that VA revise the HVAC project to propose a more comprehensive contract that would call for identifying, documenting, and correcting all the Surgery Suite deficiencies. Because Facility Management Service staff did not include an engineer, we also suggested that a VA engineer appointed by the VISN should manage the proposed project. System management agreed with both suggestions.

Unused EEG System

An allegation was also made that the System had purchased an EEG for the Neurology Clinic but had not utilized it. We concluded that the allegation was substantiated. At the time of our review, the System was exploring options for making use of the EEG.

Background. An EEG is a diagnostic tool used to measure and record the electrical activity of the brain. In November 1996, prior to the activation of the new ACC, an EEG system was purchased at a cost of \$55,509. In July 1997, the vendor installed the EEG at the ACC.

Results of Review. According to management, the EEG was one of several hundred equipment items purchased for the activation of the ACC. The EEG was requested by the Medical Service. Service officials could not find the original written justification. They told us that they had requested the EEG in the belief that opening the ACC would lead to enough increase in EEG workload to justify an in-house capability, which would consist of the EEG and a technician to operate it. However, the anticipated workload increase did not occur, no EEG technician was hired, and as a result the EEG was not utilized.

Before and after the opening of the ACC, the System has obtained EEG tests through a contract with a community hospital. In FY 1998, the System ordered only 65 EEG tests at a cost of about \$100 per procedure. Based on this limited EEG workload, the practice of obtaining EEG services under contract is more cost-effective than hiring a technician and performing EEG tests in-house.

As of April 1999, officials were exploring ways to utilize the EEG. The System had begun negotiations for a sharing agreement under which a community hospital would operate the EEG and perform EEG tests at reduced rates, which could allow for a return on investment. Because the negotiations were at a preliminary stage, we could not determine if this arrangement would be cost-beneficial. If after further negotiations it does not appear that the proposed sharing agreement will provide a reasonable return on its investment in the EEG, the equipment should be excessed to a VA facility requiring one.

To determine if the System had purchased other high cost medical equipment that was not properly utilized, we reviewed all 14 medical equipment items costing \$20,000 or more that had been purchased in FYs 1998 and 1999 (through March 1999). The total cost of the 14 items was \$546,269, with the cost of individual items ranging from \$21,153 to \$86,378. To evaluate the procurement and use of the equipment, we reviewed purchase and justification documents,

interviewed responsible clinical and administrative officials, and inspected equipment items. For 13 of the 14 equipment items, the purchases were appropriate and the equipment was either used or would be used after installation and/or completion of staff training.

The one item that was not used was a \$23,495 speech/voice therapy system that had been purchased in September 1997. We found this item in the Audiology Clinic, stored in its original carton. The system had not been installed or used because the ACC did not have a speech pathologist to operate it. (The ACC obtained speech therapy services from local providers and from other VA medical centers.)

Our inspections of various clinical, administrative, and storage areas did not identify any other high cost medical equipment that was not used or that would not be placed into use in the near future. We did note that many equipment items were stored in their cartons in the Ambulatory Surgery Suite. This equipment will be used when the Suite becomes operational.

Conclusion. An EEG system and a speech/voice therapy system were purchased and not used. However, from the time the two purchases were made, equipment procurement procedures have been improved. In March 1998, policy was established and procedures put in place that should prevent the purchase of unnecessary equipment. Memorandum No. 138-98-20, "Equipment Committee and Equipment Request Procedures," requires that requests for new equipment be reviewed and approved by the Equipment Committee chaired by the Associate Director. Requestors must provide detailed written justifications including such information as: a description of the need for the equipment and its relevance to the program's mission; anticipated cost reductions and payback period; requirements for staffing, space, and supplies; and, installation and maintenance costs.

Contracts for Radiology and MRI Services

An allegation was made that the System may have paid too much for radiology and MRI services. We concluded that this allegation was partially substantiated. The System had negotiated reasonable contract prices for radiology/MRI procedures. However, improvement was needed in contract management to ensure that payments were consistent with negotiated prices.

Background. The System had two contracts for radiology and MRI services. One contract was with American Shared/Curacare to provide MRI procedures for both VA and Air Force patients using a mobile MRI unit, which was set up at the MOFH. The Curacare contract was awarded in August 1996 and had been extended for each year. In FY 1998, the System paid about \$299,600 for procedures done under the Curacare contract.

