Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review
VA Pittsburgh Healthcare System

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VA Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

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Combined Assessment Program Review
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Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Pittsburgh Healthcare System (VAPHS) during the week of July 10 – 14, 2000. The purpose of the review was to evaluate selected VAPHS operations, focusing on patient care and quality management, financial and administrative management controls, and fraud prevention.

The VAPHS is an integrated facility comprised of three divisions: University Drive, Heinz, and Highland Drive. The University Drive Division is a 146-bed tertiary care facility, providing a full range of services in medicine, surgery, and neurology. The Heinz Division is a 396-bed geriatric facility providing nursing home and intermediate care. The Highland Drive Division is a 267-bed comprehensive psychiatric facility. The VAPHS' Fiscal Year (FY) 2000 budget was $226.1 million and the staffing level was 2,407 full-time equivalent employees. In FY 1999, the VAPHS treated 42,928 unique patients and provided 356,250 outpatient visits.

Patient Care and Quality Management. The VAPHS managers had demonstrated a strong commitment to quality management (QM) and performance improvement. The VAPHS had a comprehensive, well organized QM program that effectively coordinated patient care activities and provided strong oversight of the quality of care. We identified a number of opportunities to further improve patient care services and QM. Managers were in the process or agreed to take appropriate action on various patient care issues and concerns including: (a) ensuring that medical records were properly secured; (b) monitoring clinic workload, staffing, and appointment timeliness; (c) monitoring restraint usage; (d) developing guidelines for the oversight and administration of neuromuscular blocking agents; (e) assessing the suitability of space used for hospice patients; (f) addressing delays in providing dental prosthetics; (g) ensuring nurses properly record patient pain level assessments; and (h) improving the patient care environment in some areas.

Financial and Administrative Management. Financial and administrative activities were generally operating satisfactorily and controls were generally effective. We identified some opportunities for improvement and suggested that the VAPHS Director: (a) improve analysis of denied Medical Care Collection Fund (MCCF) claims; (b) improve MCCF billings and collections; (c) improve contract community nursing home rate negotiations; (d) strengthen controlled substance inspections; and (e) strengthen unannounced audits of the agent cashier. To further improve operations we also recommended that the VAPHS Director: (a) reduce supply inventories; (b) strengthen controls over the purchase card program; (c) improve Automated Information System security; (d) strengthen controls over means testing; and (e) improve classification and negotiation procedures for clinical services contracts.

Fraud Prevention. The VAPHS managers fully supported fraud prevention efforts. In the past, management had referred numerous issues to the OIG's Office of Investigations. As part of our review, we provided Fraud and Integrity Awareness briefings to 163 VAPHS employees.

Healthcare System Director Comments. The VAPHS Director concurred with the CAP review findings and recommendations. He provided acceptable plans to take corrective action. (See Appendix III for the full text of the VAPHS Director's comments.) We consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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Introduction

VA Pittsburgh Healthcare System

The VA Pittsburgh Healthcare System (VAPHS) is an integrated, university-affiliated healthcare system providing a full continuum of medical, surgical, psychiatric; and nursing home care at three divisions. Two divisions, University Drive and Highland Drive, are located in the city of Pittsburgh while the Heinz Division is located in the community of Aspinwall. Outpatient care is provided at the three divisions and at three community based outpatient clinics. The VAPHS is one of 10 facilities in Veterans Integrated Service Network 4. The VAPHS' primary service area includes Western Pennsylvania and parts of Eastern Ohio and West Virginia. The veteran population in the service area is about 360,000.

Affiliation and Programs. The VAPHS is academically affiliated with the University of Pittsburgh and Allegheny University of the Health Sciences. The VAPHS supports 109 medical resident positions in 25 training programs. Clinical training rotations are also provided for about 522 medical students and 250 nursing students. The University Drive Division has 146 hospital beds and is the major medical and surgical tertiary care facility for veterans in the primary service area. The Heinz Division has 316 nursing home and 80 intermediate care beds. The Heinz Division is also a Geriatric Center of Excellence and has been designated as a National Clinical Center of Excellence for home based care. The Highland Drive Division has 267 beds and is the neuropsychiatric tertiary care center for veterans in western Pennsylvania. In Fiscal Year (FY) 1999, the VAPHS' medical research program had 217 active projects and expenditures of $12.7 million.

Resources. The FY 2000 budget was $226.1 million, 4.5 percent more than the FY 1999 expenditures of $216.3 million. FY 1999 staffing totaled 2,425 full-time equivalent employees (FTEE), including 113.1 physician FTEE and 813 nursing FTEE.

Workload. In FY 1999, the VAPHS clinicians treated 42,928 unique patients, a fractional increase from FY 1998. The inpatient care workload included 8,038 admissions, with an inpatient average daily census of 636 patients. The outpatient care workload was 356,250 visits.

Objectives and Scope of Combined Assessment Program Review

The purpose of the Combined Assessment Program (CAP) review was to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to the VAPHS employees.

Patient Care and Quality Management Review. We reviewed selected clinical activities to evaluate the effectiveness of quality management and patient care management. The Quality Management (QM) program is a set of integrated processes

designed to monitor and improve the quality of patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient safety and treatment. QM includes risk management, resource utilization management, total quality improvement, and coordination of external review activities. Patient care management is the process of planning and delivering patient care and includes patient-provider interactions, coordination between care providers, and ensuring staff competence. To evaluate the QM program and patient care management, we inspected patient care areas, reviewed pertinent clinical and QM records, and interviewed managers, employees, and patients. We also used questionnaires and interviews to survey employees' and patients' opinions and perceptions about the quality of care and various other matters, such as waiting times, and satisfaction with care received. We reviewed the following 18 program and patient care areas:

- Acute Care Medicine
- Physical Medicine and Rehabilitation
- Ambulatory Care Services
- QM Program
- Employee Education Program
- Clinic Appointment Timeliness
- Hospice Program
- Pain Management
- Narcotic Usage
- Geriatrics and Extended Care
- Substance Abuse Treatment
- Psychiatry Service
- Clinician Staffing
- Medical Record Security
- Restraint and Seclusion
- Dental Service
- Laboratory and Pathology Service
- Patient Feeding Program

