Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Alexandria, Louisiana

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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Executive Summary

Introduction

During the week of June 10-14, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (VAMC) Alexandria, Louisiana. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 238 employees.

Results of Review

Medical center management actively supported high quality patient care and performance improvement. Organizational strengths were noted in the management of nurse staffing levels, the exceptionally low nosocomial infection rate, implementation of a restraint free program, and the management of the Government purchase card program. However, QM activities reviewed required improvement. Financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the Veterans Integrated Service Network (VISN) Director needs to ensure that the Medical Center Director:

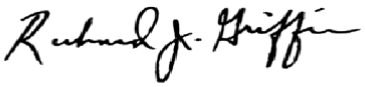
- Improves the peer review process.
- Improves the Homemaker/Home Health Aide (H/HHA) Program's clinical and administrative procedures.
- Strengthens the Root Cause Analysis (RCA) process.
- Installs an electronic surveillance system to contain patients at high-risk for wandering or elopement.
- Improves Automated Information Systems (AIS) security.
- Improves supply inventory management.

We also made suggestions regarding access to guardianship status, prosthetics storage, inventory and disposal of controlled substances, and noncompetitive contracts.

VISN Director Comments

The VISN Director agreed with the findings and recommendations, except for moving the back-up tapes off-site. However, the action taken by the Medical Center Director to move the back-up tapes to another building met the intent of our recommendation. Also, the VISN is pursuing clarification of "off-site" versus "off-station" with VA's Office of Cyber Security. (See Appendix A, page 15, and Appendix B, page 18, for the full text of the Directors' comments.)

The VAMC Director provided acceptable improvement plans. We will follow up on planned actions until they are completed.



RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. VAMC Alexandria is a specialty referral facility for long-term psychiatric care that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics located in Jennings and Lafayette, Louisiana. The medical center is part of VISN 16 and serves a veteran population of about 96,000 in a primary service area that includes 26 parishes in Louisiana.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 138 hospital beds and 154 nursing home beds and operates referral and counseling programs in Alexandria, Louisiana. In addition, the medical center has sharing agreements with the U.S. Army base at Fort Polk, the State of Louisiana, and several community hospitals.

Affiliations and Research. The medical center is affiliated with the Tulane University School of Medicine, and supports three medical resident positions in three training programs. In fiscal year (FY) 2001, the medical center's Research Program had four projects in the areas of congestive heart failure and hypertension.

Resources. In FY 2001, medical care expenditures totaled over $86.2 million. The FY 2002 medical care budget is over $86.6 million. FY 2001 staffing totaled 908.7 full-time equivalent employees (FTEE), including 38.7 FTEE physicians and 294 FTEE nursing employees.

Workload. In FY 2001, the medical center treated 23,761 unique patients. The medical center provided 36,562 inpatient days of care in the hospital and 52,946 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 2,352 discharges, and the average daily census for the hospital was 100.2 and 145.1 for the NHCU. The outpatient care workload was 185,419 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, and financial and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, patients, and Veterans Service Organization representatives; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following activities:

Quality Management	Automated Information Systems
Infection Control	Contract Administration
Utilization Review	Government Purchase Card Program
Credentialing and Privileging	Generic Inventory Package Implementation
Long-Term Care	Part-Time Physician Time and Attendance
Community Residential Care Program	Prosthetics Service Inventory Accountability
Homemaker/Home Health Aide Program	Controlled Substances Accountability

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The results indicated high levels of patient and employee satisfaction and did not disclose any significant issues. The full survey results were provided to medical center management.

During the review, we also presented four fraud and integrity awareness briefings for VAMC Alexandria employees. A total of 238 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Our review covered VAMC Alexandria operations for the period January 1, 2000, through June 14, 2002, and was conducted in accordance with the Inspector General's standard operating procedures for CAP reviews.

In this report, we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN 16 and/or VAMC management until corrective actions are completed.

Results of Review

Organizational Strengths

VAMC Alexandria management created an environment that supported high quality patient care and performance improvement. The patient care administration and financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. We interviewed a total of 35 inpatients and outpatients. The quality of care provided at the medical center was rated by 94 percent of the patients interviewed as excellent, very good, or good, and those interviewed reported that they would recommend treatment at the facility to an eligible family member or friend.

A Nursing Service Database Assessed Nurse Staffing Effectiveness. Management was aware that effective July 1, 2002, the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) would require participating hospitals to comply with a standard to evaluate nursing levels in relation to the occurrence of adverse events. The standard would mandate that hospitals use data on at least two clinical/service indicators in combination with at least two human resources indicators to assess staff imbalances that may affect quality of care or patient safety. Medical center managers anticipated the need for data collection and began tracking the following JCAHO screening indicators on September 1, 2001:

- Patient falls
- Medication errors
- Decubiti (pressure ulcers)
- Family complaints
- Patient complaints
- Adverse drug reactions
- Adverse blood transfusion reactions
- Staff injuries
- Patient injuries
- Staff injuries resulting from restraining patients

In addition to the JCAHO screening indicators, clinical managers also tracked nurse staffing variances and patient census data by shift, for all inpatient areas, and used the data to identify adverse events that could have been related to nurse-staffing variances. As a result of these reviews, management had adjusted staffing levels accordingly.

Nosocomial Infection Rate Was Exceptionally Low. The medical center's number of nosocomial infections (hospital acquired infections) decreased from 16 in FY 2000 to 7 in FY 2001. The infection control managers attributed the lower rate to prevention methods, including the administration of influenza and pneumococcal immunizations for a majority of their patients.

Managers Implemented a Restraint Free Program. In May 2002, medical center managers implemented a restraint free program. Under the program, staff nurses consulted with the Associate Chief, Nursing Service, or nursing supervisors, to ensure that all restraint free alternatives were attempted before requesting a doctor's order to place a patient in restraint or seclusion. During the 6 months prior to implementing the program, the medical center averaged

16 patient restraint episodes a month, but only 9 during the month of May after implementation of the program.

The Government Purchase Card Program Was Effectively Managed. The VAMC had a full-time Purchase Card Coordinator who monitored and followed up on purchase card transactions. Cardholders had appropriate warrants for spending limits over $2,500, purchases were not split to stay within card limits, reconciliations and approvals of Government purchase card transactions were timely, and all cardholders and approving officials received Government purchase card training.