The other contract was with Desert Radiologists to provide two kinds of services -- radiology procedures that, for various reasons, could not be provided at the ACC and "open" MRI procedures for obese or claustrophobic patients for whom the enclosed MRI unit could not be used. In FY 1998, the System paid about \$305,000 for radiology and MRI procedures done under the Desert Radiologists contract.

Results of Review. In evaluating the radiology and MRI contracting practices, we asked two questions: (1) Were contract prices reasonable? (2) Were the contracts properly managed to ensure that billed services were actually received and that billed charges were in line with contract prices?

Prices under both radiology/MRI contracts were reasonable. The benchmark for VA procedure-based clinical services contracts is Medicare rates -- that is, procedure prices generally should be no higher than Medicare rates. The MRI procedure prices under the Curacare contract were 5 percent less than Medicare rates. The prices on the Desert Radiologists contract were also below Medicare rates, with discounts varying depending on the procedure.

Although contract prices were reasonable, the two contracts were not properly managed to ensure that authorized contract payments were consistent with negotiated prices. At the time of our review in March 1999, a Radiology Service employee was responsible for managing both contracts. He simply authorized payment of billed amounts without comparing them to the contract price schedules. He told us that he had never seen either of the two contracts and did not know the contract prices.

This employee had been responsible for the Curacare contract since December 1998 and for the Desert Radiologists contract since 1996. We found that as of March 22, 1999, he had not processed any of Curacare's bills or authorized any payments. (The employee did not process these bills because he thought that funds were not available in the fund control point to pay the bills. However, we found that on December 14, 1998, the fund control point balance had been increased by \$250,000.) Before December 1998, a Network Business Center (NBC) contract specialist had managed the Curacare contract. That employee had ensured that payments were consistent with contract prices, and our review of selected October and November 1998 payments found no indication of overpayments.

For the Desert Radiologists contract, the bills that had been paid in FY 1998 and earlier were not readily available for review because they had been sent to the VA Finance Center in Austin, Texas. However, we reviewed unpaid bills for the period December 1998 through March 1999 and noted a number of charges that exceeded contract rates. For example, the March bill included 12 MRI procedures at prices ranging from \$757 to \$1,450, when the highest contracted price was \$500. Given these apparent overcharges, it is likely that overpayments occurred on prior bills.

Conclusion. Radiology/MRI contract prices were reasonable, but improvement was needed in managing the contracts. As a result of our review, management assigned responsibility for both radiology contracts to another employee. This should lead to better management of these contracts. To address the problem of possible overpayments on the Desert Radiologists contract, we recommend that the Director ensure that contract payments for at least FYs 1998 and 1999 to date are audited and that, if overpayments are identified, recovery is pursued from the contractor.

Administrative Activities and Management Controls

We concluded that the administrative activities reviewed were generally operating satisfactorily and management controls were generally effective. We found no significant deficiencies in several of the activities reviewed, as illustrated by the following examples:

- **Clinical Services Contract Prices Were Reasonable.** We reviewed contract negotiation records for the five largest clinical services contracts and found that contract prices were reasonable. The total cost of the five contracts was \$3.0 million. Four of the five contracts were procedure-based contracts under which various clinical procedures were purchased. For all four contracts, prices were equal to or below Medicare rates, which is the benchmark for VA procedure-based contracts. The other contract was for the services of various clinical personnel such as nurses and medical technicians. Prices under this contract were based on U.S. Department of Labor wage and salary data for the Las Vegas area.
- **Medical Insurance Billing and Collection Procedures Were Effective.** Under the provisions of the Medical Care Cost Fund (MCCF) program, VA medical centers are required to bill health care insurers for the reasonable cost of treatment for non-service connected conditions provided to certain veterans with health insurance. Our limited review did not find deficiencies in medical insurance billing and collection procedures. We reviewed a sample of 20 billings for outpatient services that the staff had prepared in December 1998. To determine if billings accurately represented services actually provided, we compared procedure codes on the billing documents with information from the automated Patient Care Encounter System and patient medical records. In all 20 cases, System records confirmed that the episode of care billed to the insurer had occurred. Procedure codes accurately represented the type and level of service and the type of clinician providing the care. Our review of collection reports and telephone logs indicated that controls for delinquent medical insurance billing and other third party accounts receivable were effective. System collections staff were sending follow-up notices and initiating telephone contacts with insurers at appropriate intervals.
- **Equipment Was Properly Accounted For.** System controls provided accountability for nonexpendable equipment. Memorandum No. 138-98-24 (September 1998) contains policy and procedures for the control of equipment. The Facilities Management Service (FMS) is responsible for scheduling and coordinating annual inventories of nonexpendable equipment. Under the direction of FMS, each designated official must perform a physical inventory of the equipment under his or her charge once a year. We reviewed 26 equipment inventory listings covering 1,891 items valued at \$16.1 million and found that the listings had been reviewed and certified by the designated official in the past year. In addition, we reviewed a judgment sample of 19 high cost equipment items and found that all these items were properly accounted for.