Financial and Administrative Management Review. We reviewed selected administrative activities to evaluate the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, to prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed managers and employees, and reviewed pertinent financial, administrative, and clinical records. The review covered the following 14 financial and administrative activities and controls:

- Unliquidated Obligations
- Accounts Receivable
- Contract Beneficiary Transportation
- Printing Services Procurements
- Denied Medical Care Collection Fund (MCCF) Claims
- MCCF Billing and Collection Activities
- Contract Community Nursing Homes
- Controlled Substance Inspections
- Agent Cashier
- Supply Inventory Management
- Purchase Card Program
- Automated Information System Security
- Means Test Implementation
- Clinical Services Contracts

Fraud Prevention. The VAPHS managers have been supportive of fraud prevention. In the past, several issues had been referred to the OIG's Office of Investigations. We provided 3 Fraud and Integrity Awareness briefings, 1 briefing at each division, to 163 VAPHS employees. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Scope of Review. The CAP review covered the VAPHS operations from October 1, 1998 through June 30, 2000. The review was done in accordance with draft standard operating procedures for the VA Office of Inspector General Combined Assessment Program Reviews.

Results and Recommendations

Patient Care and Quality Management

Patient Care and Quality Management were Generally Effective

We concluded that the VAPHS' patient care and QM programs were comprehensive and well managed and that clinical activities were operating satisfactorily, as illustrated by the following examples:

Top Managers Showed Commitment to QM. The VAPHS management team demonstrated a strong commitment to QM and performance improvement. The Director had assumed his position just prior to our visit, but had already had an impact on facility operations. He had informed all clinical managers and leaders that emphasis would be placed on improving the quality measures (clinical indicators) scores, appointment timeliness, and patient flow in the outpatient clinics. The Director also planned to complete implementation of the Computerized Patient Record System. To facilitate communication, the Director had established a "Leadership Board" which included both clinical and administrative leaders, and planned to hold quarterly town meetings at all divisions where he would discuss the quality measures. Managers also made scheduled and unscheduled rounds in all patient care areas to observe operations and speak with employees and patients. Top managers were in the process of relocating their offices from the Heinz to the University Drive Division during our visit. This is an important move because University Drive Division sees the most patients, has the highest turnover rates, and is financially the most active.

The QM Program was Comprehensive and Well Organized. The Office of the Director's QM Section was providing direction, coordination, and oversight for the VAPHS' QM program. This comprehensive program included such activities as total QM, risk management, and utilization review. Our review found that QM employees were effectively tracking results of and ensuring appropriate follow-up for patient incident reports, focused reviews/root cause analyses, and administrative investigations. QM employees trended patient safety-related data and recommended corrective actions to clinical managers when appropriate.

The facility had a comprehensive peer review program. All peer reviews were first reviewed by the Chief of Staff. The peer review was then sent to the Operative and Other Procedures Committee. This committee consisted of physicians from both Medical and Surgical Services. Committee members reviewed and discussed all aspects of the peer reviews and made the final determinations as to what the ratings should have been. Members also made recommendations for corrective actions if appropriate.

Nursing Home Patient Feeding Program was Effective. In the Heinz Division's Nursing Home Care Unit (NHCU) on 1 North, the number of patients who required total or partial assistance with feeding far exceeded the number of NHCU nursing employees. However, NHCU employees had developed an Eating Program that assured that all patients were properly fed. We witnessed physicians, social workers, volunteers, and nursing employees all feeding patients. The program recognized that ensuring adequate patient nutrition was the responsibility of the treatment team, not just Nursing Service. All of the employees who fed patients had received training on proper feeding techniques. This program also included the Speech Pathologist, who provided family training during meal times on feeding techniques that reduced aspiration risks.

The Ancillary Testing Program was Effective. The VAPHS had a comprehensive and well-managed laboratory ancillary testing program. The system's ancillary testing program included whole blood glucose by fingerstick, occult blood testing, hemoglobin AIC by fingerstick, cholesterol screening, pregnancy testing, fingerstick Prothrombin time, and urine dipstick testing. The ancillary testing program coordinator had established effective procedures to monitor the ancillary testing conducted outside the laboratory, to control the quality of the testing, and to follow-up and validate critical test values. She also trained employees to ensure their competence with ancillary testing. The program improved timeliness by reducing test result turn around times.

Employee Education and Retention. Managers had established a formal leadership development program to train their employees for future mid-level and top manager positions. Managers had also sent five nursing assistants to school to become practical nurses, and planned to send an additional five this year.

Most Patients and Employees were Satisfied with the Quality of Care. We interviewed top managers, clinicians and clinical managers, as well as 19 acute care patients, 67 long-term care patients, and 61 outpatients. We also sent survey questions to 331 randomly selected full-time employees; 198 or 60 percent responded. The results of the surveys and interviews showed that the VAPHS employees and patients were generally satisfied with the care that system clinicians provided. For example, 97 percent of the patients rated their care as good, very good, or excellent. Similarly, 86 percent of employees rated the quality of care as good, very good, or excellent. Ninety-four percent of the patients and 81 percent of the employees would recommend treatment at the VAPHS to family members or friends.

Management Should Address Various Patient Care and Quality Management Issues.

During our review, we noted a number of patient care and QM issues that did not require individual recommendations, but that warranted management attention.

Medical Records Should be Safeguarded. During our review, we found an unattended cart containing medical records in a second floor hallway of the University Drive Division. The responsible clerk had left the cart unattended for a short period of

time in an area accessible to the public. The Veterans Health Administration (VHA) requires an assurance of medical record integrity and requires preservation of patient record privacy and restricted access to patient information. Unsecured records pose a risk because patients may be able to view other patients' records, resulting in a breach of privacy, and/or may be able to view their own records and possibly misinterpret information or even remove or alter important documents. We discussed this issue with the Director and he informed us that he would ensure that medical records are properly secured.

Clinic Appointment Timeliness Needed Improvement. We found that the VAPHS had not met VHA national waits and delays standards for the six clinics that are tracked. VHA had set a standard of no more than a 45-day wait for appointments in Primary Care, Eye Care, Audiology, Cardiology, Orthopedics, and Urology. The VAPHS waiting times for these clinics ranged from a low of 52 days for Audiology to a high of 123 days for Eye Care. The Director was aware of this issue and assured us that decreasing waiting times would be a top priority.