Other Results. Selected aspects of utilization review, credentialing and privileging, long-term care, and part-time physician time and attendance that we reviewed were generally operating satisfactorily.

Opportunities for Improvement

Peer Reviews – Primary Care Service Should Improve Their Process

Conditions Needing Improvement. Peer reviews of Primary Care Service were not completed within 30 days, and appropriate corrective actions were not initiated for Level 2 and 3[1] care findings, as required by local policy. Between January 1, 2000, and June 10, 2002, QM staff initiated 110 Primary Care Service peer reviews, of which 40 (36 percent) remained open at the time of our visit. One open peer review case dated back to January 18, 2000. The QM manager informed us that some peer review cases remained open because the peer review findings had not been discussed with the involved providers.

The peer reviewers judged 22 of the 70 closed cases as Level 2 and 1 as Level 3. Some of the peer reviews were recorded in the involved provider's profile[2]; however, we found little evidence that responsible clinical staff had taken corrective actions to improve the quality of care delivered by the providers. In one case, a provider who had seven Level 2 care findings was reprivileged 6 months prior to our visit. Six of the seven Level 2 care findings were pending completion at the time of our review, four of which were opened prior to the reprivileging period. We found no evidence of thorough case reviews or recommendations for improving care in Primary Care Service staff meeting minutes. The peer review process should be utilized to document the quality and appropriateness of patient care, and identify problem areas that reduce the effectiveness of that care. Subsequent to our onsite review, managers reported that all outstanding peer reviews had been addressed and resolved.

Recommended Improvement Action 1. The VISN Director should ensure that the Medical Center Director implements controls to:

[1] Level 2 is defined as *most practitioners would have probably handled the case differently* and Level 3 as *most practitioners would have definitely handled the case differently*.
[2] A file that includes provider specific information including QM data and proficiency reports.

a. Complete and return peer reviews to the Office of Quality Management within 30 days of receipt.
b. Develop and document appropriate corrective actions for Level 2 and 3 findings.
c. Consider peer review data in reprivileging decisions.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Homemaker/Home Health Aide Program – Clinical and Administrative Procedures Should Be Improved

Conditions Needing Improvement. The H/HHA Program's patient assessment procedures and program oversight needed improvement; and, the prevailing Medicaid rates should be used when negotiating rates for homemaker services. The H/HHA Program was designed to provide functionally impaired veterans with in-home support to assist with activities of daily living (ADL) such as bathing, dressing, and mobility; and, with instrumental activities of daily living (IADL) such as cooking, housekeeping, and shopping. The goal of the program is to help patients remain out of nursing homes for as long as possible.

Medical center program staff authorized about $31,600 in H/HHA Program services for 18 veterans during the first quarter of FY 2002. At the time of our visit, medical center staff contracted with 3 Community Health Agencies (CHAs) to provide H/HHA Program services for 14 veterans at an approximate monthly cost of $8,150. We interviewed five veterans who were receiving services at the time of our review and all five reported that the services they received enabled them to stay out of nursing homes. However, we found several areas that required management attention.

Patient Assessments Were Not Always Complete or Interdisciplinary. We reviewed the medical records of 10 patients currently receiving H/HHA Program services. Initial interdisciplinary assessments were not completed in 6 of the 10 medical records reviewed. Veterans Health Administration (VHA) and medical center policies require that a physician, nurse, and social worker complete the Nursing Care Referral Form documenting the patients' deficits, needs, and clinical eligibility for services. We found that the referring social worker completed the H/HHA Medical Determination Form that documents the patients' ADL and IADL dependencies and other conditions that indicated the patients' need for nursing home care. Only 4 of 10 medical records reviewed contained nursing assessments. We also found that in 6 of the 10 cases, the physicians merely cosigned the referrals rather than completing their own assessments to document that the patients needed H/HHA Program services. When interdisciplinary assessments are not completed, the referring physician, nurse, or social worker could make inappropriate referrals.

Clinical Eligibility for H/HHA Services Was Not Adequately Monitored. Three of five patients currently receiving homemaker services did not meet clinical eligibility requirements. VHA

policy states that to be eligible for H/HHA Program services, a veteran would, in the absence of such services, need nursing home care. The need for nursing home care is determined by several indicators, including one or more ADL dependencies, and two or more other conditions, including dependency in three or more IADLs, advanced age, depression, cognitive impairment, or living alone.

Three of the patients' records we reviewed had no documented ADL dependencies. One of the three patients told us he was able to live alone and drive himself around, and stated that the homemaker cleaned his carpets and took his clothes to the laundromat. The patient also stated that he would not need nursing home care at this point in his life, even if he were not receiving homemaker services. Another patient, whose documented deficit was chronic back pain, received homemaker services for "general housekeeping" 3 hours per week. The H/HHA Program Coordinator told us that ineligible patients received homemaker services because he misinterpreted VHA policy regarding eligibility for H/HHA Program services. Medical center program managers believed that patients could qualify for homemaker services even if they only needed assistance with IADLs, such as housekeeping.

Eight patients were on the H/HHA Program's waiting list, and one patient had been on the list for 8 months. The eight patients met clinical eligibility requirements and some were in greater need than some patients currently receiving services. Using program resources for patients that do not meet clinical eligibility requirements, or for those who do not need the services, limits provision of services to eligible patients with greater deficits.

Clinical and Administrative Oversight of the Program Needs Strengthening. The H/HHA Program Coordinator did not comply with some VHA or medical center policies. Specifically, the medical center's policy stipulated that the coordinator review referral forms for completeness and appropriateness of referral, yet we found six incomplete assessments and three ineligible veterans receiving H/HHA Program services. Medical center policy also states that the coordinator should monitor the quality of services provided and the continued appropriateness of the patients for H/HHA services. Quality of services provided was not monitored and one patient received services that he did not need. Furthermore, H/HHA Program managers did not obtain documentation of CHA supervisory and performance improvement activities as mandated by VHA policy.