Improvement was needed in the nine activities and controls discussed below:

Pharmacy Security -- Access to Pharmacy Work Areas Should Be Better Controlled

Our review of pharmacy operations identified two security issues that should be addressed. First, Pharmacy Service management needed to make sure that unauthorized persons are not allowed into the pharmacy work area. Several pharmacy staff expressed concerns about their safety because patients and other individuals had been allowed to enter the pharmacy without adequate security precautions being taken. (b)(2)·(b)(5)..... (b)(2)·(b)(5)..... (b)(2)·(b)(5)..... (b)(2)·(b)(5).....

Second, during inspections of pharmacy and clinic areas, (b)(2)·(b)(5).....

We also identified two physical improvements that could further enhance pharmacy security. First, only one of the three pharmacy entrance doors was equipped with an electronic keypad, and it was inoperable. By installing keypads on the other two doors and repairing the existing one, Pharmacy Service could eliminate the necessity to rekey the locks and distribute new keys when a key is lost, stolen, or when a pharmacy employee leaves employment. Second, one of the doors into the pharmacy and the door into the prescription turn-in area did not have windows or peepholes. Installing peepholes in these doors would eliminate the necessity of opening the doors to determine who is knocking for entry.

Controlled Substances Inspections -- Unannounced Inspections Should Be Better Scheduled

VA medical centers are required to conduct monthly unannounced inspections of all Schedule II-V controlled substances. The purpose of these inspections is to ensure that controlled substances are properly accounted for. The inspectors must be VA employees who do not work in the Pharmacy Service. Inspectors are supposed to physically count the quantities of controlled substances on hand and reconcile these quantities with perpetual inventory records. If any shortages are noted, this must be reported to the VA medical center Director, who must ensure that the shortage is investigated.

As part of our review, we requested and observed a surprise controlled substance inspection. We also reviewed records of the inspections done for the 12-month period February 1998-January 1999. Both our surprise inspection and the prior inspections found good accountability for all controlled substances.

Although controlled substances were properly accounted for, the System needed to improve inspections by (1) making sure that all inspections were done on the selected date every month

and (2) reducing the number of inspectors and properly training them. Early every month, management assigned an employee to perform that month's inspection but did not specify an inspection date. The inspector decided when the inspection would be done. For 3 of the 12 months reviewed, inspections were not completed on time. The inspection requested on January 4, 1999, was not completed until February 12. The inspection scheduled for May 1998 was not completed until June 5, 1998, when it was done concurrently with the June inspection. In July 1998, the assigned inspector had to make three attempts on different days before completing the inspection because pharmacy staff said they were too busy to make time. Delaying inspections in this way removes the element of surprise. (When subsequently informed of this problem, management told Pharmacy Service that they must allow the inspections to be completed properly.)

System management had designated 12 employees as inspectors, with each employee usually performing only 1 inspection per year. The inspectors received no training other than an orientation that a pharmacy employee provided during the inspections. This employee was usually one of the technicians who had day-to-day responsibility for handling controlled substances. In our opinion, the inspections would be more effective if the inspectors were better trained and performed more than one inspection a year. This would reduce the risk of the inspectors being overly dependent on the pharmacy technicians whose duties are the subject of the inspection.

Agent Cashier -- Unannounced Audits Should Be Performed on Time

To ensure that Agent Cashier operations are sound and to guard against monetary losses, VA medical centers are required to perform unannounced audits of the Agent Cashier's advance and undeposited collections at least every 90 days. The VA medical center Director or an authorized designee should schedule the audits. To ensure surprise and to avoid establishing a pattern of regularity, the audits should be scheduled at varying times and dates.