Critical Care Unit (CCU) Restraint Usage Should be Monitored. The Critical Care Committee minutes for May 2000, reported that on average, patients were restrained for 3.7 hours per unit admission. CCU managers were aware that this was an issue that needed to be addressed and had taken action that should reduce restraint usage. Managers had initiated a program entitled "restraint protocols" that involved both nursing and physical therapy employees. The program required that before applying restraints, employees would explore alternatives to restraints, would encourage family involvement, and would provide diversional activities for patients. Management has monitored and should continue to monitor restraint usage in the CCU to ensure appropriateness.

Neuromuscular Blocking Agents (NMBA) Should be Controlled. Succinylcholine is a NMBA that has a rapid onset of action. During a tour of the Surgical Intensive Care Unit (SICU), we noted nine vials of succinylcholine in the medication room refrigerator. Nursing employees stated that this medication was used to prevent patients from "fighting" the respirator. However, when we discussed this with the Vice President (VP) for the Critical Care Service Line (CCSL) he told us that succinylcholine was controlled by Anesthesia Service, and that when the medication is needed an Anesthesiologist must be contacted. The VP for the CCSL assured us that the issue of NMBAs will be an agenda item at the next Critical Care Committee meeting. His recommendation will be to develop guidelines for the oversight and administration of all NMBAs.

Location of Hospice Patients Should be Assessed. The Heinz Division's 30-bed NHCU, on 3 North, included 6 Hospice beds that had piped oxygen available at the bedside. However, the NHCU had only three remaining rooms with piped oxygen capability. Nurses told us that because oxygen is not available in all rooms, hospice patients who might not require oxygen, might be temporarily moved off the unit to make room for patients who required oxygen. This is unnecessarily disruptive to terminal patients and negatively affects their continuity of care. Managers should assess this

issue to determine if there is a more suitable unit to house hospice patients that would ensure continuity of care.

Delays in Obtaining Dental Prosthetics Should be Addressed. Both patients and employees informed us that patients had experienced long delays in obtaining dental prosthetics. Managers agreed that delays in obtaining dental prosthetics has been a problem. The VAPHS managers attributed the problem to the fact that dentures were no longer made on station, and that they had only one technician who could make the denture molds. One patient we interviewed told us he had been waiting 11 months for his dentures. While some of the delays could be attributed to the patient's minor surgeries during this period, an 11-month delay is not acceptable. Managers need to address this issue to ensure patient waiting times for dental prosthetics are within community standards.

Pain Management Documentation Should be Assessed. We reviewed 16 medical records to determine if nursing employees had properly assessed and treated patients' pain levels. Twelve records included documentation to show that nursing employees had assessed and properly treated the patient's pain according to policy. However, four records did not include a rating of the patients' pain levels. Management needs to ensure that responsible nursing employees properly record patient pain level assessments using their Continuous Pain Assessment/Intervention Flow Sheet.

Intensive Care and Dialysis Units' Physical Environments Should be Improved. The physical environment of the Intensive Care and Dialysis Units needed greater management attention. The units were cluttered and the floors, especially in the corners and abutting the walls, needed cleaning. Management needs to ensure greater environmental support for the Intensive Care and Dialysis Units.

Outpatient Interviews. Patients generally told us that: their primary care provider managed their overall care; they were able to see a specialist within 45 days of referral; they were involved in decisions about their care; and they received education about medications, tests, and procedures. However, patients also told us that generally they could not schedule appointments with their primary care provider within 7 days nor did they receive their outpatient prescriptions within 30 minutes. Improvements are needed to improve timeliness in these areas.

Employee Interviews. Generally, employees told us that: they gained personal satisfaction from their job; they felt they were evaluated fairly; they felt safe coming to and working at the VAPHS; coordinated care was provided to patients; and they were offered preventive health measures. However, 60 percent of the employees who responded to our staffing question told us that they did not have enough employees in their areas to provide care to all patients who needed it. Management needs to address the perception that the VAPHS has insufficient staff.

Eighty-three percent of the employee respondents told us that they felt comfortable reporting errors that involved themselves. However, only 48 percent felt comfortable

reporting errors that involved a colleague. Also, 42 percent of the respondents told us that they did not feel that managers took constructive actions when errors were reported. During our review of patient incident reports, we found that generally when a nurse reported a medication error the corrective actions involved counseling or policy review. Management should assess this issue to ensure compliance with VHA's new patient safety initiatives.

Financial and Administrative Management

Management Controls were Generally Effective

The VAPHS management had established a positive internal control environment, 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, including: controls over unliquidated obligations; accounts receivable collection efforts; contract beneficiary transportation services; and printing services procurements.

Suggestions for Management Attention

During our review, we noted several administrative issues that warranted management attention. We made suggestions for improvement in the following areas:

Management Should Ensure that Employees Analyze and Trend the Reasons for the VAPHS' Denied Medical Care Collection Fund (MCCF) Claims. The goal of the MCCF Program is to maximize the recovery of funds due VA for the provision of health care services to veterans, dependents, and others using the VA system. Legislation has authorized VA to submit claims to and recover payments from veterans' third-party health insurance carriers for treatment of non-service connected (NSC) conditions. In cases where insurance carriers deny payment of a claim, the carrier advises VA of the denial reason on an explanation of benefits remittance advice.

We found that the VAPHS employees had reviewed denied claims and contacted the insurance carrier in cases where payment of the claim could be obtained by providing additional information. However, we also found that employees had not trended and analyzed the reasons for denial. Trending and analyzing denied claims could assist management in identifying systemic causes for denied claims and opportunities to provide enhanced medical service to veterans in a more economical manner.

We reviewed the VAPHS' Medical Care Cost Recovery/Utilization Review (MCCR/UR) Denied Days Report, to determine the number of and reasons for denied claims. In the 6-month period ending May 31, 2000, health insurance carriers had denied VAPHS inpatient care claims for 864 days representing $1,249,890 in billings. About $262,000 (21 percent) of the $1,249,890 in billings had been denied based on the insurance carriers' determination that the hospitalizations were not necessary. Hospitalizations were considered unnecessary due to inappropriate admissions or excessive lengths of stay. For example, we found admissions for procedures or treatment that could have been provided on an outpatient basis. In another instance, a veteran no longer needing acute care was discharged from a private hospital and admitted as an inpatient to University Drive Division, when only nursing home care was required. Our analysis identified one provider who had three instances of denied third-party reimbursement due to care being considered medically unnecessary by the carriers.