State Medicaid Rates Should Be Used for Contracted H/HHA Program Services. We found that contract rates for home health aide services were comparable to state Medicaid rates; however, the contract rates for homemaker services were more than twice as high as the state's Medicaid rates. According to Federal Acquisition Regulations (FAR), contracting officers are responsible for evaluating the offered prices to ensure that the final price is fair and reasonable. During the first quarter FY 2002, the medical center paid $7,245 for homemaker services for six patients, ranging from $21.00 to $21.75 per hour. At the same time, the state Medicaid rate was $10.00 per hour for homemaker services. According to contracting officials, the medical center accepted the prices quoted without comparing them to state Medicaid rates. As a result, the medical center paid $3,897 more than the state Medicaid rate.

Recommended Improvement Action 2. The VISN Director should ensure that the Medical Center Director requires that:

a. Complete interdisciplinary patient assessments are documented on all patients referred to the H/HHA Program.
b. Patients receiving H/HHA Program services meet clinical eligibility requirements.
c. The H/HHA Program Coordinator complies with program policy on clinical and administrative oversight.
d. Contracting officers consider the prevalent state Medicaid rates when contracting for H/HHA Program services.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Root Cause Analysis – The Process Should Be Strengthened

Conditions Needing Improvement. Corrective actions recommended by the RCA team were not always measurable, implemented, or followed until resolution. RCAs are usually completed by interdisciplinary teams in response to an adverse event. RCA teams make recommendations to improve systems so that similar adverse events do not recur.

Although our review of 10 files showed that the RCA team completed RCAs within the 45-day requirement and determined the root cause of the problems, we found that the recommended corrective actions to improve identified deficiencies were not always measurable. For example, one RCA corrective action was to "Maintain a controlled professional environment." This recommendation is neither clear nor measurable. Additionally, we did not find evidence that the QM managers routinely evaluated the effectiveness of corrective action plans. Without this evaluation, QM managers could not ensure that corrective actions adequately addressed the deficiencies and produced the desired results.

Although senior managers assigned target dates for corrective actions and responsibilities to line managers, they did not require line managers to provide reports showing the status of the corrective actions. At the time of our review, we found that responsible staff had either not developed policies recommended by the RCA team, or the policies were still in draft format, even though the implementation dates had passed. When senior managers are closely involved with implementation and follow up of RCA recommendations, the outcomes are more likely to be successful.

Recommended Improvement Action 3. The VISN Director should ensure that the Medical Center Director requires that:

a. The RCA team's recommended corrective actions are measurable and the effectiveness is evaluated.

b. QM managers develop a procedure for implementing and tracking corrective actions until issues are resolved.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Patient Safety – An Electronic Surveillance System Is Needed on Ward 45A

Conditions Needing Improvement. Ward 45A, a long-term care unit, did not have mechanisms in place to properly contain patients at high-risk for wandering or elopement. When a person passed within the range of an electronic sensor, the main doors to Ward 45A automatically opened to an outside porch and parking area. Nursing station staff could not see who entered or exited the ward because a bank of elevators obscured their view of the doors. During April 2002, patients wandered from the ward on three occasions. Given the physical layout of Ward 45A, an electronic surveillance system is needed. With these systems, patients identified as high-risk for wandering or elopement wear electronic bracelets or anklets, which either sound an alarm or automatically lock the doors if a patient wearing the device approaches a monitored door. An electronic surveillance system would be an appropriate mechanism to reduce wandering and elopement of high-risk patients.

Recommended Improvement Action 4. The VISN Director should ensure that the Medical Center Director has an electronic surveillance system installed at the main doors of Ward 45A to safely contain patients that are at high-risk for wandering or elopement.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needs Improvement

Conditions Needing Improvement. Although medical center managers had implemented policies and taken actions to ensure AIS security, we found the following conditions required management attention:

- The Information Security Officer (ISO) was part-time, lacked technical knowledge of the AIS, and was not organizationally aligned to promote independence and objectivity.
- Contingency plans were not comprehensive.
- Procedures for disposal of equipment containing sensitive information were not adequate.
- Computer back-up tapes were not stored off-site.

- Policy was needed to address system access by disgruntled employees and employees undergoing a reduction in force (RIF) action.
- Controls over granting remote access to the Local Area Network (LAN) were inadequate.

VHA policy requires that all of the above issues be addressed in order to enhance the overall security of the AIS environment. Without strong controls, system security is weakened, vulnerabilities are increased, and the medical center's AIS are susceptible to inadvertent or deliberate modification, destruction, and/or release of sensitive information.

The ISO Was Part-Time, Lacked Technical Knowledge, and Was Organizationally Aligned Under the Chief Information Officer. The ISO worked on AIS security related issues on a part-time basis; did not have a technical background in information technology; had not received training in information security related issues; did not understand how to use the audit tools available to monitor major AIS; and reported to the Chief Information Officer (CIO). VA policy requires that the ISO work on information security related issues as their principal responsibility; be knowledgeable in information security related issues; and report to someone who does not have operational responsibilities for information management. The ISO expressed little interest, involvement, commitment, or ownership of the ISO function. The ISO spent about 1/8th of his time on AIS security related duties and the remaining 7/8ths as the Decision Support System site manager. A week prior to our visit, the CIO assigned an alternate ISO to assist in the technical aspects of AIS security.

The current organizational alignment does not promote independence and objectivity required for an effective AIS security program. Medical center management aligned the ISO function under the CIO, who coordinated and supervised information security related duties. Normal business practice is that an individual who has oversight responsibility for a function does not report to the manager responsible for that function. To do so would impair the ISO's independence and objectivity. Since the ISO function is one of oversight, the ISO should not report to the manager responsible for the AIS program. The current organizational alignment does not promote independence and objectivity required for an effective AIS security program.

AIS Contingency Plans Were Not Comprehensive. AIS contingency plans had not been sufficiently developed and implemented to reduce the impact of disruptions in services, to provide critical interim processing support, and provide the ability to resume normal operations. AIS contingency plans generally did not:

- Identify mission-critical functions.
- Identify roles key personnel would play in a disaster recovery process.
- Prioritize specific tasks to be completed in a disaster recovery process.
- Identify an off-site storage site for critical back-up files and copies of AIS contingency plans.

AIS contingency plans that are not comprehensive will be of little use in a catastrophic event. The disaster recovery process will be slowed and the delivery of essential health care could be affected.