The System had two Agent Cashiers, one at the ACC and one at the MOFH. As part of our review, we requested and observed unannounced audits of both Agent Cashiers. The audits were properly performed and identified no overages or shortages in Agent Cashier balances. However, our review found that prior unannounced audits had not been done at 90-day intervals as required by VA policy:

- The last three unannounced audits of the ACC Agent Cashier had been done at 91-day, 133-day, and approximately 180-day intervals. (Documentation of the earliest of these three audits was not available, but we were told that it had occurred in December 1997 and that the next audit had not been done until about 180 days later in June 1998.)
- The last three unannounced audits of the MOFH Agent Cashier had been done at 132-day, 115-day, and 108-day intervals.

The System Director's designee stated that she had experienced difficulty in establishing a method for calling the unannounced audits and she acknowledged that the 90-day time frame had been missed repeatedly. Her current method was to diary her calendar at the 80-day point to ensure that the audit was done within the 90-day period. However, this approach tended to

establish a pattern of regularity and to take away the element of surprise. The designee needed to develop a method of scheduling the unannounced audits on unpredictable dates.

Medical Care Cost Fund -- Means Test Forms Should Be Obtained from Veterans

As part of VA Medical Care Cost Fund (MCCF) requirements, copayments are collected from certain veterans to offset the costs of treatment provided for non-service connected medical conditions. Veterans with income below certain income thresholds are exempted from these copayments. Each year veterans who may be subject to copayments must provide an updated income information by signing a means test income verification form. The veterans' reported income is entered into a national eligibility database that is further verified with Social Security and IRS records.

Our limited review found that means test income verification processes needed improvement. We reviewed a random sample of 36 of the 258 means test cases processed during the period December 1, 1998 - March 15, 1999, in which the reported veterans' income was zero. In 21 of the 36 cases (58 percent), a signed means test form properly supported the veteran's reported income. However, in the remaining 15 cases (42 percent) the veteran's administrative medical record did not contain a signed means test income verification form to support the reported income. Without a completed means test form on file, these veterans may have been inappropriately entered into the income verification database, which could ultimately result in unnecessary income verification match workload or delays in copayment collections.

The Medical Administration Service (MAS) had been implementing a means test improvement plan. Among recent initiatives was a pilot project utilizing new software in two clinics. The software was intended to help medical clerk and health benefits advisors ensure that means test income verification and other information is up to date when a veteran comes in for medical care. However, the results of our review indicate that MAS staff were still not obtaining signed means test forms for a significant number of veterans.

Supply Inventory Management -- Excess Inventories Should Be Reduced and Automated Inventory Controls Implemented

We evaluated the System's management of medical and prosthetics supply inventories to determine if there was excess inventory. Inventories should contain enough supplies to meet current operating needs, and purchases above this level should be avoided so that funds are not tied up in excess inventory. The demand for most medical and prosthetic supply items can be met by maintaining inventories at no more than a 30-day level. In recent years, VHA has encouraged VA medical centers to modernize inventory management by utilizing the Generic Inventory Package (GIP), VA's automated inventory management system.

In FY 1998, medical and prosthetic supply purchases totaled \$2.1 million. We reviewed available inventory records, interviewed responsible staff, and inspected supply storage areas for the four primary supply inventory points: Prosthetics, Radiology, Pharmacy, and Supply Processing and Distribution. Although the activities did not maintain large quantities of excess

supplies, management of supply inventories could be improved and inventories could be reduced:

- The prosthetics activity was the only inventory point using the automated GIP to manage inventories. Prosthetics inventory records were complete and accurate. However, the stock levels for most inventory items exceeded a 30-day supply and could be reduced. At the time of our review, Prosthetics maintained an inventory of 202 items valued at \$64,738. Of the 202 items, 190 (94 percent) had more than a 30-day supply and 88 (44 percent) had more than a 1-year supply.
- The other three inventory points were not using GIP and did not have any other procedure for inventory records to track items stocked, quantities on hand, or demand. Based on our review of supply purchases and our discussions with inventory managers, we estimated that inventories were maintained at 60-90 day levels, or at least 2 to 3 times higher than necessary. Officials said that they had been trying to install GIP for the past 2 years but had encountered computer problems. They had recently sought VA Central Office technical assistance to solve these problems.