We concluded that management needs to ensure that the MCCR/UR Denied Days Report is trended and analyzed. MCCR/UR data analysis and trending could develop evidence to justify admissions and enhance third-party collections. In addition, trending and analyzing could identify providers who had multiple cases where avoidable hospitalizations occurred, possibly indicating a need for training.

Minor Improvements Should be Made in MCCF Billings and Collections. Public Law 105-33 granted VA the authority to begin billing for "reasonable charges" instead of billing average cost-based per diem for health care provided to veterans. This change applies to NSC care provided on or after September 1, 1999. In accordance with Title 38, Code of Federal Regulations, Part 17; VHA will bill reasonable charges for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and certain non-physician provider charges. These charges are computed based on an adjustment for geographic areas and a variety of factors including: per diem charges for room and board; ancillary services; diagnosis related groups for inpatient facility charges; and Current Procedural Terminology (CPT) codes for professional charges and outpatient facility services.

To assess whether the VAPHS was properly billing for reasonable charges, we reviewed a judgmental sample of 28 MCCF billings for care provided to 13 unique patients after September 1, 1999. With the aid of the Health Information Management (HIM) Director and a certified coding specialist, we reviewed a wide range of applicable computerized records and the patients' medical charts to determine the accuracy of coding for billing purposes. Our review disclosed the VAPHS had generally billed properly for reasonable charges. We identified only two minor errors of CPT code omissions, and these had not affected insurance reimbursement. However, we did identify other issues that impacted on MCCF collections and how the collections are applied.

- With the assistance of the MCCF Coordinator, the lead biller, and the lead accounts receivable technician, we reviewed the computerized Third-Party Accounts Receivable Profiles, and the explanation of benefits remittance advice provided by the insurers. We identified one insurance denial that could have been avoided. Payment was denied by the insurer due to "Medicare noncompliance". The patient was admitted for "observation" (23-hour stay) and had undergone same day surgery. The MCCF Coordinator informed us that Medicare does not pay for "observation" and most of the insurers follow suit. VA billing identifies the "observation" bill type as "Inpatient" which is rejected by the insurers in cases such as this where the procedure should be performed on an outpatient basis. According to the MCCF Coordinator, the VAPHS could have billed over $20,000 for the surgery if the patient had instead been admitted as an outpatient to same day surgery and, if necessary, transferred for observation post-operatively. In addition, the VAPHS has hospitality rooms available to patients for pre-operative overnight stays. MCCF employees informed us that similar situations had occurred in the past.

- VA may not bill third-party carriers for care given by certain categories of providers. For example, care given by medical residents is generally not billable. As part of our review, we checked the Patient Care Encounter (PCE) records for outpatient visits in our sample. We found that a provider was identified in the Person Class component of the PCE record as a medical resident. As such, the encounter would not have been billable. Further review disclosed that the provider was actually an employee and that the Person Class File had not been properly updated to reflect the physician's correct status. The HIM Director informed us that coders do not currently access the PCE File, although this could save time in identifying billable care providers. However, the Person Class File must be accurate to enable coders to verify that providers are billable. If the information in the file is not accurate, billing problems could occur.

- We also reviewed the accuracy of payment applications. VHA Directive 99-014 states that health insurance benefits should be applied to veterans' copayment obligations. For Medicare supplemental insurance (Medigap), all reimbursement from the health plan, without deduction, should be applied to the veteran's VA copayment before application of proceeds to the third-party debt. Reimbursement from health plans of veterans who are not Medicare-eligible should be applied to the portion of the veteran's copayment obligation (after subtracting plan deductibles) that corresponds to the same percentage as the plan's coverage liability for allowable charges. For example, if the plan covers 70 percent of the charges, and all deductibles have been satisfied, then 70 percent of the veteran's copayment debt would be paid and the remainder of the reimbursement amount would be applied to the third-party debt. We identified one unique Category C sample patient for whom two insurance payments, totaling $91.87, should have been applied to his means test copayments before application of the proceeds to the third-party carrier's debt. If we had not identified this error, the veteran would have been erroneously billed for copayments. MCCF employees corrected this oversight.

We concluded that management needs to make minor improvements in the area of MCCF billings and applications of collections. To avoid denial of third-party payment for outpatient surgical procedures, management should ensure that patients are admitted as outpatients to same day surgery rather than scheduled as inpatient observation cases. In addition, to ensure that providers are properly identified and billings are appropriate, the Person Class File should be properly updated and maintained. MCCF employees should also be trained on proper application of collections.

Contract Community Nursing Home (CCNH) Rates that Exceed Those Established by Medicaid Should be Supported. As of June 30, 2000, the VAPHS had 45 CCNH contracts. Through June 30, 2000, the VAPHS had spent about $4 million for CCNH care, $3.1 million locally and $900,000 on multi-state CCNH contracts. The VAPHS is responsible for negotiating only local contracts. We reviewed the local CCNH contracts to determine if the negotiated rates were in compliance with Medicaid rates (for room, board, and routine nursing care) plus an allowable factor of 15 percent for ancillary costs.

VA policy allows exceptions to the Medicaid rate policy in four instances: lack of availability; special services are being provided; indicators of quality (placement of hard to place patients); and ancillary costs exceeding 15 percent for VA patients. VA policy further requires that responsible CCNH employees provide the Director with supporting evidence that acceptable alternatives within the Medicaid rate policy are not available in the community. The Director must approve these rate exceptions and must annually certify the rate exceptions to VHA by March 15.

We found that 12 of the 18 (67 percent) local CCNHs that participated in the Medicaid Program had contract rates higher than the allowable 15 percent for ancillary costs. The average ancillary cost percentage on the 12 contracts was about 34 percent. The VAPHS employees had not formally requested rate exceptions nor developed supporting documentation that the exceptions were necessary. As a result, the VAPHS may be paying more than necessary for CCNH care. For example, one veteran had been placed in a CCNH that had a Medicaid daily rate of $113.55. Adding the allowable 15 percent factor would have increased the rate to $130.58. However, the VAPHS negotiated a daily rate of $180, about 59 percent higher than the Medicaid rate. As a result, the VAPHS paid $18,360 for the veteran's 102-day CCNH stay. With a 15 percent factor they would have paid $13,319, or $5,041 less, for the same stay.