Procedures for Disposal of Equipment Containing Sensitive Information Were Not Adequate. Medical center management had not designated in writing an official to certify that equipment with storage media had been properly cleared of all sensitive information before disposal, as required by VA policy. Consequently, management had no assurance that the equipment was properly cleared before disposal.

LAN Back-Up Tapes Were Not Stored Off-Site. Medical center management did not ensure that LAN back-up tapes were stored off-site. VA policy requires the back-up of automated data and the storage media to be stored in a secure off-site location, so that a catastrophic event affecting the main computer room would not also affect the back-up location.

Policy Had Not Been Developed to Address the Termination of System Access for Disgruntled Employees and Employees Undergoing a RIF Action. Medical center management should strengthen the overall information security program by developing procedures to address termination of system access for disgruntled employees and employees undergoing a RIF action. Without such procedures, medical center data are vulnerable to malicious modification, destruction, and/or unauthorized release of sensitive information.

Controls Over Granting Remote LAN Access Were Inadequate. Medical center management had not issued policy regarding the granting of remote LAN access, and the LAN manager did not maintain written justifications when remote access was granted. As of May 2002, the LAN manager had granted 46 medical center employees and 15 contractor employees remote LAN access. While our review of the 61 individuals having remote LAN access showed that continued access was needed, we found the following areas require management attention:

- Medical center management had not issued policy governing the granting of remote LAN access.
- Neither the ISO nor CIO maintained documentation to justify the granting of remote LAN access.
- The ISO had not performed quarterly reviews of the continued need for remote LAN access.
- The CIO had not documented equipment and software used by employees for remote LAN access capability.

A policy should be developed to address the granting of remote LAN access. This policy should require that justifications for remote access are documented, quarterly reviews of the continued need for remote access are performed, and documentation to identify equipment and software signed out to employees with remote access is maintained by the CIO. Without strong controls, overall AIS security is weakened.

Recommended Improvement Action 5. The VISN Director should ensure that the Medical Center Director requires that:

a. A qualified individual is assigned as the ISO.
b. The ISO is properly trained to conduct information security duties.
c. The ISO reports to the Director or Associate Director.
d. AIS contingency plans are comprehensive and contain required elements.

e. An official is designated to certify that sensitive data has been cleared from equipment with storage media before disposal.
f. Computer back-up tapes are stored in a secure off-site location.
g. Policies are developed to address termination of system access for disgruntled employees and employees subject to RIF.
h. A remote LAN access policy is implemented.

The VISN Director agreed with the findings and recommendations, except for moving the back-up tapes off-site. Action taken by the Medical Center Director to move the back-up tapes to another building met the intent of the recommendation. Also, the VISN is pursuing clarification of "off-site" versus "off-station" with VA's Office of Cyber Security. The VISN Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Need Improvement

Conditions Needing Improvement. VHA's Inventory Management Handbook mandates the use of the Generic Inventory Package (GIP) to effectively manage all inventories. However, Acquisition and Materiel Section (A&MS) staff were not effectively using GIP to manage supplies. According to the Days of Stock On-Hand Report, dated May 15, 2002, the 7 primary inventory points[3] had 1,543 inventory items valued at about $324,000. Although medical center staff had entered inventory balances into GIP for all seven primary inventory points, we found that responsible staff for six primary inventory points had not fully implemented GIP. Only the Supply Processing and Distribution (SPD) inventory reports showed stock usage data. As a result, we could not effectively test inventory levels.

We sampled 20 of the 967 items stocked in SPD to determine the accuracy of the inventory balances in GIP. Even though SPD had fully implemented GIP, we determined that 19 of the 20 items (95 percent) inventoried did not agree with the inventory balances shown in GIP. According to the Inventory Management Supervisor, the SPD wall-to-wall physical inventory performed in January 2002 was incomplete, because some stock items did not have barcode labels and other stock items' levels were not scanned into GIP. As a result, the inventory data in GIP was incorrect. The Inventory Management Supervisor informed us that he initiated corrective action. To achieve VHA inventory management and reduction goals, GIP should be fully implemented and effectively utilized to manage inventories.

Recommended Improvement Action 6. The VISN Director should ensure that the Medical Center Director requires that GIP be fully implemented for all inventory points and stock levels should be reduced to a 30-day supply, where appropriate.

[3] (1) Dental, (2) Electrocardiogram/Diagnostic and Testing Healthcare Line, (3) Housekeeping, (4) Integrated Financial Operations, (5) Imaging, (6) Laboratory Medicine, and (7) SPD.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Guardianship Status – Improved Electronic Medical Record Documentation Is Needed

Conditions Needing Improvement. Documentation of patients' legal guardianship status was not readily accessible in the electronic medical records. As electronic medical records make data retrieval significantly easier, healthcare providers no longer routinely utilize hard copy medical records. Thus, healthcare providers do not always know when a patient has a legal guardian because the documents are usually filed in the patient's hard copy medical or administrative record. We reviewed two guardianship cases, which we identified during our review of medical records, and found information about the patients' guardians in generic progress notes. Although the information was located in the electronic medical records, it was not easily identifiable by other providers with a need-to-know.

The Community Residential Care (CRC) Program Coordinator told us that there were several incompetent patients enrolled in CRC. However, because there was no standard location to document a patient's legal guardianship status in the electronic medical record, we could not identify those patients and their guardians without reviewing each patient's progress notes. This effort could be cumbersome, particularly in the event of an emergency. Legal guardianship status should be readily accessible in the electronic medical record to ensure that providers communicate information and secure consent from the appropriate persons.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires patients' legal guardianship status to be noticeably posted in the electronic medical records.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Prosthetics Storage – Monthly Inventories of VA Equipment Stored at a Local Contractor's Warehouses Would Improve Accountability

Conditions Needing Improvement. Prosthetics and Sensory Aids Service (PSAS) staff did not conduct required monthly inventories of durable medical equipment (DME) stored by a local contractor. The local contractor also managed DME for other Government agencies. The PSAS representative told us that he made infrequent visits to the contractor's warehouses. Instead of performing complete inventories, he relied on physical inventory counts made by the contractor's warehouse personnel. The potential for co-mingling of inventories and subsequent loss of VA equipment is increased when monthly physical inventories are not completed.