To improve inventory management, the Director should ensure that activities with supply inventories resolve problems, complete the installation of GIP as soon as possible, and reduce inventories to levels consistent with current operating needs. When GIP becomes operational, inventory managers should be provided training that will allow them to make the most effective and efficient use of GIP in managing supply inventories. The training should cover such topics as maintaining complete and accurate inventory information, setting reasonable stock levels based on actual item demand, and utilizing barcode-scanning equipment to automatically generate replenishment orders.

Purchase Card Program -- Transactions Should Be Promptly Reconciled and Approved

VA medical centers are required to use commercially issued purchase cards for small purchases of goods and services (usually \$2,500 or less per order). VHA has established internal controls to ensure that items purchased were actually received, charges were for official purposes only, and bills were correctly paid. As part of these control requirements, cardholders are to reconcile payment charges listed on a report provided by the purchase card contractor with the purchase amounts recorded in VHA's financial system, IFCAP (Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System). Reconciliations should be completed within 5 days of the IFCAP message confirming VA payment to the contractor. Approving officials should certify the reconciled purchase transactions within 14 days of receipt from the cardholder.

We reviewed the timeliness of cardholder transaction reconciliations and approving official certifications for the System's purchase card transactions. During the 5-month period October 1998 - February 1999, cardholders processed 5,567 purchase transactions totaling approximately \$2.0 million. Our review found that reconciliations and certifications were not always completed within the required timeframes:

- **Delayed Cardholder Reconciliations.** Of the 5,567 transactions, 855 (15 percent) were not reconciled within the required 5-day timeframe. Delinquent reconciliations ranged from 6 to 80 days and averaged 18 days. Forty-seven (68 percent) of the 69 cardholders had delinquent reconciliations. One cardholder accounted for 373 (44 percent) of the 855 late reconciliations. This cardholder stated that many delays had resulted from a large number of partial shipments and split billings for his purchases.
- **Delayed Approving Official Certifications.** Of the 5,567 transactions, 431 (8 percent) had not been certified by the approving official within 14 days. Delinquent certifications ranged from 16 to 335 days and averaged 74 days. Eighteen (69 percent) of 26 approving officials were responsible for the delinquent certifications. One approving official accounted for 170 (39 percent) of the late certifications. Another official completed 88 of his 101 delinquent certifications on a single day, which brings into question the thoroughness of his review of the transactions. Both of these approving officials attributed the delays to the demands of other duties on their time.

As part of the Government purchase card program, the purchase card contractor provides VA with convenience checks, which are similar to bank checks. The System typically used the checks in limited circumstances; such as to pay suppliers who do not accept the purchase card. The Chief Financial Officer (CFO) should designate in writing those individuals who are authorized to sign convenience checks.

We reviewed 25 convenience checks issued since January 1999. All checks were used to make appropriate payments. However, 13 of the 25 checks had been signed by three individuals who had not been formally designated to sign checks. Apparently, at the direction of VISN officials, the System had provided some blank checks to the Network Business Center (NBC). The NBC performs some centralized procurement and fiscal functions for VISN facilities, including the System. The CFO told us that he had informally agreed to allow one specific NBC employee to sign checks. He did not know that other NBC employees were signing checks. As a result of our review, on April 1, 1999, the CFO took corrective action and issued an updated written delegation of authority to sign convenience checks that included designated NBC staff.

To eliminate excessively delinquent reconciliations and certification of purchase card transactions, the Director should have Fiscal Service closely monitor delinquent cardholders and approving officials, work with individual employees and responsible supervisors to improve timeliness, and if necessary, reassign their purchase card responsibilities.

Information Technology Security -- Contingency Plans Should Be Revised

We performed a limited review of the Automated Information System (AIS) controls. Overall, the System had implemented policies to protect the integrity and confidentiality of data. Procedures were in place to control and monitor access to automated data bases and local area network applications. Physical security for computer rooms and equipment was adequate. Our review did find that the AIS contingency plan could be improved.

VA medical centers are required to develop and implement information system contingency and recovery plans. The plans should be designed to reduce the impact of disruptions in services, to

provide critical interim processing support, and to resume normal operations as soon as possible. Plans should be sufficiently detailed so that their success does not depend on the knowledge or expertise of one or two employees.