We concluded that management needs to ensure that CCNH rates which exceed Medicaid rates are supported, approved, and certified to VHA. During our review, the Geriatric and Extended Care Line Business Manager, who is responsible for the CCNH program, agreed with our results and initiated corrective action.

Management Needs to Strengthen Monthly Controlled Substance Inspections. VHA Handbook 1108.2 "Inspections of Controlled Substances", dated July 23, 1997, requires that VA medical facilities 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 are not pharmacists, nurses, physicians, or supply officials. No inspector should inspect the same area 2 months consecutively nor conduct more than 6 monthly inspections in a 12-month period. Inspectors should physically count the quantities of controlled substances on-hand and reconcile these quantities to inventory records. To assess the VAPHS' inspection program, we reviewed records of the inspections conducted during the 12-month period June 1999 to May 2000. We identified the following weaknesses:

- All controlled substance inspectors at the VAPHS' three divisions were registered nurses (RNs). Management informed us that they had begun utilizing nurses as inspectors based on a 1996 recommendation from a JCAHO surveyor that the VAPHS utilize nurses with consistent assignments to better identify possible inappropriate use or diversion of narcotics. During our review, management agreed that utilizing nurses as controlled substance inspectors did not meet the requirements of VHA Handbook 1108.2.

- Inspectors had inspected the same area 2 months consecutively on three occasions at the Heinz Division and on one occasion at the University Drive Division.

- Twenty of the 24 inspectors had conducted more than 6 inspections during the 12-month period of our review.

- Inspectors had not properly reconciled clinic or ward inventories. Investigators should have verified a sample of ward dispensing entries to patient records to assure that amounts removed from clinic or ward inventories were supported by doctors' medication orders and drug administration records in the patients' records.

- There was no documentation of inspections having been conducted on 14 controlled substance areas at the University Drive, 12 areas at the Highland Drive, and 4 areas at the Heinz Divisions during the 12-month period reviewed.

We concluded that management needs to ensure inspections are performed by appropriate employees and in the manner prescribed in VHA Handbook 1108.2. Current RN inspectors should be removed from the inspection team. They should be replaced with employees who are not nurses, pharmacists, physicians, or supply officials and the replacements should be trained to conduct inspections in accordance with VHA guidelines. Management should also follow-up to ensure that all areas with controlled substances in stock are inspected monthly.

Unannounced Audits of the Agent Cashier Should Include a Determination on the Appropriateness of the Agent Cashier Advance. VA policy provides that as part of unannounced agent cashier audits a review of the last consecutive 3-month's cash disbursements should be performed to determine whether the amount of the cashier advance is appropriate based on actual cash needs. VA policy also requires that the advance be turned over 100 percent every 3 weeks.

We reviewed the VAPHS' 12 unannounced agent cashier audits performed during FYs 1999 and through May 2000. We determined that the quality and timeliness of unannounced audits were generally good. However, facility employees conducting the unannounced audits had not always determined the appropriateness of the agent cashier advance.

We found that auditors had not reviewed the previous 3-month's cash disbursements or reviewed the turnover rate in 9 of the 12 (75 percent) audits completed. Auditors had only calculated a turnover rate in one of the three remaining audits. During this time period, the advance totaled $42,000 and the auditors determined that on average $36,000 had been turned over every 3 weeks for a 3-month period. We reviewed cash disbursements for FY 2000 audit, at which time the advance totaled $42,000, and determined that on average $32,000 had been turned over every 3 weeks for a 3-month period. Based on the rate at which the cash advance is being turned over, as much as $10,000 of the advance may be excess.

We concluded that management needs to ensure that unannounced audits of the agent cashier are complete, and include determinations of the appropriateness of the advance. In addition, management should adjust the level of the advance when necessary.

Recommendations for Improving Management Controls

Excess Medical Supply Inventories Need to be Reduced. We evaluated management of medical supplies to determine if excess inventory was being maintained. 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 medical supply items can be met by maintaining inventories at no more than a 30-day level. VHA is currently finalizing a new VHA Inventory Management Handbook that will mandate both the utilization of the Generic Inventory Package (GIP), VA's automated inventory management system, and a 30-day maximum inventory level.

During the 1-year period ending May 31, 2000, the VAPHS expended $2,013,763 on medical supplies. At the time of our review, the Supply Processing and Distribution (SPD) GIP primary inventory file included the medical supply inventory for the University Drive, Heinz, and Highland Drive Divisions. However, to facilitate accuracy and accountability, management planned to establish separate primary inventory files for each of the three divisions by the end of August. We reviewed available inventory records, interviewed responsible employees, and inspected supply inventory areas.

- At the time of our review, the VAPHS' GIP inventory records indicated 825 items, with a total value of $379,062, were on hand. Our analysis of GIP records disclosed stock levels for 758 of the 825 total inventory items (92 percent) exceeded a 30-day supply. The excess inventory was valued at $250,794.

- Our physical inventory of the same 10 items at each facility disclosed inaccurate inventory records for all 10. Eight items had higher levels and two had lower levels, than recorded on GIP. SPD management attributed the inaccuracies to SPD employees not recording items received and issued.

- We also noted that physical security at the University Drive Division needed improvement. Adjacent to the receiving dock is an SPD breakdown area where items received from the vendors are uncrated and inspected. A garage door that should close off the area is kept open during normal working hours to allow receiving dock employees sufficient space to maneuver equipment. This unguarded area increases the risk of diversion of valuable medical supplies.

We concluded that management needs to improve medical supply inventory management by reducing inventories to levels consistent with current operating needs and the mandated 30-day stock level. Establishing separate inventory files for each

division should improve accuracy and accountability over the inventory. However, given the inaccuracy of the automated records shown by our testing, a wall-to-wall inventory should be performed at the three divisions to determine actual inventory levels. In addition, SPD employees should be trained in timely and accurate data entry, and security at the University Drive SPD breakdown area should be improved. These steps could reduce inventory costs by up to $250,794.

Recommendation 1. The Director should ensure that: (a) a wall-to-wall inventory is completed at each division; (b) inventories are reduced to levels consistent with current operating needs; (c) SPD employees are trained in timely and accurate data entry regarding the recording of items received and issued; and (d) security over the University Drive SPD breakdown area is improved.

