



Office of Audit Services – Region III
Public Ledger Building, Room 316
150 South Independence Mall West
Philadelphia, PA 19106-3499

AUG 30 2006

Report Number: A-03-05-00207

Mr. Donald Blanchon
Executive Director
Whitman-Walker Clinic
1407 S Street, NW
Washington, DC 20009

Dear Mr. Blanchon:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), report entitled "Audit of Whitman-Walker Clinic's Adequacy of Patient Care." Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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Please refer to report number A-03-05-00207 in all correspondence relating to this report.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Douglas H. Morgan
Director, Division of Service Systems, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane; Parklawn Bldg., RM 7A-55
Rockville, MD 20857

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF WHITMAN-WALKER
CLINIC'S ADEQUACY OF PATIENT
CARE**



Daniel R. Levinson
Inspector General

August 2006
A-03-05-00207

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

We performed our audit in response to an allegation submitted on June 4, 2005, to the Department of Health and Human Services, Office of Inspector General (OIG). The allegation stated that Whitman-Walker Clinic (the Clinic) conducted medically unnecessary and time-consuming testing procedures that contributed to the medical deterioration and eventual death of an AIDS patient.

The Clinic is a non-profit community-based health organization primarily serving people living with HIV/AIDS in the District of Columbia metropolitan region. The Clinic provides outpatient medical and dental care, pharmacy and medical laboratory services, counseling, and HIV testing and prevention. It receives funding from several sources, including the Federal Government's Health Resources and Services Administration (HRSA).

The individual who wrote to the OIG also raised concern about the Clinic's billing practices. During our review, we determined that several parties, including the District of Columbia's Department of Health and HRSA, were in the process of examining the Clinic's funding and billing practices. We did not audit the Clinic's billing practices during our review.

OBJECTIVE

Our objective was to determine if the allegation could be substantiated that the Clinic conducted medically unnecessary and time-consuming testing procedures that contributed to the medical deterioration and eventual death of an AIDS patient.

RESULTS OF AUDIT

There was no evidence to substantiate the allegation that the Clinic conducted medically unnecessary and time-consuming testing procedures that contributed to the medical deterioration and eventual death of an AIDS patient. The tests performed for the patient were both necessary as a basis for treatment and conducted within acceptable timeframes.

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INTRODUCTION

BACKGROUND

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OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the allegation could be substantiated that the Clinic conducted medically unnecessary and time-consuming testing procedures that contributed to the medical deterioration and eventual death of an AIDS patient.

Scope

Our audit focused on one patient who accessed HIV/AIDS medical services at the Clinic in 1998.

Payments of HRSA funds to the Clinic were being reviewed by the District of Columbia's Department of Health, with HRSA's involvement. At the time of our audit, the Department of Health had retained an independent public accounting firm to address billing practices. We did not include billing practices in our audit pending the results of the independent review.

We limited our review of internal controls to the procedures needed to accomplish our audit objective. Meeting the objective did not require a complete understanding or assessment of the internal control structure at the Clinic.

We conducted our fieldwork during the period from August to November 2005 at the administrative offices of the Clinic and at the District of Columbia's Office of Inspector General.

Methodology

To accomplish our objective, we:

- interviewed the individual who made the allegation about the Clinic's handling of the patient's condition;
- reviewed Federal standards of care for HIV/AIDS that were in effect in 1998;
- examined the Clinic's medical records for the patient and discussed these records with the Clinic's current medical director (both the attending physician and the medical director of the Clinic had died before the audit period);
- researched regulations for HRSA grants, the primary source of funding at the Clinic; and
- met with parties who were conducting reviews of the Clinic's use of funding and billing practices at the time of our audit to determine if it was necessary for the OIG to conduct work in the billing area.

Our audit was conducted in accordance with generally accepted government auditing standards.

RESULTS OF AUDIT

There was no evidence to substantiate the allegation that the Clinic conducted medically unnecessary and time-consuming testing procedures that contributed to the medical deterioration and eventual death of an AIDS patient.

The patient file indicates that, in 1998, he was a new Clinic patient for medical services and that his blood levels had not been monitored after his HIV positive diagnosis 7 years earlier. The file shows that blood was drawn at the first appointment for testing for CD4 count and viral load, among other indicators. A follow-up appointment was scheduled for 2 weeks after testing in order to allow time for the results of the tests to be available. Records in the patient file showed that his viral load test was completed in 7 days following his first appointment at the Clinic and his CD4 count test was completed the same day.

The HIV virus replicates itself by attacking and destroying immune system cells. Draft HIV/AIDS treatment guidelines released by the Department of Health and Human Services on June 19, 1997, state: "The decisions about treatment for people with

HIV/AIDS should be guided by regular monitoring of the amount of HIV in the patient's blood (viral load) as well as the number of CD4+ T cells, the immune system cells that fight infection." According to the guidelines, and as a matter of routine practice in 1998 and today, a new patient who is HIV positive would require two main tests as a basis for treatment: CD4 count and viral load. The tests guide the decision to initiate treatment and, if treatment is indicated, provide the basis for determining the most appropriate anti-retroviral medications for the patient's condition.

The Clinic's testing procedures appeared to be in agreement with the guidelines established by the Department of Health and Human Services. However, we learned from the individual raising the allegation that the patient decided not to return to the Clinic for the follow-up appointment, preferring to seek treatment elsewhere. The patient died a few months later, in May 1998.