The contingency plan could be improved by placing mission-critical functions in priority order, designating an alternative processing site, establishing off-site storage for critical backup files, and identifying key personnel:

- **Identifying Mission-Critical Functions.** The plan did not adequately identify mission-critical functions and technology applications. The plan identified only three major system components -- VISTA (Veterans Health Information Systems and Technology Architecture), data communications, and administrative/clinical microcomputer-based systems/servers. The plan designated VISTA as most critical and the other two components as critical. However, in our opinion these designations and priorities were not detailed enough to be of use in a disaster, when some activities would be curtailed and some applications would not be operated. VISTA alone included more than 100 different applications supporting critical clinical, financial, and administrative activities. When only limited or phased recovery is possible, officials will have to decide which functions and applications will be restored and their priority order in the restoration process. To facilitate this, an inventory of mission-critical applications and priorities should be developed and incorporated into the contingency plan.
- **Designating an Alternate Processing Facility.** The plan did not include a designated alternative processing facility that could provide backup to AIS services in the event that the primary facilities are severely damaged or cannot be accessed. System officials indicated that they were in the process of establishing an agreement with VAMC Prescott, a facility with compatible systems and software. When arrangements have been completed, the designation of the alternative site should be added to the plan.
- **Establishing Off-Site Backup Storage.** The System had not established off-site storage for critical backup files. Backup media were stored in a fireproof safe within the ACC. To ensure that critical files can be accessed in the event of severe damage to the ACC, the System should make arrangements for off-site storage, such as at the MOFH.
- **Identifying Key Personnel.** The contingency plan did not list names and telephone numbers of key personnel that would be involved in disaster recovery. Apparently to address privacy concerns, the list of key personnel was deleted from the plan when it was last revised. Instead, cards listing names and phone numbers had been distributed to key staff. In our opinion, the contingency plan should contain a list of key personnel. If the distribution of the contingency plan is properly controlled, then the privacy of key staff should be adequately safeguarded.

To strengthen information technology security, the Director should ensure that contingency plans are revised to include prioritization of mission-critical functions, designation of an alternate processing facility, establishment of an off-site storage point for critical backup files, and identification of key personnel.

Employee Accounts Receivable -- Employee Debts Should Be Aggressively Pursued

We performed a limited review of debt collection practices for employee accounts receivable. VA facilities are required to pursue collection of valid debts of current and former employees. Employee debts may be collected by offset from current salary payments, final salary and lump sum payments, and retirement benefits. Under certain circumstances, debts of former employees can be referred to the Internal Revenue Service (IRS) for offset of income tax refunds. VA facilities may terminate collection actions and write off debt when a substantial amount cannot be collected, the debtor cannot be located, costs of collection will exceed recovery, or the debt is without merit or cannot be substantiated.

We reviewed all eight active accounts receivable of current and former employees as of February 1999. The outstanding balances totaled \$27,000. In three cases, the debts were being collected by salary offset. However, additional actions were needed in five cases:

- Additional collection efforts were needed to recover excessive relocation expenses paid for two employees. As needed, the System CFO should request the assistance of the Director in obtaining the cooperation of the employees in repaying these debts. If these efforts are not successful, the CFO should recover the debts by establishing offsets from the employees' salary payments.
- The accounts of two former employees should be referred to IRS for possible offset of income tax refunds. One debtor could not be located and the other had not made voluntary repayments.
- The \$361 debt of a former employee should be written off as uncollectable since the employee could not be located and the amount is below the minimum threshold **.(b)(2)-(b)(7)(E)** ... for referral to IRS.

We also reviewed eight-employee accounts receivable that had been written off in FY 1998. For all eight cases, fiscal records showed that appropriate collection steps had been taken before the accounts were written off. For example, four of the debts had been formally waived by a Committee on Waivers and Compromises.

The Director should ensure that necessary steps are taken to continue collection efforts for accounts receivable and to write off uncollectible debts.

Telephone Personal Identity Number (PIN) Security -- Procedures Needed To Reactivate PIN System After Inadvertent Shutdown

In July 1997, a PIN telephone security system was installed. The purpose of the PIN system is to deter employees and visitors from making unnecessary or unauthorized long distance calls. The system requires callers to enter a PIN before making long distance calls. VA medical centers can significantly reduce long distance costs by issuing PINs only to employees who have a need to make long distance calls.