Director Comments. The VAPHS Director concurred with the recommendation and reported that the Acquisition Program will establish implementation plans for all recommendations. The target date for completing all corrective actions will be soon after the close of FY 2000.

Office of Inspector General Comments. The comments and planned corrective actions are acceptable and we consider the issue to be resolved. We may follow-up on the implementation of planned actions.

Controls Over the Purchase Card Program Should be Strengthened to Ensure Procurement Competition Requirements are Followed. VA facilities are required to use Government purchase cards for small purchases of goods and services (usually $2,500 or less). The VAPHS' purchase card program included 18 purchase cardholders and 6 approving officials. During the 18-month period ending March 31, 2000, the VAPHS purchase cardholders processed 30,028 transactions totaling approximately $22.1 million.

VHA Handbook 1730.1 establishes procedures for the use of the Government purchase card. These procedures identify responsibilities and controls within the program to include ensuring that Federal Acquisition Regulations (FAR) are followed. Our review focused on determining whether the VAPHS cardholders and approving officials complied with established procedures. We tested transactions to determine whether purchase contracting officers complied with their warrant authorities, cardholders split purchase orders to stay within cardholder limits, reconciliations and certifications were completed on time, and whether purchase cardholders made prudent procurement decisions.

We found that cardholders designated as contracting officers had been warranted in accordance with FAR. We also reviewed a sample of 150 purchases valued at $2.2 million and found no instances where purchases had been split to stay within purchase limits. We reviewed cardholder transaction reconciliations and approving official certifications of purchase card transactions and found that both reconciliations

and certifications had generally been completed on time. However, we found that controls over the purchase card program needed to be strengthened to improve compliance with procurement competition requirements to ensure the Government receives the best available price.

FAR requires purchasing officials to promote competition to the maximum extent practicable to obtain supplies and services from the source whose offer is most advantageous to the Government. Purchasing officials should contact more than one source or vendor when making purchases. Generally, purchases may be made without competition only when there is only one source capable of providing the goods or services. In these instances, purchasing officials need to document the reasons for the sole source purchases.

We found that controls need to be strengthened over the selection of sources for the purchase of supplies such as prosthetic implant devices and accompanying components. For a 20-month period ending May 31, 2000, two purchase cardholders had not solicited competition for 30 separate purchases of prosthetic supplies totaling approximately $145,000. The orders were placed with one non-Federal Supply Schedule (FSS) vendor based on the direction of requesting physicians. There was no justification accompanying these sole source acquisition requests. However, cardholders had not returned incomplete requests for sole source acquisition of prosthetic supplies to requesting officials. Acquisition & Materiel Management Service (A&MMS) employees also indicated that purchases of prosthetics from this particular vendor may have resulted in VA paying more for the items than if the prosthetic supplies had been purchased from an FSS vendor. In fact, the following example demonstrates how VA had paid considerably more for prosthetic implants purchased from the non-FSS vendor:

> A purchase of a hip system implant and accompanying components was made on December 9, 1999, from the non-FSS vendor at a cost of $6,125. At our request, procurement employees priced the hip implant and components with an FSS vendor and found that VA would have paid $2,805 for similar items. As a result, VA paid approximately $3,320 more (54 percent) for this implant on the open market as compared to what they would have paid had the items been purchased from the FSS vendor.

It should be noted that shortly before our review, the VAPHS management had identified a condition similar to the one we identified. Management had found durable medical beds had been purchased from a non-FSS vendor, when similar equipment was available, at lesser cost, from an FSS vendor. At that time, management transferred purchasing responsibility for prosthetics equipment from Prosthetics Service to A&MMS. Our results indicate additional monitoring may be needed.

We concluded that controls over the VAPHS' purchase card program were generally adequate. However, management should ensure that controls are strengthened to improve compliance with procurement competition requirements as set forth by FAR.

Recommendation 2. The Director should ensure that: (a) cardholders and requesting officials are made aware of the need to obtain competition to the maximum extent practicable when obtaining supplies and services; and (b) cardholders return unjustified sole source acquisition requests to the requesting official for proper support.

Director Comments. The VAPHS Director concurred with the recommendation and reported that Acquisitions has increased their review of "Sole Source" justifications and are working toward better recording and filing of same. Changes are being made to improve the purchasing practices for Prosthetic items. In addition, quarterly audits by Fiscal and Acquisitions are being implemented. The target date for completing all of these actions is December 31, 2000.

Office of Inspector General Comments. The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow-up on the implementation of planned actions.

Automated Information System (AIS) Security Should be Improved. VA Handbook 6210 and Office of Management and Budget Circular A-130 provide procedures and practices for protecting sensitive automated resources from unauthorized access, disclosure, modification, destruction, or misuse. Each VHA facility must establish, maintain, and enforce a comprehensive security program.

We found that the VAPHS' Security Awareness and Training, Incident Response Capability, and Remote Dial-Up Access policies and practices were adequate. However, we noted several information technology areas where security could be enhanced:

- VHA policy requires that each VHA facility Director assign an Information Security Officer (ISO) to establish, maintain, and enforce a comprehensive AIS security program. VHA policy further requires that the ISO position should be a full-time position in larger and consolidated facilities and, at a minimum, the primary responsibility for ISOs in smaller facilities. From a security standpoint, key positions must have a separation of duties so that any one person will not be able to adversely affect the AIS resources due to conflict of interest or malicious intent. We found that AIS security was not the primary responsibility of the VAPHS' ISO. The ISO informed us he spent about 2 hours daily on ISO activities and the remainder of his time as the VAPHS' MCCF Coordinator. We recognize that even though the VAPHS is a large integrated facility, it may be difficult for management to designate a full-time ISO. However, appointing an ISO whose primary responsibility is the ISO function would enhance security.

- VHA policy requires that each facility operating an Internet gateway on a VA Network publish an Internet policy, dealing with all aspects of their Internet connection (e.g., user privileges and responsibilities, risk assessment, password management, etc.). We found that the VAPHS had not published an Internet policy.

The ISO informed us that Internet monitoring is conducted through the VA Internet Gateway filtering software. While the Internet Gateway is a filter and does regulate access to certain Internet sites, it does not satisfy the need for publishing a facility Internet policy.