We requested physical counts of the DME stored in the local contractor's warehouses and copies of PSAS DME stock control records to test the reliability and accuracy of PSAS's DME inventory balances. Our review showed that 36 of the 42 (86 percent) DME line items stored in the contractor's 2 warehouses showed inconsistent stock-on-hand balances. In addition, the local contractor also reported inventory balances for 11 items not included in the 42 PSAS DME line items. The PSAS representative attributed the inability to achieve an accurate inventory and reconciliation to the lack of adequate PSAS staff. VA policy requires that PSAS staff perform inventories of DME line items stored in contractor warehouses. However, the PSAS representative informed us that PSAS had three employees whose primary responsibility was purchasing stock and they were not responsible for inventory control.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that DME items stored in the contractor's warehouses are inventoried monthly by PSAS staff, and the results reconciled against PSAS records.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Unusable and Expired Controlled Substances – Disposition of Controlled Substances Should Be Improved

Conditions Needing Improvement. Medical center staff did not properly depose of unusable and expired controlled substances. VA policy requires that unusable and expired controlled substances be turned into A&MS for destruction, witnessed and attested to by the A&MS manager, or his representative, the Chief, Pharmacy Service, or designee, and an inspecting official. The inspecting official witnessing the exchange of custody of controlled substances scheduled for destruction is an essential control technique that provides final certification of the correctness of the controlled substances inventories.

We reviewed the disposition records for unusable and expired controlled substances for the 12-month period ending May 31, 2002. We found that Pharmacy Service staff disposed of unusable and expired controlled substances quarterly as required; however, we found no evidence that an inspecting official witnessed the dispositions.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that an inspecting official witnesses and documents the exchange of custody of unusable and expired controlled substances scheduled for destruction.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Controlled Substances Oversight – Administration of the Inspection Program Should Be Strengthened

Conditions Needing Improvement. Unusable and expired controlled substances retained in the narcotics vault were not inventoried and verified during unannounced monthly inspections. Our review of inspection reports and supporting documentation for the 12-month period ending May 31, 2002, showed that unusable and expired controlled substances logged on the Pharmacy Service's Destruction Holding File (DEA Form 41) were not included in the inventory of the narcotics vault during the inspections. VA policy requires medical centers to maintain strong controls to ensure that all Schedule II-V controlled substances are accounted for and the potential for diversion is reduced. One essential control is the unannounced monthly inspection of all controlled substances in all storage locations, including verification of unusable and expired controlled substances stored in pharmacy bulk storage facilities.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that all unusable and expired controlled substances are included in monthly inspections.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Noncompetitive Contracts – Contract Price Negotiations Should Be Documented

Conditions Needing Improvement. Contracting officers did not document the negotiations of contract pricing in three of nine noncompetitive contracts reviewed. The FAR requires that the contracting officer prepare a Price Negotiation Memorandum (PNM) that contains, among other explanations, the most significant facts and considerations controlling the negotiated agreement, including any significant differences between the contractors' and contracting officers' positions.

We reviewed nine noncompetitive contracts with a total value of $5 million to determine if the contracting officers documented the negotiations with the vendors. Although the contracting officers may have negotiated the contract prices, they did not prepare PNMs for three contracts with a total value of $1.7 million. The A&MS manager agreed that the contracting officers for the three contracts should have documented the contract price negotiations and prepared PNMs. The A&MS manager stated that he would ensure that PNMs are prepared and documented in the contract file.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires A&MS staff to prepare PNMs for all noncompetitive contracts.

The VISN and VAMC Directors agreed with the findings and suggestions, and the VISN Director concurred with the VAMC Director's corrective action plan. The VAMC Director provided acceptable improvement plans.

Appendix A

VISN 16 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 14, 2003

From: Network Director (10N16), South Central VA Health Care Network (VISN 16)

Subj: OIG Combined Assessment Program Review (CAP), VA Medical Center, Alexandria, LA, (Project No. 2002-01985-R3-0114), Facility Responses to Recommendations

To: Office of Inspector General (53B)
Thru: Management Review and Administration (105E)

1. The South Central VA Health Care Network (VISN 16) has reviewed the response from the VA Medical Center, Alexandria, Louisiana, regarding the subject CAP report.

2. An electronic copy of the response is being forwarded for your review.

3. The South Central VA Health Care Network (VISN 16) concurs with the facility's response to the OIG recommendations.

4. Regarding the Medical Center's statement in the section "*Automated Information Systems – Security Needs Improvement, Recommendation F., Computer back-up tapes are stored in a secure off-site location"*, the South Central VA Health Care Network (VISN 16) concurs with the statement "The Medical Center does not concur with the OIG finding and recommendations". The Network's concurrence with the Medical Center's non-concurrence is pending clarification of "Off-site" versus "Off-Station" by the Office of Cyber Security (OCS).

5. Please refer to the attached memorandum from the Network's acting Chief Information Officer' inquiry to the OCS seeking clarification on this issue.

5. VISN 16 staff will be researching the possibility of a VISN-wide contract to provide secure pickup and transportation to off-site secure storage locations for all of our medical centers. Execution of this contract will render the recommendation moot.

Signed by Albert Archie, Executive Assistant to the Network Director, on behalf of Robert Lynch, M.D.

Attachment

Appendix A

Date: February 7, 2003

From: Associate VISN 16 CIO (Acting VISN 16 CIO)

Subj: Alexandria's Response to Recommendations by OIG CAP

To: Network Director

Specific recommendation considered: Computer back-up tapes are stored in a secure off-site location.

Facility response: The Medical Center does not concur with this OIG finding and recommendation. The backup tapes have been relocated to a more secure site on the second floor of Building 6, which is approximately 675 feet from the Computer Room in Building 7. This building has extremely thick walls and is used as a civil defense shelter. The tapes are on the second floor (no danger of flood) in a secure room, inside a large heavy steel, fireproof vault type safe. No catastrophe occurring in the building and location of the computer system would have any effect on this separate building across our campus (this includes natural disasters and fire, flood, explosion, etc.) Storage of backup tapes in another location in the city could delay their retrieval or make them inaccessible in cases where roads are flooded or otherwise restricted.