On March 22, 1999, the first day of our review, we tested the ACC's PIN system and found that it was not working -- that is, we could make long distance calls without entering a PIN. The Chief Information Officer (CIO) could not explain why the system was not working and he did not know how long it had been inoperable. He believed that the problem may have occurred in early March 1999, either when the ACC power had been shut down for repairs to the electrical system or when software changes were made to make the telephone system year 2000 compliant. After we notified the CIO, he immediately corrected the problem and brought the system back on line.

Conclusion. To prevent a recurrence of this problem, the Director should ensure that the Information Technology Service develops procedures to make sure that the PIN system is functional after any power interruptions or other events that may affect the telephone lines.

Summary of Recommendations

We recommend that:

6. The Director (1) follow through with the April 1999 project to identify and correct the construction deficiencies and (2) arrange to have the project managed by a VA engineer appointed by the VISN.

VASNHS Response: Concur.

Deficiencies have been identified, the contract is in the process of being awarded by the VISN 22 Network Business Center (NBC). A Contracting Officer from the NBC will manage the contract with input from an Engineer also employed by the NBC. Completion is anticipated on October 1, 1999.

7. The Director (1) follow through on negotiating a cost-effective sharing agreement for the EEG system or excess it to a VA facility that can use it; and (2) determine if the speech/voice therapy system can be used by another VA facility or returned to the vendor for a refund.

VASNHS Response: Concur.

(1) The award of a University of Nevada School of Medicine sharing agreement for joint use of the EEG machine should be accomplished by 7/99.

(2) We will initiate the processes required to excess existing Speech Therapy equipment for use within VISN 22.

8. The Director ensure that contract payments for at least FYs 1998 and 1999 to date are audited and that, if overpayments are identified, recovery is pursued from the contractor.

VASNHS Response: Concur.

A fiscal Service Auditor will be assigned to perform an audit of expenditures during the timeframes as specified above and we will take any necessary action as required.

9. The Director (1) require Pharmacy Service to provide training reminding all pharmacy staff to consistently take security precautions by *(b)(2)*...*(b)(5)*.....; and (2) ensure that electronic keypads are installed on all pharmacy entrance doors and that peepholes are installed in the doors that need them.

VASNHS Response: Concur.

(1) The Chief, Pharmacy Service will coordinate with the Chief, Police & Security Service to offer an in-service training session on security measure enhancements.

(2) The Chief, Pharmacy Service has submitted appropriate work orders to Facility Management Service to ensure compliance.

10. The Director (1) reduce the number of controlled substances inspectors so that each conducts more than one inspection per year; (2) develop procedures to ensure that inspections are conducted every month and done on the date selected; and (3) ensure that inspectors are properly trained in inspection requirements and techniques.

VASNHS Response: Concur.

(1), (2) & (3) The Associate Director is revising the processes required for the inspection of controlled substances to ensure inclusion of the recommendation as stated.

11. The Director ensure that procedures are implemented to perform randomly Agent Cashier audits at least every 90 days.

VASNHS Response: Concur.

We will ensure that audits are accomplished in a timely manner as stipulated.

12. The Director ensure that MAS provide staff with refresher training emphasizing the importance of obtaining means test information from veterans.

VASNHS Response: Concur.

The Chief, Resource Enhancement Service has developed a “Means Test Improvement Plan” which outlines an array of enhancements to ensure that service staff are aware of the importance of capturing means test information. A training schedule has also been developed by the Chief, Resource Enhancement Service.

Fraud and Integrity Awareness

Objectives and Scope

The objectives of the Office of Investigations were to determine if: (1) the issues/allegations referred by GAO were substantiated; and (2) provide key facility employees with insight into the types of fraudulent activities that can occur in VA programs by providing an overview of OIG activity and case-specific examples of fraud that can affect healthcare procurements; false claims; conflicts of interest; bribery; and illegal gratuities.

Administrative Investigations Division

Allegations/Issues Referred by GAO

The Administrative Investigations Division investigated three allegations/issues. Two allegations involved reprisal actions and one involved the misuse of Government cellular telephones and vehicles by union officials. The results of the investigation will be addressed in a separate report.

Criminal Investigations Division

Fraud and Integrity Awareness Briefings

The Special Agent in Charge (SAC) of the Western Field Office, Criminal Investigations Division (CID), conducted three Fraud and Integrity Awareness Briefings, met with staff concerning fraud awareness, and received numerous walk-in complaints/concerns. Eighty-two employees from the System's executive office and operating components attended the briefings, which included a verbal presentation, a short videotape presentation, and question and answer opportunities.