- VA policy requires that appropriate contingency plans be developed for AIS applications. The purpose of such a plan is to ensure that users can continue to perform critical services in the event of a disruption to an AIS. We found that the VAPHS had not developed an adequate facility contingency plan. When asked, the ISO provided the VHA Contingency Planning Boilerplate as the facility's overall contingency plan. However, this boilerplate lacked any facility data. The ISO agreed that the facility's contingency plan needed additional work.

- VA policy requires that user passwords be at least eight characters in length and contain a combination of letters, numbers, and special characters that are not alphanumeric. VA policy further requires that these passwords be changed every 90 days. We were informed that the VAPHS had not implemented this password policy. In a highly interconnected environment such as the VAPHS', it is imperative that strong password controls be implemented to reduce the risk of unauthorized access to VA systems.

- Access to sensitive VA resources should be limited to only those individuals with a need for access to perform their duties. To further restrict access to sensitive data, access should be timely removed when an employee terminates VAPHS employment or when established test/dummy accounts are no longer needed. We identified 667 Veterans Integrated System Technology Architecture (VISTA) user accounts that remained open subsequent to employees' termination dates or in the case of test/dummy accounts, subsequent to the need for the accounts because either the individuals' termination dates were not recorded in VISTA, or the test/dummy accounts had not been properly monitored. We provided the list of 667 accounts to Information Resource Management employees who agreed to review the accounts and terminate those that were no longer needed.

- Physical security needed to be strengthened at the Highland Drive Division. We found that the computer room alarm was turned off first thing each morning. This alarm should be set at all times to control and restrict access to the computer room.

- We also identified two environmental security issues: the Heinz Division lacked a smoke detector in its computer room; and the division's off-site emergency recovery disks had not been properly secured in a locked fireproof cabinet.

Recommendation 3. The Director should improve management oversight of AIS Security by ensuring that: (a) the ISO position is readdressed so that its primary responsibility is AIS security; (b) an Internet policy is developed and maintained; (c) a facility contingency plan is developed; (d) VA password policy is implemented; (e) VISTA access is deactivated when employees terminate employment or test/dummy

accounts are no longer needed; and (f) physical and environmental security deficiencies identified at the Highland Drive and Heinz Divisions are addressed.

Director Comments. The VAPHS Director concurred with the recommendation and reported that: the Information Security Officer (ISO) position is being reclassified as a full-time position with recruitment/selection to immediately follow reclassification; development of an Internet policy will be the new ISO's top priority; the facility AIS Contingency Plan is being revised; all existing VISTA system and Network (Exchange) account passwords meet the 90-day password requirement; the computer systems have been improved to deactivate accounts not accessed in 90 days and new accounts not accessed in 14 days; and the physical and environmental security deficiencies have been addressed. The target date for completing all of these actions is December 31, 2000.

Office of Inspector General Comments. The comments and implementation plans are acceptable and we consider the issues to be resolved. We may follow-up on implementation of planned actions.

Management Needs to Strengthen Controls Over the Means Tests Program. As part of MCCF requirements, copayments are collected from certain veterans to offset costs of treatment provided for NSC conditions. Patients with income below certain thresholds are exempted from these copayments. To qualify for exemption, each year veterans who receive care for NSC conditions must provide VHA with family income (means test) and health insurance information. By signing their means test disclosures, veterans attest to the accuracy of the income information provided and certify receipt of a copy of the Privacy Act Statement. The Privacy Act Statement advises veterans that the income information they provide is subject to verification by computer matching with the income records of the Internal Revenue Service and the Social Security Administration. VHA facilities are required to retain signed means test forms in the veterans' administrative records.

During the period October 1, 1999 through May 30, 2000, the VAPHS processed 434 means test cases in which the patients reported zero income. We reviewed 31 of these cases and found that for 16 cases (52 percent) a signed means test verification form was not in the patient's administrative file. The signed form is necessary to support the patient's reported income. If the form is not on file, the patient's identifying information could be inappropriately entered into the income verification database, which could result in violation of the veteran's privacy, unnecessary income verification match workload, and/or delays in copayment collections. According to Patient Account officials, missing means test records had not been completed, had been lost, or were awaiting filing in the records section.

We concluded that management needs to ensure that means tests are properly completed, signed, and filed in the patients' administrative records.

Recommendation 4. The Director should establish controls to ensure that means test forms are completed, signed and filed.

Director Comments. The VAPHS Director concurred with the recommendation and stated that more stringent monitoring and education will be implemented. The target date for completing the action is December 31, 2000.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issue to be resolved. We may follow-up on the implementation of planned actions.

Classification and Negotiation Procedures for Clinical Services Contracts Need to be Improved. As of June 30, 2000, the VAPHS had 19 clinical services contracts, 18 noncompetitive and 1 competitive, valued at $9.1 million. Most of the VAPHS' clinical services contracts were negotiated with its affiliate, the University of Pittsburgh. When VA facilities contract non-competitively for clinical services, they should develop sufficient pricing information to ensure that contract prices are reasonable. To determine if the VAPHS had negotiated reasonable prices for contracted clinical services, we reviewed nine contracts, valued at $6.4 million. Eight of the nine contracts had been negotiated with the affiliate. We examined contract files and interviewed contracting officials and contracting officer technical representatives.

We found that the VAPHS needed to improve classification and negotiation of noncompetitive contracts. We identified three contracts with the University of Pittsburgh, valued at $2.5 million, that not been properly classified. The three procedure-based contracts, Neuroradiology for $759,000, Perfusionist for $722,000, and Vascular Surgery for $1,038,000, were inappropriately classified as commercial item acquisitions. As a result, required certified cost or pricing data was not obtained and the contracts were not subjected to contract audits. FAR defines commercial items as services that are offered and sold competitively in substantial quantities in the commercial marketplace based on established catalog or market prices. The three contracts had not met the FAR definition of commercial items sold competitively.

The responsible contracting official informed us that the VAPHS' affiliate controls most of the hospital services in the Pittsburgh area. However, to ensure that commercial item contracts are for commercial services, VHA requires that contracting officers conduct market surveys. The required market surveys were not performed. The contracting officer also informed us that he believed VHA's Medical Sharing and Purchasing Office preferred the use of commercial items services whenever possible. We discussed contract classification with Medical Sharing and Purchase Office employees, who informed us that they preferred the commercial services classification be used whenever appropriate. However, our analysis showed that the contracts in question clearly did not meet the FAR definition of commercial services.