In an effort to determine the accepted definition of off-site storage within the Department of Veteran Affairs, the Acting VISN 16 CIO consulted the VA Office of Cyber Security (OCS), recognized as the departments Information Security leadership. The following *guidance* was provided by, the Chief, Program Management Division of OCS.

Current VA Handbook 6210, Chapter 1 states the following:

It is important to store, in a secure environment, up-to-date copies, including one in electronic format, of the contingency plan in several locations, including any **off-site locations, such as alternate processing sites or backup data storage facilities**.

Current VHA Directive 6210 states the following:

At a minimum, essential data must be backed-up and stored in a location physically separate from the AIS. Appropriate physical and environmental controls must be in place to ensure viability of such back-ups. **NOTE: The actual location of backed-up data must be determined by analysis of local risk.**

A "draft" of VA Handbook 6210 that is currently under review states:

Requirements for Critical Information Systems
Off-site storage of backup media is required for critical information systems.

Appendix A

NIST Special Publication 800-34, Contingency Planning Guide for Information Technology Systems under the FAQ Section has the following:

What is the standard distance an alternate site or offsite storage location should be from my primary site?

The distance between an alternate site or offsite storage facility from the primary site should be determined by the scope of the potential threat being considered rather than a specific distance. The Contingency Planning Coordinator should use the risk assessment to determine what geographic area, accessibility requirements, security requirements, environmental conditions, and cost factors are necessary for selecting a safe and practical offsite facility.

[The Chief] **also checked some other CISSP reference books, NIST self-assessment, and OIG recommendations and they do not specify exact criteria for off-site locations. [*Also found]* these two definitions:**

OFF-SITE STORAGE:
Alternate facility, other than the primary production site, where duplicated vital records and documentation may be stored for use during disaster recovery. (Disaster Recovery Journal - Glossary)

Offsite Storage:
Data (or whatever) stored offsite (somewhere outside the normal computer center) must have a level of security and control at least as good as the computer center has. Extremely tight security in the computer center does little good if backup copies of the same data and information are unsupervised in a warehouse without adequate fire or access control. The same considerations apply while media are being transported. (CISSP Training Guide, Roberta Bragg, Author)

Based on the guidance provided by OCS, it appears that the Alexandria has made an effort to secure their critical data backups in a location that is secured, structurally sound and at an acceptable distance from the primary processing site. I recommend we accept their provisions for now.

However, as a result of discussions by the VISN 16 IT Chiefs and VistA Systems Managers during a February 2003 meeting in Little Rock Arkansas, VISN 16 staff will be researching the possibility of a VISN-wide contract to provide secure pickup and transportation to off-site storage locations for all of our medical centers. It is hoped we can utilize the PCHS-II contract vehicle to provide this service throughout VISN 16. Presently the Houston facility is utilizing this option with great success.

Charles Gephart, ACIO V16

Appendix B

Medical Center Director Comments

OIG Combined Assessment Program Review (CAP)
VA Medical Center, Alexandria LA
(Project No. 2002-01985-R3-0114)

Facility Response to Recommendations

Peer Reviews – Primary Care Service Should Improve Their Process
Recommended Improvement Action 1.
(OIG Draft 11/19/02 – Page 5)

A. Complete and return to the Office of Quality Management (QM) within 30 days of receipt.

The Alexandria VAMC concurs with the OIG findings and recommendations.

1. Following the CAP review, the ACOS/Ambulatory Care personally addressed 20 completed Peer Reviews from Primary Care (PC) with individual practitioners, and forwarded to the QM Office. Pending PC peer reviews for 2001 and 2002, were completed and addressed with practitioners by the ACOS / Ambulatory Care. **Completed: September 13, 2002**

2. A list of overdue peer reviews is provided monthly to all services and the COS, by the QM Office. The COS tracks these overdue peer reviews and takes action to ensure they are completed as soon as possible. The COS reports general information regarding the peer review process to the Executive Committee of the Medical Staff. **Initiated January 2002**

3. Primary Care Administration has changed with the appointment of an Acting Chief, PC, replacing the former ACOS/AC. He is a senior physician with both clinical and management experience, who is also an active practitioner. This change has resulted in more timely completion of reviews, and discussion with practitioners. The Acting Chief, PC is an active peer reviewer as well. **Completed: September 16, 2002**

4. The (internal) peer review process for PC has been revised. Peer review assignments are rotated among practitioners with timeframes for completion and return to the Chief, PC within 14 days. The Administrative Officer for PC tracks open peer reviews closely and provides reminders to practitioners as completion deadlines approach. The Chief, PC is informed of peer reviews that are not completed within the 14-day (for PC) deadline and takes action to ensure these reviews are completed as soon as possible. The Acting Chief, PC personally supports the process, examines peer reviews from a clinical and management perspective, and addresses the findings with individual practitioners. Practitioners who disagree with the final outcome are now obligated to provide rationale for their disagreement including literature sources. Once discussed with practitioners and their response made, a copy is placed in the provider file maintained in the service. The review is forwarded to the COS, then to the QM Office. This process is designed to insure completion and return to the QM Office within 30 days of receipt. This process will strengthen the improvements made following the CAP review, and complete all previously over due peer reviews. **Target Date: December 20, 2002**

5. Peer Review findings, redacted to protect patient and practitioner identity, will be discussed in the Primary Care Physician staff meeting, currently held on the 4th Thursday, and reflected in

minutes. This will include systems problems, recommendations to resolve these issues and, recommendations for improved care and outcomes for similar patients. **Target Date: January 27, 2003**.