The fraud briefing furnished information on the Inspector General Act of 1978, which provides the legal authority for establishing Offices of Inspectors General (OIGs). The four primary components of the OIG were identified as Healthcare Inspections; Investigations; Audit; and Management and Administration. A brief overview of each component was given.

The presentation emphasized that the OIG's Office of Investigations is responsible for conducting criminal and administrative investigations and is the primary point of contact for reporting allegations of criminal activity to the OIG.

Reporting Requirements

All employees were encouraged to report allegations of fraud, waste, or abuse to the OIG in compliance with MP-1, Part 1, Chapter 16 which sets forth the responsibilities of VA employees

in reporting such allegations. Subordinate employees were encouraged to report such activities to their management and advised that reporting allegations of wrongdoing through the chain of command was not required. Employees were informed that they could contact the OIG directly, either through the OIG's Hotline or by speaking with an available auditor, investigator, or healthcare inspector. Attendees were also informed of the OIG web site and that numerous examples of investigations are published on that site. Management is required to forward allegations to the OIG once they have been made aware of the situation. The OIG relies upon VA employees to report suspected instances of fraud, waste, or abuse and for this reason, all contacts with the OIG are handled as confidential contacts.

Referrals to the Criminal Investigations Division

Upon receiving an allegation of criminal activity, CID will assess the allegation and make a determination as to whether or not an official investigation will be opened and conducted. Not all referrals are accepted for investigation. If the CID decides to open an investigation, the matter is assigned to an agent, who then conducts an investigation. If the investigation substantiates criminal activity, the matter is referred to the local U.S. Attorney's Office for a prosecutive determination. If the U.S. Attorney's Office accepts the matter, either an indictment or a criminal information follows. These two vehicles are used to charge an individual with a crime under Federal statutes.

Important Information to Provide When Making a Referral

The briefing advised that it was very important to provide as much detail/information as possible when making a referral. The more information we know before we formally begin the investigation, the faster we can complete it. There are five items one should always provide, if possible, when making a referral. They are:

1. Who -- We need names, position titles, connection with VA, other identifiers.
2. What -- Specify the alleged illegal activity.
3. When -- Dates and times are critical.
4. Where -- Specify locations that alleged illegal activity has occurred or is occurring.
5. Witnesses/Documents -- To substantiate the allegation.

Importance of Timeliness

Attendees were reminded that it is important to report allegations promptly to the OIG because we generally have a 5-year statute of limitations period. Many investigations rely heavily on witness testimony. The greater the time interval between the occurrence and an interview, the greater the likelihood that people will not recall the event in significant detail. Over time, documentation can be misplaced or destroyed.

Areas of Interest for the Office of Investigations -- Criminal Investigations Division

The types of investigations conducted by the CID cover almost every area within the Department including; wrongful deaths, theft and diversion of pharmaceuticals, illegal receipt of medical services, improper fee basis billings (medical & transportation), bribery, workers' compensation fraud, fiduciary fraud, loan guaranty fraud, equity skimming, procurement fraud, benefits fraud, defective pricing, double or overbilling, false claims, and violations of the Sherman Antitrust Act.

The videotape presentation covered the same basic information but provided real scenarios. Attendees were given points of contact for VA OIG and encouraged to call and discuss any concerns.

The SAC also had the opportunity to meet with the Acting Chief of Police to discuss investigations and the role of the OIG in combating crime in VA.

System Director's Response Memorandum

**Department of
Veterans Affairs**

Memorandum

Date: June 25, 1999
From: Southern Nevada Healthcare System (593/00)
Subj: Draft Report, Combined Assessment Program Project, VASNHS, Las Vegas, Nevada
To: Assistant Inspector General for Investigations (51)

1. Enclosed is our response to the draft report of the Combined Assessment Program Review, dated June 7, 1999. We have reviewed the report findings and concur with its recommendations (Attachment 1). However, in reviewing the Executive Summary, we have determined that information pertaining to facility annual budgetary allocations and annual workload data require clarification. This clarification is outlined in Attachment 2 for your convenience.
2. If you require any additional information or further clarification regarding the content of our response, please feel free to contact me at (702) 636-3010.

(Original signed by:)
Ramon J. Reevey
Director

Attachments

VA FORM 2105
MAR 1989

Note: The System Director's comments are included in their entirety in pertinent Appendices of this report.

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