As a result of misclassifying the three contracts and not developing sufficient pricing information, the VAPHS faces a risk of being overcharged for the contract services. It is

noteworthy that the prior year Perfusionist Service Contract had not been classified as a commercial item acquisition, but rather had been appropriately classified as Scarce Medical Specialist Service. As such, the contract had been subjected to a field-pricing audit by the Department of Health and Human Services (HHS). HHS had questioned $289,000 of the proposed $711,339 contract costs (41 percent).

We concluded that management needs to improve clinical services contract negotiating procedures by ensuring that the contracts are properly classified. As demonstrated by HHS' field-pricing audit of the prior-year Perfusionist contract, there is a possibility that inappropriate classifications could result in the VAPHS being overcharged by as much as $289,000. Proper classification of contracts will ensure that required cost and pricing data is obtained and reviewed, and contracts are subjected to audit.

Recommendation 5. The Director should ensure that contracts are properly classified and contract prices appropriately negotiated.

Director Comments. The VAPHS Director concurred with the recommendation and reported that enhancements of the process involved with classification and negotiations of clinical services will take place through in-depth review and monitoring by the Contracting Section. The target date for completing all of these actions is December 31, 2000.

Office of Inspector General Comments. The comments and implementation plan are acceptable and we consider the issue to be resolved. We may follow-up on the implementation of planned actions.

Fraud and Integrity Awareness Briefings

As part of the CAP review, we conducted three 90-minute Fraud and Integrity Awareness briefings, which included a brief film on the types of fraud that can occur in VA programs, a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. One hundred sixty-three VAPHS employees attended the briefings. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1 delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Management is required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that are not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division is responsible for investigating alleged criminal activity. When an allegation is received, Division staff assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or a criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The Criminal Investigations Division conducts investigations of a broad range of criminal activities that can occur in VA programs and operations. Areas of particular interest to the Division are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, overbilling, false claims, and violations of the

Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, compensation and pension fraud, equity skimming, and loan origination fraud. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by employees and beneficiaries.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** – Names, position titles, connection with VA, and other identifiers.
- **What** – The specific alleged misconduct or illegal activity.
- **When** – Dates and times the activity occurred.
- **Where** – Where the activity occurred.
- **Documents/Witnesses** – Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses may not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

Monetary Impact in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of VA Pittsburgh Healthcare System

Project Number: 2000-02022-R1-0263

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds
1	Better use of funds through reducing medical supply inventories would ensure excess stock and inventory costs are minimized.	$250,794[1]

[1] This estimate was made to demonstrate the local impact that implementation of GIP/better supply management would have at VAPHS. The projected monetary benefits of implementing GIP on a nationwide basis were previously reported in OIG Report No. 9R8-E04-052, dated March 9, 1999.

Healthcare System Director Comments

Department of Veterans Affairs

Memorandum

Date: October 12, 2000

From: Director (646/00), VA Pittsburgh Healthcare System

Subj: DRAFT REPORT: Combined Assessment Program-VA Pittsburgh Healthcare System

To: Assistant Inspector General for Auditing (52)

1. Enclosed is our response to the draft report of the Combined Assessment Program (CAP) Review conducted at this medical center. We have reviewed the report findings and concur with the five recommendations (Attachment). We also concur with the OIG estimate of monetary impact regarding better use of funds through reducing medical supply inventories.

2. Although not required for reporting purposes, VA Pittsburgh Healthcare System is in agreement with the suggestions made by the CAP team. Appropriate follow-up actions are underway.

3. If you require any additional information or further clarification, please feel free to contact Ms. Barbara Reichbaum, Performance Improvement, at 412-784-3777.

/signed/

MICHAEL E. MORELAND

Attachment

Healthcare System Director Comments (cont.)

Recommendation 1:

We concur with this recommendation and will implement the following corrective actions:

- The Acquisitions Program has been charged with responsibility to establish implementation plans for all mentioned recommendations soon after the close out of fiscal year 2000.

Recommendation 2:

We concur with this recommendation and will implement the following corrective actions:

- Acquisitions has increased their review of "Sole Source" justifications and are working toward better recording and filing of same. Changes, including additional FTEE, are being made to improve the purchasing practices for Prosthetic items.

TARGET DATE FOR IMPLEMENTATION: 12-31-00

- In addition, quarterly audits by fiscal and acquisitions are being implemented.

TARGET DATE FOR IMPLEMENTATION: 12-31-00

Recommendation 3:

We concur with this recommendation and will implement corrective actions.

- Draft PD for a full-time Information Security Officer has been developed and is in final stages of review. Recruitment/selection will immediately follow classification of PD.
- Composition of an internet policy is viewed as top priority for new ISO upon hire as above. In the meantime, facility will utilize the current policy which is a standard such policy but is lacking local security measures.
- The facility AIS Contingency Plan is being revised. The CPRS team has developed a draft policy and other service lines have also developed such plans but are pending finalization of the overall plan. As new programs come on board, (BCMA, etc.) specific plans addressing these programs will be incorporated in the facility's overall plan. This also will be an action item for the new ISO.
- Existing VISTA system is already set for 90 days password changes; the network (exchange) accounts have recently been changed to also reflect this requirement. A more strict VA password policy has been implemented.
- With regard to ex-employees, systems have been improved to include deactivation of accounts not accessed in 90 days and also new accounts not accessed within 14 days.
- Computer room alarm is now activated 24 hours; 7 days a week.
- A Work Order has been submitted for installation of smoke detector; and a fireproof cabinet for off-site storage has been ordered.

TARGET DATE FOR IMPLEMENTATION: 12-31-00

Recommendation 4:

- The overall Means Test process is an area that has shown much improvement. It is now anticipated that fewer than 100 means tests will be delinquent at the close of FY 00. However, more stringent monitoring and education in this regard will be implemented.

TARGET DATE FOR IMPLEMENTATION: 12-31-00

Recommendation 5:

We concur with this recommendation and will implement the following corrective actions:

- Enhancement of the process involved with classification and negotiation of clinical services will take place through in-depth review and monitoring by the Contracting Section.

TARGET DATE FOR IMPLEMENTATION: 12-31-00

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