B. Develop and document appropriate corrective actions for Level 2 and 3 findings.

1. See A.5 above

2. The practioner with the high rate of peer review referrals and Level 2 findings met with a panel of physicians who discussed practice issues with him. The services of this Fee Basis physician are no longer utilized and his VetPro file has been marked "inactive" (the practitioner's status as a Fee Basis physician has been terminated) as of 11/1/02. **Completed: November 1, 2002**

3. A service and practice specific provider profile is under development, which will record quarterly outcomes of clinical and educational activities. This profile will remain in the service provider-specific folder, and will be evaluated during annual proficiency reports, considered as a part of reprivileging decisions, and made available to the Privileging Committee for review at the time of reprivileging. Minimum parameters, unless not a part of the practitioner's privileges, include:

a. Workload data
b. Medical Record Reviews
c. Drug Usage Review
d. Peer Review Outcomes
e. Malpractice / Tort Claim / NPDB issues
f. Surgical / Invasive / Non-Invasive Procedures reports
g. Blood Usage Reviews
h. Continuing Medical Education and Mandatory Training
i. Performance Measures

Target Date: January 2, 2003

4. Issues associated with trends (i.e., the number of cases referred for peer review divided by the number of level 2 and 3 findings) in performance by individual practitioners are currently referred to Service Chiefs / HCL Directors, and the COS. Sources include congressionals, patient complaints, information from clinical reviews, and other sources. The COS addressed Level 3 findings with an individual practitioner; altered physician assignments; restructured MOD coverage; and, arranged for external reviews of critical incidents in response to these issues. **Completed: July 1, 2002**

C. Consider Peer Review Data in Reprivileging Decisions

1. See B (3) and (4) above.

2. Actual data from peer reviews, maintained in individual provider folders in services, will be made available to the Privileging Committee at the time of reprivileging and validates reprivileging decisions. In addition, a quarterly and annual review of the practitioner profile and a summary will permit Service Chiefs / HCL Directors and practitioners to review and correct trends in performance well in advance of the reprivileging cycle. This profile will be provided to the Privileging Committee. **Target Date: January 15, 2003**

Appendix B

Homemaker/Home Health Aide Program – Clinical and Administrative Procedures Should Be Improved
Recommended Improvement Action 2. (OIG Draft 11/19/02 – Page 7)

A. Complete interdisciplinary patient assessments are documented on all patients referred to H/HHA Program

The Medical Center concurs with the OIG findings and recommendations.

The patients in the H/HHA program have been re-evaluated by the primary care teams and all areas of the initial interdisciplinary assessment forms have been completed. **Completed: November 20, 2002**

B. Patients receiving H/HHA Program services meet clinical eligibility requirements.

All H/HHA program participants were re-evaluated. Missing documentation was provided and all program participants meet VHA requirements for eligibility. **Completed: November 20, 2002**

C. The H/HHA Program Coordinator complies with program policy on clinical and administrative oversight.

All H/HHA program participants were re-evaluated. Missing documentation was provided and all program participants meet VHA requirements for eligibility. The program coordinator is now collecting agency data regarding Community Health Agency (CHA) supervisory and performance improvement activities and developing a medical center performance improvement monitor. The interdisciplinary team will meet semi-annually to discuss operational issues and quality of H/HHA services provided by CHA's.
February 1, 2003

D. Contracting officer consider the prevalent state Medicaid rates when contracting for H/HHA Program services.

The Louisiana Medicaid H/HHA reimbursement rates were considered during the negotiating process for these services. The new contract (effective October 1, 2002), rate for the HHA component of the program is $3.38 an hour below the state Medicaid rate of $24.38. However, a contract for Homemaker Services could not be negotiated at the Medicaid reimbursement rate. VHA Directive 96-031, Purchase of Homemaker/Home Health Aid Services, dated April 16,1996, item 9 titled *Fiscal Cap on Cost of Services* states, "the cost of H/HHA services on a per patient basis will not exceed 65% of the average per diem cost of VA NHCUs." The NHCU rate at this VAMC is approximately $170 per day per patient, 65% of this is $110.50 per day. The Medical Center's current negotiated costs for H/HHA services are well below this VA directed cap. In addition, the facility is pursuing the possibility of renegotiating our existing contract for Homemaker services to be more in line with the State of Louisiana's Medicaid rate of $10.00 per hour.
April 1, 2003

Root Cause Analysis – The Process Should Be Strengthened
Recommended Improvement Action 3.
(OIG Draft 11/19/02 – Page 8)

A. The RCA team's recommended corrective actions are measurable and the effectiveness is evaluated.

The Medical Center concurs with the OIG findings and recommendations.

The National Center for Patient Safety (NCPS) provides ongoing critiques of RCA's completed by all VA facilities and provides feed back on corrective actions if not written in measurable terms. Outcomes of recommended actions are evaluated and stated in terms of the intent. Copies of evidence demonstrating evaluation of outcomes (i.e. policies; reduction in falls; installation of lights, etc.) are maintained in the QM Office. **Completed: July 15,2002**

B. QM managers develop a procedure for implementing and tracking corrective actions until issues are resolved.

A database is being developed to allow for easy tracking of pending action items. The VISN 16 Patient Safety Manager will utilize VHA software (SPOT) to track RCA corrective actions. The software has been installed and training is under way. **Target Date: January 1, 2003**

Delinquent action items are reported to the responsible employee requesting a status report. A copy of this status report request is sent to the employee's supervisor. Once action items become delinquent 30 days, they are referred to the Medical Center Director for corrective action. **Completed: December 2, 2002**

Patient Safety – An Electronic Surveillance System Is Needed on WARD 45A
Recommended Improvement Action 4.
(OIG Draft 11/19/02 – Page 9)

Ensure that the Medical Center Director has an electronic surveillance system installed at the main doors of Ward 45A to safely contain patients that are at high-risk for wandering or elopement. The Medical Center concurs with the OIG findings and recommendations.
A meeting with potential vendors for installation of a patient wandering system was held. The Medical Center received two vendor proposals for installation. The Medical Center estimates a cost of $8,000 to purchase this system and an installation date of April 2003. **Target Date: April 2003**

Automated Information Systems – Security Needs Improvement
Recommended Improvement Action 5.
(OIG Draft 11/19/02 – Page 11)

A. A qualified Individual is assigned as the ISO.
The Medical Center concurs with the OIG findings and recommendations.
A new full-time ISO has been appointed. This person was formally the Chief of IRM and has technical knowledge of information security issues. He has been organizationally aligned to report directly to the Medical Center Director and is not part of the Information Management Healthcare Line and does not report to the CIO. **Completed: August 2002.**

B. The ISO is properly trained to conduct information security duties.
A recognized ISO expert conducted a site visit of the Alexandria VAMC ISO Program in September 2002. On the job training was conducted for our new ISO at this time. Formal training for the ISO will be accomplished during a VISN training session to be performed later this fiscal year in Dallas, TX. **Target Date: January or February 2003.**

C. The ISO reports to the Director or Associate Director.
The new ISO reports to the Medical Center Director. **Completed: August 2002.**

D. AIS contingency plans are comprehensive and contain required elements.
All AIS Contingency Plans are being revised to identify mission critical functions, identify roles key personnel would play in the disaster recovery process, prioritize specific tasks to be completed in a disaster recovery process and identify a storage site for critical back-up files and copies of AIS contingency plans. **Target Date: February 7, 2003.**

E. An official is designated to certify that sensitive data has been cleared from equipment with storage media before disposal.

The Medical Center implemented a new policy, which clearly defines the process for cleaning and certifying that all information has been removed from IT equipment before disposal/surplus. VHA and VISN prescribed software and procedures are utilized and both the IRM staff member cleaning the equipment and the ISO must both sign a certification that the proper procedures and processes have been completed and the equipment is ready for disposal. The equipment must have the certification attached to it before the VAMC Property Officer will allow it to be removed.
Completed: July 14, 2002

F. Computer back-up tapes are stored in a secure off-site location.
The Medical Center does not concur with this OIG finding and recommendation.
The backup tapes have been relocated to a more secure site on the second floor of Building 6, which is approximately 675 feet from the Computer Room in Building 7. This building has extremely thick walls and is used as a civil defense shelter. The tapes are on the second floor (no danger of flood) in a secure room, inside a large heavy steel, fireproof vault type safe. No catastrophe occuring in the building and location of the computer system would have any effect on this separate building across our campus (this includes natural disasters and fire, flood, explosion, etc.) Storage of backup tapes in another location in the city could delay their retrieval or make them inaccessible in cases where roads are flooded or otherwise restricted. **Completed: December 12, 2002**

G. Policies are developed to address termination of system access for disgruntled employees and employees subject to RIF.
The Medical Center has instituted a policy to insure that any employee that is deemed to be a possible threat (not merely disgruntled) to the security of the Medical Center's information, or the infrastructure/system that contains that information, will immediately have his/her access to the system revoked. Any employee that is terminated, voluntarily or involuntarily, will immediately have their access revoked upon their termination. **Completed: December 6, 2002**

H. A remote LAN access policy is implemented.
The Medical Center has drafted a written policy for granting remote access to the LAN, which requires justification and documentation of remote LAN access, quarterly reviews of the continued need for remote access, and documentation by the CIO to identify equipment and software signed out to employees with remote access. This policy requires requests for remote access to be approved by both the ISO and CIO. **Target Date: February 1, 2003**

Supply Inventory Management – Inventory Controls Need Improvement
Recommended Improvement Action 6.
(OIG Draft 11/19/02 – Page 12)

Ensure that the Medical Center Director requires that GIP be fully implemented for all inventory points and stock levels should be reduced to a 30-day supply, where appropriate.

Appendix B

The Medical Center concurs with the OIG findings and recommendations.
The Medical Center is developing a plan to fully implement GIP for all inventory points. **Target Date: July 30, 2003**

Guardianship Status – Improved Electronic Medical Record Documentation Is Needed
Suggested Improvement Action.
(OIG Draft 11/19/02 – Page 12)

Ensure that the Medical Center Director requires patient's legal guardianship status to be noticeably posted in the electronic medical record.

The Medical Center concurs with the OIG findings and recommendations.
To correct this situation, the Clinical Applications Coordinator, will develop a clinical warning for the guardianship status so that it will be easily identifiable in the patient record and also enable clinicians to pull up a list of all patients for which a legal guardian has been established. **Target Date: March 1, 2003**

Prosthetics Storage – Monthly Inventories of VA Equipment Stored at a Local Contractor's Warehouses Would Improve Accountability
Suggested Improvement Action.
(OIG Draft 11/19/02 – Page 13)

Ensure that the Medical Center Director requires that DME items stored in the contractor's warehouses are inventoried monthly by PSAS staff, and the results reconciled against PSAS records.

The Medical Center concurs with the OIG findings and recommendations.

DME items stored in contractor's warehouses will be inventoried monthly beginning December 2002. **Completed: December 31, 2002.**

Unusable and Expired Controlled Substances – Disposition of Controlled Substances Should Be Improved
Suggested Improvement Action.
(OIG Draft 11/19/02 – Page 13)

Ensure that the Medical Center Director requires that an inspecting official witness and document the exchange of custody of unusable and expired controlled substances scheduled for destruction.

The Medical Center concurs with the OIG findings and recommendations.

To comply with Federal Property Management Regulations and VHA Handbook 1108.1, a member of the narcotics inspection team will witness the exchange of custody and destruction of unusable and expired controlled substances along with a representative from Acquisition and Material Management Service and Pharmacy Service. **Completed: December 6, 2002.**

Appendix B

Controlled Substances Oversight – Administration of the Inspection Program Should Be Strengthened
Suggested Improvement Action.
(OIG Draft 11/19/02 – Page 14)

Ensure that the Medical Center Director requires that all unusable and expired controlled substances are included in monthly inspections.

The Medical Center concurs with the OIG findings and recommendations.
The Narcotics Inspection Team has added the inventory of all unusable and expired controlled substances to the monthly inventory. **Completed: July 2, 2002.**

Noncompetitive Contracts – Contract Price Negotiations Should Be Documented
Suggested Improvement Action.
(OIG Draft 11/19/02 – Page 14)

Ensure that the Medical Center Director requires A&MS staff prepare PNMs for all noncompetitive contracts.

The Medical Center concurs with the OIG findings and recommendations.

Corrective action has been taken to include Price Negotiations Memorandums in the contract file. A semi-annual internal audit is performed to ensure compliance with applicable acquisition directives/regulations. Completed: August 10, 2002.

Appendix C

Report Distribution

VA Distribution

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Appendix C

Non-VA Distribution (Continued)

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This report will be available in the near future on the VA Office of Audit web site at http://www.va.gov/oig/52/reports/mainlist.htm. *List of Available Reports.* This report will remain on the OIG web site for 2 fiscal years after it is issued.